

Policy on the use of Physical Holding Skills

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Version Control Summary

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1.0	May 2002.	Chris Tyson & Denis Doherty	First Draft	
2.0	July 2002	Chris Tyson & Denis Doherty	Final	
3.0	April 2005	Chris Tyson & Denis Doherty	Final	<p>Inclusion of full debriefing information as highlighted within the NICE guidance (2005)</p> <p>Critical incident analysis and debriefing highlighted</p> <p>Consideration to the restraint of pregnant women, older adults, race and age awareness added to policy</p>
4.0	September 2013	Denis Doherty Richard Lilley Kenneth Muzongondi	Final	<p>Policy Title Change: Terminology changes: Restraint Skills changed to Holding Skills Breakaway Skills Changed to Disengagement Skills More current national guidance has been referenced: BILD Code of Practice for use and reduction of restrictive physical interventions - BILD (2010) Staff not refreshing for 24 months will be required to repeat the initial Holding skills course again. Guidance on the use of face down (prone) restraint added</p>
5.0	December 2015	Denis Doherty Richard Lilley Kenneth Muzongondi	Final	<p>Update in view of: DOH Positive and Proactive Care: Reducing the need for restrictive interventions (DOH 2014)</p> <p>NICE (2015) NG10 guidelines: Violence and aggression: short term management in mental health, health and community settings,</p> <p>Code of Practice for use and reduction of restrictive physical interventions - BILD (2010) Mental Capacity Act (2005).</p> <p>Update in relation to physical health check during and after restraint Update of Governance Structures</p>
6.0	February 2016	Denis Doherty Kenneth Muzongondi	FINAL	

		Denis Ncube		
7.0	July 2018	Denis Doherty Kenneth Muzongondi	Final	<p>Opt Out Sequence, warning signs of physical difficulties by service user and corrective actions by staff list</p> <p>COPING debriefing Model has been added.</p> <p>These additions are to ensure safe, proportionate and supportive application of restrictive interventions as supported by NICE (2015).</p> <p>Included the Datix reporting section.</p>
8.0	April 2022	Kenneth Muzongondi Graham Adkins		<p>Name change from MAPA to Safety Intervention</p> <p>Restraints on beds,</p> <p>Restraint of female service users</p> <p>Use of Force Act 2018</p> <p>Rapid Tranquilisation monitoring</p> <p>Use of physical holding skills for taking bloods</p> <p>Reference to Restraint Reduction Network</p> <p>Clarification on NICE guideline “10 minute prolonged restraint” guideline</p>
8.1	September 2022	Kenneth Muzongondi		Minor update to include reference to the Use of Force Act
8.2	August 2024	Kenneth Muzongondi		Change of refresher period cut off point from 24 to 14 months

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Glossary

Initials	
BILD	The British Institute of Learning Disability
CAMHS	Child and Adolescent Mental Health Services Disengagement
Skills	A wide variety of physical skills that are employed by Individual members of staff in order to escape physical attack and create distance between themselves and the aggressor. Previously referred to as Breakaway Skills.
DOH	Department of Health
DSN	Duty Senior Nurse
Holding Skills	A wide range of physical skills that are employed by a minimum of two members of staff for managing service users when they present a risk to themselves or others. Previously referred to as Control and Restraint Skills.
MAPA/Safety Intervention	Management of Actual or Potential Aggression. The system of holding and disengagement skills that the Trust adopted in 1999.
MHA	Mental Health Act
MHCOP	Mental Health Care of Older People
NICE	National Institute of Clinical Excellence
NMC	Nursing and Midwifery Council,
PICU	Psychiatric Intensive Care Unit
RCN	Royal College of Nursing
Seclusion	the supervised confinement and isolation of a patient, away from other patients in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbances which is likely to cause harm to others.(MHA Code of Practice).

1.0 Introduction

- 1.1 East London Foundation NHS Trust (ELFT) is committed to delivering the highest standards of health, safety and welfare to service users, visitors, and staff. The following guidance sets out the standards of the Policy and gives advice on the appropriate use of physical interventions. The prevention of harm is of paramount importance.
- 1.2 The policy has been developed following national guidance including:
- DOH Positive and Proactive Care: Reducing the need for restrictive interventions (DOH 2014)
 - NICE (2015) NG10 guidelines: Violence and aggression: short term management in mental health, health and community settings,
 - Code of Practice for use and reduction of restrictive physical interventions - BILD (2010)
 - Mental Capacity Act (2005).
 - the recommendations of the Independent Inquiry into the Death of David Bennett – (2004)
 - The Human Rights Act
 - Age Awareness guidance.
 - The Mental Health Units (Use of Force) Act 2018 ('the Act')
- 1.3 The Use of Force Act 2018 was enacted in 2018 following the death of Olaseni Lewis, who was restrained by 11 police officers in a mental health unit in 2010. The Act outlines various staff responsibilities in the use of force and sets out specific reporting and training requirements, Staff must comply with the Act when applying physical holding interventions as this is defined as a use of force. Further reviews of this policy must take into account and reference the Use of Force Act and policy.
- 1.4 **Any placing of hands on a service user with the intention of stopping or restricting free movement** (other than what would be considered 'negligible') **constitutes the use of force.** See the section on 'Reporting' for a full definition of the negligible use of force. Any use of force must be reasonable and justified and should only be used as a last resort.
- 1.5 The guiding principal is to care for services users in the least restrictive way therefore prior to a decision to use physical interventions, all efforts must have been considered to defuse the situation.
- 1.6 Staff should only use physical holding skills as a last resort if de-escalation and other preventive strategies, including p.r.n. medication, have failed and there is potential for harm to the service user or other people if no action is taken. Continue to attempt de-escalation throughout the restrictive intervention
- 1.7 The Trust recognises that violent and aggressive behaviour can escalate to the point where physical holding skill may be needed to protect the person, staff or other legitimate users of Trust premises and facilities from significant injury or harm, even if all best-practice to prevent such escalation is deployed.
- 1.8 The objective of any holding is to maintain the safety of the person being restrained and staff present whilst establishing an appropriate degree of control (of the aggressive or violent behaviour).
- 1.9 The Trust also recognises that in making judgements to use restraint a person's mental capacity should be taken into account.

- 1.10 Any use of restraint involves increased risk to the service user and no period of time spent in restraint (especially prone restraint) is inherently safe. The risk increases when used together with sedative medication and in particular in the context of a significant or prolonged struggle. The use of prone restraint in particular has been seen as an important contributory factor in several deaths in police custody and in the NHS over several decades. Although the Trust has taken a decision not to ban the use of prone restraint, staff are encouraged to avoid its use as much as possible. If exceptionally a service user is restrained unintentionally in a prone or face down position, staff should reposition into a safer alternative as soon as possible.
- 1.11 All service users should be treated with respect and dignity at all times and be treated fairly, regardless of their diagnosis or presentation, age, sex, gender identity, sexual orientation, disability, culture, ethnicity or religious/spiritual beliefs. Staff are encouraged to challenge any use of restraint or other restrictive practice that is unsafe, or is not used as a last resort and could be perceived as punitive or discriminatory.
- 1.12 Positive and Proactive Care (DoH, 2014) sets out recommendations for services to avoid and reduce the use of restraint and other restrictive interventions. This Trust has pledged to reduce the use of restrictive practices across its services.
- 1.13 Not all eventualities can be covered within this document and staff will need to exercise initiative and professional judgement when restraint is considered. This policy should therefore be read in conjunction with:
- Mental Health Units Use of Force Policy
 - Incident Policy;
 - Long Term Segregation policy;
 - Seclusion Policy;
 - Management of Medicines Policy
 - Rapid Tranquillisation Policy;
 - Resuscitation Policy;
 - Handcuff Protocol – Forensic directorate;
 - Manual handling policy.
 - Search policy

2.0 Executive summary

- 2.1 This policy sets out the interventions which may be used to manage an individual whose behaviour may be injurious to self or others and with whom non-physical intervention, for example, communication, de-escalation and problem solving skills have been unsuccessful
- 2.2 All staff using physical holding skills with service users in Acute/Forensic/CAHMS services MUST have attended the Trust's recognised, five day, Safety Intervention course and those in Mental Health Care for Older People (MHCOP) services MUST have attended the three-day MAPA/Safety Intervention course.
- 2.3 Physical interventions must only be used as a last resort to minimise the risk and protect the safety of service users, visitors and staff.
- 2.4 Staff should have a robust knowledge of de-escalation techniques and have the ability to use these whenever possible.
- 2.5 All staff must be aware that all forms of physical holds come with risks to service users but prone (face down) has a high risk of positional asphyxia. Therefore they should be

aware of the physical observations that are to be applied during and after the use of physical interventions.

- 2.6 There should be no planned floor prone restraint of any service user. If staff and the service users end up in prone restraint they should consider disengaging or repositioning if safe to do so.
- 2.7 Staff should recognise the impact that the use of physical interventions have on the service user being held, the other service users present, staff and visitors.
- 2.8 Special consideration should be given to the use of physical interventions with:
- Older Adults;
 - Children and Adolescents;
 - Service user with an identified physical health conditions;
 - 'Service users with learning disabilities or autism' and 'service users who may find being held by others particularly distressing'.- Trauma informed care
 - Pregnant women.
- 2.9 A debriefing should be conducted and documented after each incident requiring physical interventions and support should be offered to all parties involved.

3.0 Definition of restrictive interventions (Mental Health Act Code of Practice 2015)

- 3.1 Physical Holding skills are considered a restrictive intervention.
- 3.2 Physical Holding or physical restraint is considered the 'use of force' as defined by the Use of Force Act.
- 3.3 'Physical restraint' is the use of physical contact that is intended to prevent, restrict or subdue movement of any part of the patient's body. This would include holding a patient to give them a depot injection.
- 3.4 'Mechanical restraint' is the use of a device which is intended to prevent, restrict or subdue movement of any part of a patient's body and which has the primary purpose of behavioural control, e.g. handcuffs.
- 3.5 'Chemical restraint' is the use of medication which is intended to prevent, restrict or subdue movement of any part of a patient's body. Please refer to the Trust's Rapid Tranquilisation Policy.
- 3.6 Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient'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 service user or others.
- 3.7 Restrictive interventions should NOT be used to gain compliance, punish or for the sole intention of inflicting pain, suffering or humiliation.
- 3.8 Where a person restricts a service user's movement then the force used should:
- Be used for no longer than necessary to prevent harm to the person or to others;

- Be a proportionate response to that harm; and
- Be the least restrictive option.

3.9 The most common reasons for needing to consider the use of restrictive interventions are:

- To prevent or respond to physical assault by the service user;
- Dangerous, threatening or destructive behavior;
- Self-harm or risk of physical injury by accident;
- Extreme and prolonged over-activity that is likely to lead to physical exhaustion; or
- Attempts to escape or abscond (where the service user is detained under the MHAA or deprived of their liberty under the MCA).

4.0 Physical Holding Skills

4.1 Physical restraint refers to any direct physical contact where the intention is to restrict, or subdue movement of the body (or part of the body) of another person.

4.2 The trust will develop co-produced information for patients and carers about the use of force/physical holding interventions. This should be accessible at the point of care. Staff will take reasonable practicable steps to ensure that the service users, patient and/or carer is aware of the information and understands it

4.3 Service Users should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure to the neck region, rib cage and/or abdomen. Unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor.

4.4 Full account should be taken of the individual's age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment, which may confer additional risks to the individual's health, safety and wellbeing in the face of exposure to physical restraint. Throughout any period of physical restraint:

4.5 A member of staff should monitor the individual's airway and physical condition to minimise the potential of harm or injury. Observations, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/disco-colouration), should be conducted and recorded. Staff should be trained so that they are competent to interpret these vital signs. For this reason, a senior member of staff should be part of the team.

4.6 If there is an indication that the service user's physical wellbeing is compromised, follow the Opt Out sequence. In serious situations, the term "MEDICAL EMERGENCY" should be used as prompt and staff should stop the restraint immediately.

4.7 Emergency resuscitation devices should be readily available in the area where restraint is taking place, and a member of staff should take the lead in caring for other patients and moving them away from the area of disturbance.

4.8 Physical restraint may, on occasion, need to be used to administer rapid tranquillisation by intramuscular injection to an unwilling service user, where they may lawfully be treated without consent. It must not be used unless there is such legal authority, whether

under the MHA, the MCA or otherwise. Rapid tranquillisation must not be used to treat an informal patient who has the capacity to refuse treatment and who has done so.

- 4.9 The use of physical restraint to administer psychotropic medication in non-emergency situations should be avoided wherever possible and as a general rule should only take place following a full multidisciplinary discussion, including the Responsible Clinician and Matron and, if necessary, senior management, taking into consideration the service user's human rights. Enforcing treatment in this way may sometimes be justified, especially if mental health deterioration and an emergency situation would be likely to occur if the treatment is not given - but it should never be seen as routine and something to be done just because a doctor has prescribed it. Any decision to enforce treatment using physical restraint must be documented in the service user's notes, summarising who took part in the MDT discussion and a clear rationale for the decision. Advocacy should always be offered to service users in such circumstances.
- 4.10 Following the administration of rapid tranquillisation, the service user's condition and progress should be closely monitored. Subsequent records should indicate the reason for the use of rapid tranquillisation and provide a full account of both its efficacy and any adverse effects observed or reported by the service user. Please follow the Rapid tranquillisation monitoring guidance
- 4.11 Rapid tranquillisation should never be used to manage patients as a substitute for adequate staffing.

5.0 Face down/Prone Restraint

- 5.1 Prone (face down) physical holding should be avoided in the management of all service users. If the team slips or get pushed to the floor, the team should consider disengaging or support the service user to get up if deemed safe to do so. (Opt out sequence covered in MAPA/SI Training)
- 5.2 Physical holding of service users on the floor should be avoided. If, however, the floor is used then this should be for the shortest period of time and only for the purpose of gaining reasonable control.
- 5.3 Physical holding of service users on beds or mattresses in seclusion should be avoided especially during descents to the floor as this increases the risk of injuries due to raised ends, being fixed to the wall and bedrooms being less spacious areas as well as uncontrolled movements due to height. Also beds are may not designed to sustain more people's body weight.
- 5.4 If a service user is physically held on the floor a doctor should be requested to carry out a physical health check of the service user as soon as reasonably possible.

6.0 Monitoring Vital Signs

- 6.1 All staff who may be involved in the physical holding process must be trained in:
- Basic life support (and have attended an annual update);
 - Care and management of physical risks associated with holding skills, ie., positional asphyxia and compartment syndrome;
 - Use of emergency equipment;

- Knowing how to summon appropriate assistance.
- 6.2 In all wards/units where the use of holding skills is foreseeable there should be access to basic life support equipment, which is regularly checked (in accordance with Trust policy) and maintained in working condition.
- 6.3 In all wards/ units where the use of holding skills is foreseeable and where urgent medical assistance may be required, there should be systems in place to ensure immediate access to medical/paramedical assistance via the on-call duty doctor, cardio pulmonary resuscitation teams, or paramedical services.
- 6.4 In all circumstances where there has been a restraint (unless the restraint is considered 'negligible' as defined by the Use of Force Act) the service user must be reviewed by a doctor at the earliest opportunity. This is especially required if there has been a prolonged struggle, fall, descend to the floor and/or holding on the floor.
- 6.5 The medical assessment should be recorded in the service user's notes. Any injuries must be reported through DATIX incident reporting and documented in the notes.
- 6.6 Any person to whom holding skills have been applied should be physically monitored continuously during the intervention and at least once in the 1 hour post incident. This check should include:
- Care in the recovery position where appropriate;
 - Pulse (though use of pulse oximeter);
 - Blood pressure;
 - Respiration;
 - Temperature;
 - Complexion (pallor and discoloration);
 - Respiration slows below 10/ minutes, the restraint must be ceased;
 - Under no circumstances must any undue pressure be placed onto the person the person's abdomen, neck or thorax (because this can cause increased agitation and/or cardio respiratory collapse).
- 6.7 The physical checks post holding skills should be recorded on the service user's physical observation chart and fluid balance chart.
- 6.8 If consent and co-operation for these observations is not forthcoming from the person subject to the process, then this should be clearly documented in their records why checks could not be performed and what alternative actions have been taken. (Follow Rapid tranquilisation monitoring guidance).
- 6.9 'Contact' and 'non-contact' physical observations
Staff are encouraged to use the terms 'contact' and 'non-contact' physical observations (vital signs monitoring) with regard to the physical health monitoring of service users generally. The rationale for adopting these terms is to ensure that some form of physical health monitoring takes place at all times. It is never acceptable for no physical health monitoring of any kind to take place simply because the service user is refusing to engage or co-operate.

'Non-contact' physical observations do not rely on the consent or co-operation of the service user and describe the minimum physical health monitoring that must take place for all service users following any use of force: respiration rate (breathing) per minute, and level of consciousness using ACVPU (Alert/new Confusion/responsive to Voice/responsive to Pain/Unconscious).

'Contact' physical observations generally rely on the consent and co-operation of the service user and necessitate a level of contact or proximity between staff and service user (although technology is producing methods of making physical observations and monitoring become non-contact via remote monitoring): blood pressure, temperature, pulse, and oxygen saturation are considered 'contact' physical observations.

As a minimum, a set of non-contact physical observations must always take place.

6.10 Physical monitoring is especially important:

- Following a prolonged or violent struggle;
- If the service user has been subject to enforced medication or rapid tranquilisation;
- If the service user is suspected to be under the influence of alcohol or illicit substances;
- If the service user has a known physical condition which may inhibit cardio-pulmonary function e.g. asthma, obesity, and pregnancy (when lying in prone position or a position conducive to limiting respiratory functioning).

6.11 The Trust MAPA/SI 5 day and 2 day training programmes include these options when caring for an individual in the prone position:

- Supported prone position (to enhance air flow);
- Ceasing to hold the service user, thus allowing them move to a more comfortable position;
- Supporting the service user to a kneeling/ standing position;
- Supporting the individual to be turned over onto their back (supine position) if application of holds is still necessary.

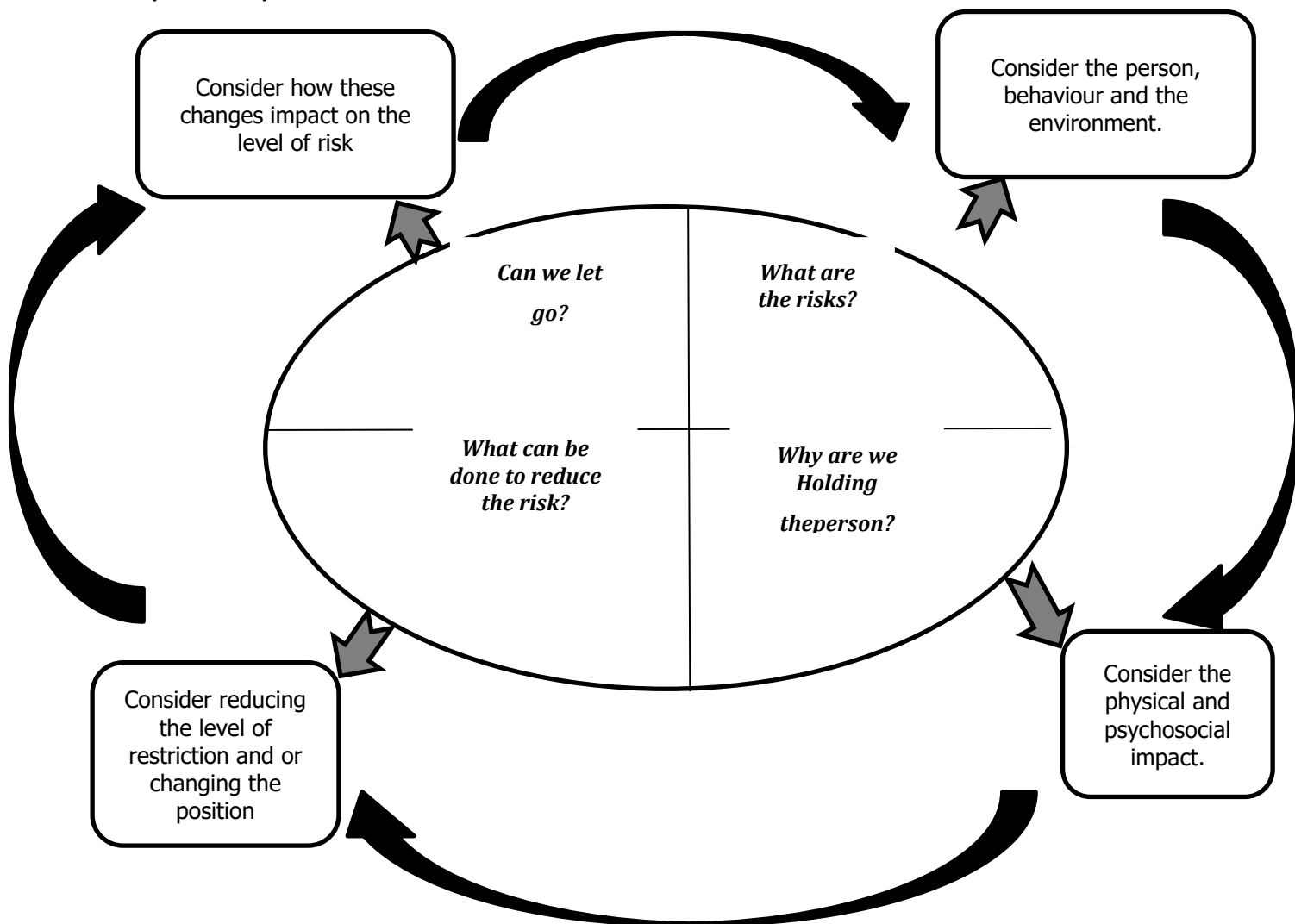
6.12 If intra-muscular medication is to be administered, the alternate to maintaining a prone position is that of a side-lying position. This would involve a measured controlled roll to a side-lying position, where holds could be maintained and intra-muscular medication given after which the service user should be rolled to a face up position. This can be utilized from prone to a side-lying position and also from a face-up position to a side-lying position. The side-lying position should be utilized only for the briefest period possible to minimize discomfort (It is not a holding position). During the process of adjusting and turning to get to the side-lying position, consideration should be given to the level of resistance/struggle exhibited by the service user so as to minimize the risk of injuries to the service user and staff involved.

6.13 If seclusion is considered as an alternative to holding skills, the Trust's Seclusion Policy must be followed.

6.14 A restrained person may be able to shout or talk despite impending asphyxia. Attention should be paid to observing the service user and taking appropriate actions. The table below gives guidance on warning signs and corrective actions to be taken:

	Warning Signs	Corrective Actions
A	<ul style="list-style-type: none"> • Shouts and swears at staff to 'let go'. • Attempts to struggle free and/or injure self or others. • Is hostile and aggressive. 	<p>Treat as IMPORTANT</p> <p>Manage prevailing risk and follow the <i>Opt-Out Sequence</i> and consider letting go as soon as possible; or reduce the level of restriction; and/or change the position of the person.</p>
B	<ul style="list-style-type: none"> • Complains of difficulty breathing. • Complains of feeling sick and/or vomits • Voids bladder and/or bowels. • Complains of pain or discomfort. • Limbs positioned awkwardly; not moving within normal range of motion and/or sounds of crepitus. • Becomes distressed and/ or cries. • Continually struggles; becomes increasingly hot/flushed/sweaty. 	<p>Treat as URGENT</p> <p>Immediately assess level of restriction and check that you are not impeding or restricting breathing. Check movement of limbs and signs of fracture and dislocation.</p> <p>Follow the <i>Opt-Out Sequence</i> and consider letting go as soon as possible; or reduce the level of restriction; and/or change the position of the person so they are seated upright, reclined (recumbent), or in a position that is not impeding or restricting breathing.</p> <p>Encourage the person to relax and to take sips of a cold drink.</p> <p>Call for help- an independent person not involved in the physical restraint is often best placed to assess what is happening and what action needs to be taken. Refer person to medical practitioner as soon as possible for further assessment.</p>
C	<ul style="list-style-type: none"> • Unresponsive to requests and instructions. • Loss of or reduced consciousness. • Abrupt/unexpectedly stops struggling or suddenly calms down. • Sudden change in breathing pattern. • Has a seizure of epileptic or no-epileptic origin. • Blueness of lips/fingernails/ear lobes (cyanosis) • Tiny pinpoint red dots/bruises (called petechial) on the skin particularly on the upper chest, neck, face and around eyes. 	<p>Treat as a MEDICAL EMERGENCY</p> <p>The term <i>Medical Emergency</i> should be used as a verbal prompt for staff to stop the restraint immediately.</p> <ul style="list-style-type: none"> • Call for emergency medical assistance. • • Follow the basic life support (BSL) algorithm Resuscitation Council (UK) and BSL sequence as outlined in the Resuscitation Council (UK) 2010 and 2015 Guidelines until qualified help arrives to take over, the person shows signs of regaining consciousness and starts responding normally, or you become exhausted.

The Opt- Out sequence



6.15 Factors associated with asphyxia risk:

- Length of time spent under restraint;
- Obesity;
- Drug/alcohol intoxication;
- Prescribed medication
- Neuroleptic/sedative medication;
- Delirium;
- Prone (face down) position;
- Cardiac disease and hypertension;
- Respiratory disease;
- Sickle Cell;
- Pregnancy.

6.16 As soon as is safe to do so they must immediately begin to undertake observations that include pulse, respiration and complexion (with special attention to pallor or discolouration), and this should continue throughout the restraint.

7.0 Inappropriate use of restraint

7.1 Inappropriate use of restraint is a form of abuse and therefore a safeguarding concern (see Trust Policy on Safeguarding Adults). Anyone who has concerns about the protection of a service can make a referral via the safeguarding procedures. This includes members of staff, visitors, employees of another organisations and member of the public.

8.0 Ethical Considerations

8.1 In these and other circumstances when it appears necessary to hold a service user for their own safety, that of others, or to prevent serious damage to property, there are certain ethical principles to be observed by all concerned. One must always act in good faith, in light of training and experience, with as much careful thought as the circumstances allow, without malice and with due regard to the service user's rights and the welfare of others. In order to guide staff through the policy, it has been divided into three main themes:

- Prevention of a violent incident, which must always be the primary aim;
- Management of a violent incident where preventative measures have been ineffective;
- Action to be taken following a violent incident.

9.0 Prevention Of A Violent Incident

9.1 A Calm & Safe Environment

9.1.1 A well-planned physical environment is one that allows service users adequate space, reasonable comfort, dignity, privacy and safety. Staff must be aware of a ward's design features.

9.2 Risk Assessment

9.2.1 It is important to acquire an in-depth knowledge and understanding of each individual service user, including their history, particularly where the service user has previously shown violent tendencies or has been involved in violent incidents. This should be identified through the process of risk assessment using an appropriate assessment tool, from which a care plan should be formulated. Wherever possible a risk assessment should be undertaken to identify the nature of the potential violence and appropriate responses.

9.2.2 Through the process of risk assessment, an individual's limiting factors identified may dictate the methods of holding skills employed. These should take into account the service user's physical condition, disabilities, age, gender, ethnicity, physiological / sensory disorder etc.

9.2.3 In applying a particular risk assessment, it must be directed towards the overall best interests of the service user, be based on the principle of the minimum necessary force or action to achieve the desired outcome and be carried out in a professional, competent and safe manner'.

9.3 Care Planning

9.3.1 Care plans/ behaviour support plans should be individual to the service user and guided by an initial risk assessment, reviewed regularly and altered accordingly. Care plans should state clearly what the risks are, what the interventions are and what is expected of the nursing staff and service user. It should be appropriate to the service user's needs, realistic and have measurable outcomes. Seeking the service user's co-operation and participation in the process helps develop and maintain good working relationships with staff. This is reinforced by NMC (2015) in the Code for Nurses and Midwives by advising that staff prioritise people by listening to them and responding to their preferences and concerns and that staff should recognize and respect the contribution that people can make to their own health and wellbeing. The care plan/ behaviour support plan (or equivalent) should state in detail the multi-component interventions to change behaviour pro-actively and to manage behaviour reactively.

9.3.2 Once completed, the care plan/support plan should then be communicated to all staff working in that area and referred to in every handover. It is the responsibility of every member of staff providing care for that service user to familiarise themselves with the risk assessment, care plan and any subsequent changes following review.

9.4 Staff / Service User Relationships

9.4.1 The relationship between staff and service users is important and staff should at all times attempt to establish a professional and therapeutic relationship with all service users and their carers. Staff attitudes and interactions should be based on honesty, empathy and respect from the staff member towards the service user. The relationship is enhanced when staff engage service users proactively and use a range of skills including; de-escalation techniques, listening and problem solving skills. There may be no need for physical interventions if staff interactions are carried out in a sensitive manner and any unnecessary actions that the service user may perceive as being provocative or threatening are avoided e.g. setting limits that are phrased positively rather than negatively.

9.5 Family and Carer Involvement

9.5.1 Family and carers often have extensive first-hand experience of dealing with aggression and violence and developed individual ways of managing this. Their experiences are vital in understanding individual responses. Carers may also witness the management of violence and aggression within the inpatient settings and the effect this may have on themselves and other service users can be traumatic. For carers, how aggression and violence is managed will be a key indicator of the quality of care delivered. This can have a major impact on the user, carer and their relationship with multi-disciplinary teams.

9.5.3 If service user's family members/ relatives are present when physical interventions are about to be used or have been used, they should be briefed/ debriefed about the situation by a senior member of staff.

9.6 Black and Minority Ethnic Groups

9.6.1 Black and minority ethnic groups are more likely to be subject to compulsory admission to hospital, prescribed anti-psychotic medication, physical intervention and seclusion. With this in mind all staff should be offered and provided with appropriate resources:

- The use of interpreters, for those people whose first language is not English, is essential in ensuring effective communication and collaboration between staff, service users and their carers/relatives when assessing, planning, delivering and

evaluating care. This will help to minimise the risk of misinterpretation of actions and behaviours on both sides;

- Spiritual, religious and cultural needs, beliefs and behaviours are part of the whole person and must be understood and taken into consideration by staff when working with service users, families and carers and responding to their needs and actions.

9.7 Women in Mental Health Services

9.7.1 Multi-disciplinary teams should work in collaboration with female service users in assessing their history relating to aggression and violence. From this assessment a clear plan of care should take into account issues pertaining to (Trauma informed care):

- Domestic violence;
- Experience of child sexual, physical and emotional abuse, sexual assault/rape;
- Self-harm;
- Attitudes to others, ie., male or female who have committed offence against women;
- Safety, privacy and dignity;
- Experiences within previous accommodation including Mental Health Services;
- Vulnerability to exploitation.

10.0 **The Management Of A Violent Incident**

10.1 De-escalation:

- A service user's behaviour needs to be treated with an appropriate, measured and reasonable response;
- Use de-escalation techniques before any other interventions. Continue to use verbal de-escalation even if other interventions are necessary;
- In crisis situations, staff are responsible for avoiding provocation. They should be aware of and monitor their own verbal and non-verbal behaviour;
- Staff should recognise what generally and specifically upsets and calms the service user. This should be noted in the care plan;
- Where possible and appropriate, encourage the service users to understand their own triggers; Note in the care plan and give a copy to the service user;
- Encourage the service user to discuss and negotiate their wishes should they become agitated.

10.2 De-escalation techniques:

10.2.1 One staff member should assume a lead role in the management of potentially disturbed/violent situations. This staff member should:

- Consider which de-escalation techniques are appropriate for the situation;
- Manage others in the environment – move to safe place if necessary;
- Explain to the service user what you intend to do, giving, brief, clear and assertive instructions, but not threatening;
- Ask for facts about the issue and encourage reasoning – attempt to establish a rapport, offer and negotiate realistic options, avoid threats, ask open ended questions and ask about the reason for the service user's behaviour. Where limit setting is necessary. Use it positively: for example, "If we do this, then we can do that" "When you do this then you can do that";
- Avoid being drawn into power struggles
- Show concern and attentiveness through verbal and non-verbal responses;

- Listen carefully and pay attention to facts and feelings: para verbal's (tone, volume and rhythm);
- Listen to understand the issues and NOT to respond
- Paraphrase to check understanding using the facts and feelings identified. Do not patronise or minimise the concerns raised;
- Where there are potential weapons, the de-briefing situation should try and be located in a safe environment;
- If a weapon is involved, ask for it to be put in a neutral location rather than handed over;
- Consider asking the service user to make use of a designated area or room to help calm the behaviour. Seclusion rooms should not routinely be used for this purpose.

10.3 When holding skills may be used

10.3.1 The most common reasons for employing holding skills/ use of force as highlighted by the Mental Health:

- Physical assault;
- Dangerous threatening or destructive behaviour;
- Non-compliance with treatment; in line with MHA or Consent to Treatment
- Self-harm or risk of physical injury by accident;
- Extreme and prolonged over-activity likely to lead to physical exhaustion.

10.4 Methods of Holding Skills

10.4.1 It is not possible or desirable to outline specific holding skills in this document, however any techniques used should be in line with the skills taught within the Trust's holding skills training programme (MAPA/SI). Mechanical or other non 'hands on' restraint, such as the use of handcuffs, sheets, etc. **must never be used** by staff. An exception to the use of handcuffs is made within the Trust's Forensic services, where they may be used during external escorts to court hearings and or for medical treatment. For further guidance on the appropriate use of handcuffs, staff should refer to the Trust's Handcuff Procedure. Holding skills should be used as little as possible, as a last option and only when absolutely necessary. Seclusion and locked door segregation, although restrictive in nature, are dealt with in separate policies.

10.4.2 Restraint which involves tying (whether by means of tape or by using a part of the person's garments) to some part of a building or to its fixtures or fittings **must never be used**.

10.4.3 Staff must make a balanced judgement between the need to promote an individual's autonomy by allowing him or her to move around at will and the duty to protect that person and others from likely harm,

10.4.4 The techniques should not involve neck compression and should avoid excess weight being placed on any area, particularly stomach, neck, back and chest.

10.4.5 The use of face down (prone) restraint is a contentious issue. It should be avoided wherever possible as it presents an increased risk to health of the service user. The reasons for its use are as follows:

- The team slips or are pushed to the floor whilst already in holds;
- The overall plan is to administer Intramuscular Medication and all other attempts to administer the injection without restraint have failed. Once in prone position, consider side lying position for the intervention;

- The team feel the risk of being pushed over is high so they may choose to relocate to a kneeling position in a controlled manner. The team can then attempt to encourage the service user back to their feet or disengage from holds as alternatives to transitioning all the way to the floor.

10.5 If face down (prone) physical holding is being used it should be for the least amount of time that is practical and thereafter consider disengaging moving to a kneeling or standing position as soon as possible. NICE (2015) advise that services should consider using rapid tranquilisation or seclusion as alternatives to prolonged manual restraint (about 10 minutes or longer). **This is just a guide for prolonged restraints** and SHOULD NOT be mistaken for the period for which service user can be held in face down position.

10.6 Face down holding is used in seclusion for safe exit as taught in training

10.7 If high level arm restriction holds are being applied in the face down (prone) position then the service user's arms should be placed directly under their shoulders (supported prone position) as this will promote a higher blood oxygen level (Barnett, R. et al – 2013)

10.8 During application of holding physical interventions, the service user's physical health can easily get compromised due to a number of factors that include effect of illicit substances, alcohol, exhaustion, prescribed medications (including any rapid tranquilisation) and co-existing medical conditions. It is therefore important that the service user's vital signs are checked during and after the application of physical holding skills and documented in the service user notes.

Where this is not possible due to the service user's disturbed presentation or refusal other discrete ways of checking the vital observations like respiration rate should be used both for during and after and documented.

10.9 The holding skills taught to staff do not use pain stimulus as a means of gaining compliance and as such are appropriate for all of the Trust's clinical settings where holding skills may be applied.

11.0 General Guidelines For Safe Use Of Holding Skills

11.1 If staff are to carry out a nursing intervention which is likely to result in the use of holding skills, e.g. enforcing medication, detaining, sectioning, etc., then good practice would be to plan for such an eventuality. In the event of the increased need for holding skills being used, then good practice would indicate that a care plan is formulated to provide guidance to staff. Physical holding skills are not to be used for the purpose of taking bloods if the service user does not want this intervention to take place. This poses increased risk of injury to both staff and service user being held.

11.2 Shift co-ordinators have a responsibility together with other ward staff to take charge of the situation and decide on a plan of action based on their knowledge of the service user's assessed risk and planned care. The base team should be present to guide staff responding from other wards to assist in terms of care plan issues known to the base team.

11.3 The Duty Senior Nurse (DSN) should be contacted and made aware of staff plans / needs. On arrival to the ward, the DSN should make themselves known to the shift co-ordinator in order to offer assistance. **Staff should not automatically assume that the DSN will take control of the situation**, as they may have no prior knowledge of the service user, nor any awareness of the service user's assessed risk or planned care.

The restraint team formed should be balanced (race, gender if safe and possible, and a senior member of staff to help with decision making and guiding the team) DSN would assume responsibility for managing incidents that occur away from the wards where there is no clearly identified person taking control of the situation, Someone who was not involved in the incident should take a lead in both post-incident and in-depth reviews with those affected and people who use services. Reviews should be in a blame free context.

11.3.1 **Use Of Holding Skills With Pregnant Women - Clinical risk assessment and management related to pregnancy:**

- All female service users should be treated as pregnant until otherwise to minimise risk to baby and mother;
- Teams should endeavour to conduct a pregnancy test to female service users at admission stage;
- Use of holding skills must only be considered as a last option in the management of pregnant women;
- Advanced statements for the planning of any potential use of holding skills must be written in collaboration with the service user (wherever possible);
- A comprehensive care plan must reflect the care of pregnant women, which will include consideration to proactive assessment of any identified risk factors. The following recommendations should be covered:
 - Minimising the management of pregnant women in the prone position when holding skills are used where avoidance of floor descent has not been possible;
 - Proactive use of holding skills with pregnant women in the seated position – ideally on a chair /bean bag;
 - The staff should be mindful of the actual physical holding position utilised, which should be reflected in an awareness of the use of the supine position (face upwards). This should always be of priority in the third trimester of pregnancy;
 - A further preferred position should reflect the comfort of the semi-recumbent seated position;
 - Most recommendations regarding the holding of pregnant women are addressed within the 5-day and annual 2-day refresher MAPA/SI training.
 - Staff should utilise *The Opt – Out Sequence* as referenced in 6.12
 - Managers should seek advice and support from MAPA/SI trainers for bespoke training if required e.g. semi recumbent and other situations where taught skills may not suffice.

11.4 **Age Awareness - Mental Health Care for Older People (MHCOP)**

11.4.1 Training for staff working within MHCOP inpatient services is addressed by the Trust's 3 day course and annual 1 day refresher MAPA/SI training. It must be noted that any member of staff likely to form part of the rapid response team should attend the 5 day and subsequent 2 day refresher courses 3 day or 1 day refresher course.

11.5.2 Recommendations within the three day course include guidance that:

- Prone (face down) holding should be avoided in the management of the older people. If the team got pushed to the floor, they should disengage from the holds or support the service user to get up;
- Staff must ensure that the application of holding skills is conducted off the floor.g.: the service user remaining in the seated position or escorted to the bed area;
- Specific care should be utilised to address any physical problems that may be associated with 'the ageing process, such as arthritis, dislocation and the increased

risk of bruising. In the event of the increased need for holding skills being used, then good practice would indicate that a care plan is formulated to provide guidance to staff.

11.5 Age Awareness - Child and Adolescent Mental Health Services (CAMHS)

11.6.1 Due to the stand alone nature of one part of the CAMHS inpatient unit based nurses and other disciplines will attend the five day MAPA/SI training course initially and then subsequent 2 day annual refreshers. For CAMHS Galaxy PICU, this applies only to nursing staff as it is based within Newham Centre for Mental Health. There is no explicit training for those staff based within services for younger people. Due care and consideration must be given to the vulnerable nature of the younger person and subsequent distress that using holding skills may cause.

11.6 Use Of Lifts And Stairs – Across all services

11.6.1 Attempting to relocate a service user via stairs or lift whilst in holds presents a heightened risk of injury to all parties involved. No physical holding skills for this purpose are taught on any of the Trust's MAPA/SI courses. Staff are encouraged to summon assistance from the ENT / RRT and use other ways of managing the risks within the environment that they present themselves in. If this is an ongoing presentation by a particular service user, other proactive measures should be considered, e.g., transfer of service user to the floor where the seclusion is.

11.6.2 Staff are readily encouraged to contact the MAPA/SI trainers for advice which may include further guidance regarding the use of holding skills and addressing areas of best practice.

12.0 Requests For Assistance

12.1 If staff are considering the use of holding skills then the ringing of other wards for assistance would be appropriate. They should also inform the DSN. It should however, be stressed by the caller that the response is urgent and that the response team member is expected to attend immediately.

12.2 Staff requesting emergency assistance should follow local guidelines and also indicate whether any weapons are involved, so that staff responding are made aware of the potential dangers before intervening. Staff must ensure that where radios are issued, they must be worn at all times by the relevant bleep holder member of staff. This allows for staff to communicate the presence of weapons or update staff responding to the incident.

12.3 Staff requesting emergency assistance should send someone to the ward entrance to ensure that the team are able to gain entry to the ward and where possible make them aware, however briefly, what / where the problem is. Best practice would be to allocate this role to someone at the beginning of every shift.

13.0 Briefing And Choosing A Team

13.1 When sufficient staff are present the shift co-ordinator should brief them about the current situation, making them aware of the agreed plan for managing the incident. If the plan involves the use of medication, then staff should ensure that it is prescribed, available, prepared, and checked in advance.

- 13.2 Best practice would be that a three-person team should be chosen that meets the needs of the service user / situation and should be appropriate to the age, size, gender and history of the service user (trauma informed care). Consideration should also be given to the service user's health issues, culture and any communication needs, in particular language barriers and sensory impairments, etc.
- 13.3 Roles and responsibilities for the restraint team should be allocated, including having the person with the best rapport talking to the service user and a senior member of staff. Other staff can be allocated tasks such as holding the legs if needed, drawing up medication and managing bystanders, etc.
- 13.4 The team should have plans A and B. Plan A would involve de-escalating the situation as some service user will work will comply once they see the team, thus applying the least restrictive intervention. Plan B would be to apply the holding skills are planned in order to manage the risk that may present.
- 13.5 All team members must be aware of how the lead person will indicate that they should apply the holding skills. e.g. '**Now**' or '**Go**'. In the event that the service user presents a direct risk to the team, the staff tasked to manage the arms may use their discretion in proactively applying their holds before instructed to.
- 13.6 Try to remove bystanders, family, service users or non-involved staff away from the scene.
- 13.7 Before approaching the service user, a visual check for weapons should be carried out and vigilance maintained, as Trust staff do not receive training in how to disarm an armed attacker. Further advice on this subject can be found under 14.0.
- 13.8 Before trying to hold a service user, Staff should be mindful as to what they are wearing or carrying and remove any sharp objects, except for unit keys within the forensic service. Long sleeves will offer some protection against biting and scratching, any objects around the neck should be removed if they pose a danger.
- 13.9 Approach the service user by moving steadily and firmly forward. Do not rush and do not use hesitant movements. The member of staff that has been tasked with the lead role should communicate with service user on approach and they should be flanked on each side by another member of staff. De-escalation should always be the first option- Stop and Think
- 13.10 If the service user co-operates with staff, prior to holding skills being initiated the person leading the team should decide what subsequent action to take. This may include: low stimulus environment, de-escalation, setting limits / boundaries on future behaviour, offering of medication and reflective session etc.
- 13.11 If the service user's co-operation can't be gained and their presentation is judged by the person leading the team to require the use of holding skills then they should initiate the management plan proactively by giving the agreed signal. Staff would then assume their agreed roles for restricting the service user and adopt proportionate response to manage the service user's presentation e.g. medium or high level holds and then the transitioning towards, seated / kneeling / prone / supine, etc.
- 13.12 If holding skills are initiated as an emergency response then all the members of the team should respond quickly and effectively until the service user is managed safely and staff can take charge of the situation.
- 13.13 **All staff** have a duty to intervene in an emergency where violence has or is likely to occur, however the method of intervention will be dictated by the level of risk identified

and the training received by staff members. It is **not** good practice for staff untrained in Trust techniques (MAPA/SI) to take part in **planned holding interventions**.

14.0 Use Of Physical Force

- 14.1 It is permissible to use physical force when necessary, but the degree of force used should be the minimum required to manage the situation, and should be applied in a manner that reduces the violence rather than provokes further acts. What is reasonable in any situation depends upon the assessment of staff present at that time. Proportionate levels of holding skills are taught in the Trust's holding skills related training programmes.
- 14.2 The degree of force used is therefore a matter of professional judgement. However, it is important to ensure that the force you use is only of a degree appropriate to the actual danger or resistance shown by the service user. A clear focus on the least restrictive level of holding skills is applied in training, and is in keeping with the DOH 2014 guidelines and also the 'Let go to calm' concept' as utilized in MAPA/SI training.
- 14.3 It is acknowledged that staff and response teams have sometimes to deal with visitors or relatives whose behaviour is considered to be placing themselves, staff and / or service users at risk. In this case staff should be guided by The Policy for **Handling Incidents of Violence and Aggression, both Physical and Verbal, towards Staff**.
- 14.4 The nurse in charge of the incident should assess the situation and if their continued presence is considered detrimental to staff / service user safety, then they should be asked to leave trust premises, and security and /or police called to assist, the latter especially if a crime has been committed. The DSN should be informed and advice sought.

15.0 Use Of Weapons

- 15.1 When confronted or threatened by an individual with what you feel to be a weapon, then your safety and that of all other staff and service users within the immediate vicinity is paramount. Staff are expected to work within their limitations and not place themselves at unnecessary risk by attempting to disarm the individual.
- 15.2 Where possible attempts should be made to isolate the individual from others and seek assistance by the most appropriate means, e.g. use of personal / wall mounted alarms, radios, informing the DSN, rapid / emergency response teams. Consideration should be given as to the need for police involvement, especially if there are pre- agreed protocols in place (Use of force Act 2018).

16.0 Involving the Police

- 16.1 It is acknowledged by the police service that there will be rare occasions when staff has to deal with a service user who is so violent or potentially violent that it is beyond their capability to safely hold them with minimum risk to the safety of staff and other service users. In such circumstances police have a duty in law to assist (Use of force Act 2018).
- 16.2 Staff may request police support in one of two ways, either proactively as the result of a risk assessment and involvement of the clinical team prior to a situation developing, or as an emergency response. If a planned use of the police is being considered, then there needs to be a fully documented agreed strategy from the clinical team responsible

for the service user and agreement from the appropriate senior nurse/manager in line with any agreed protocols.

- 16.3 In an emergency, or outside of office hours, it is expected that the person in charge of the incident would have consulted where possible in the first instance with the duty nurse/ senior nurse/manager on call prior to calling the police. Staff must be aware that once police assistance has been requested, the ultimate decision as to the numbers of officers, and what resources are deployed, remains with the police.
- 16.4 If there are any concerns about police responses or engagement during the incident, teams should consult with the Trust's Health, Safety, Security and Emergency Planning Manager.
- 16.5 The Use of Force Act (Seni's Law) is named after Olaseni Lewis who died after being restrained by police officers who attended an incident on a mental health unit in South London. All staff should be familiar with the document and guidance called Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings, which can be found in Appendix 4.

17.0 Reporting

- 17.1 Reporting incidents is important as it allows the Trust to monitor risks to staff and service users. From the reported incidents, analysis is made and learning points identified are used to reduce similar incidents in future. This also serves as a measure of whether violence and aggression related incidents are increasing or decreasing. DATIX reporting does not replace RiO / case notes reporting.
- 17.2 Any use of force must be recorded using a DATIX incident reporting form. ELFT have set up the incident reporting system to ensure that we adhere to the formal reporting systems that satisfy the legal requirements, but also contractual reporting requirements with NHSEI.
- 17.3 Staff must complete the incident report in full, further guidance can be found in the Incident Management Policy and Procedure.
- 17.4 Below are some of the key requirements that must be detailed into the incident form:
- The reason and type of the use of force
 - The place, date and duration of the use of force
 - whether the type or types of force used on the patient formed part of the patient's care plan and if notifiable persons (if any) were contacted following use of force as described in the care plan
 - A description of how force was used
 - The name and job title of any member of staff who used force on the patient
 - Whether the patient has a learning disability or autism
 - A description of the outcome of the use of force
 - Whether the patient died or suffered any serious injury as a result of the use of force
 - Any efforts made to avoid the need for use of force on the patient
 - If the police were involved, details of how they managed the situation

If there are any concerns about police management of the situation, this should be escalated immediately to a senior manager or the senior manager on call.

17.5 Guidance on the negligible use of force

The duty to keep a record of the use of force does not apply if the use of force is negligible. Negligible does not mean irrelevant to a person's experience of care or treatment. It is expected that negligible use of force will only apply in a very small set of circumstances. Whenever a member of staff makes a patient do something against their will, the use of force must always be recorded.

17.6 If a member of staff's contact with a patient goes beyond the minimum necessary in order to carry out therapeutic or caring activities, then it is not a negligible use of force and must be recorded. The use of force can only be considered negligible where it involves light or gentle and proportionate pressure.

17.7 The use of force can never be considered as negligible in any of the following circumstances:

- Any use of rapid tranquillisation.
- Any form of mechanical restraint.
- The patient verbally or physically resists the contact of a member of staff – for example, telling a member of staff to get off them, stop touching them or take their hands off them. It would also include a patient struggling to regain control over their body. It will be important to consider the communication needs of patients with autism or a learning disability, and the employment of a more complete behavioural and communication assessment may be needed to establish whether behaviour is used to communicate discomfort.
- Where the use of force involves the use of a wall or floor (or other flat surface), and the use of force is disproportionate. In practice, it will be unlikely that such a surface would be used where a patient is not resisting.
- A patient complains about the use of force either during or following the use of force – for example, telling a member of staff they are hurting them.
- Someone else complains about the use of force. This does not have to be a formal complaint and can include another patient telling a member of staff they are hurting a patient.
- The use of force causes an injury to the patient or a member of staff. In this context, this would include any type of injury or other physical reaction including scratches, marks to the skin and bruising.
- The use of force involves more members of staff than is specified in the patient's care plan.
- During or after the use of force, a patient is upset or distressed.
- The use of force has been used to remove an item of clothing or a personal possession.

An example of a negligible use of force would be the use of a flat (not gripping) guiding hand by one member of staff to provide the minimum necessary redirection or support to prevent potential harm to a person. Using this example, it is important to note that the contact is so light or gentle that the person can at any time override or reject the

direction of the guiding hand and exercise their autonomy. It is essential that the guiding hand does not cause distress to the person.

- 17.8 If the same routine negligible force (which is the minimum necessary to carry out therapeutic or caring activities) is used on the same patient on a regular basis, then it must be subject to a restraint reduction plan that includes the justification and proportionality of the measures taken.#

18.0 Service user and staff debriefing

- 18.1 Any service user and/or staff member involved in an incident of violence and/or in applying holding skills should expect to be given support, advice and reassurance from management/other staff present and should also have access to de-briefing. It should be the decision of the nurse in charge and the associated team as to how the de-brief will be organised. It should be noted that the individual being held or other service users witnessing the event should be offered support and reassurance. The team will decide on how best this support should be offered and implemented. It should be acknowledged that sometimes staff and service users may not be emotionally ready to discuss the incident and therefore flexibility on timing should be exercised.
- 18.2 A Critical Incident De-brief is a group process whose purpose is to enable participants to share their views in a safe, supportive environment. With understanding, it is hoped that participants can make some sense of their experience thereby enabling them to integrate such experience into their life's repertoire and hopefully move on.
- De-briefing should be undertaken following incidents by staff who understand the rationale and purpose of de-briefing. The Trust's MAPA/SI Training Programmes include a brief de-brief model: The COPING Model (Appendix 3) is discussed with staff on training and can be used as a guide rather than a prescriptive feature.
- 18.3 The de-briefing has three phases and the structure allows participants in the group to discuss the incident in a controlled manner which does not leave them feeling out of control of themselves. The de-briefing process uses certain techniques common to counselling but it is not counselling or psychotherapy nor a substitute for either.
- 18.4 One of the main components which makes a de-briefing different is the fact that it deals with the immediacy of the situation and that a substantial portion of the de-briefing process is dedicated to enabling participants to develop a reality concerning the event rather than allow that reality to become distorted.
- 18.5 It is important that de-briefers have expertise in dealing with and understanding the special needs of the populations they serve. If this is not the case, the ability of the debriefing team to achieve the primary goals of debriefing may be severely jeopardized.
- 18.6 It is acknowledged that some clinical areas have their own procedures and support structures in place for de-briefing. Clear Guidance can also be found in the **Trust Incident Policy** regarding the action to be taken regarding de briefing tools and actions to be followed.
- 18.7 A full detailed account of why restraint was considered necessary should be documented in the service user's clinical notes. An incident form should be completed, regardless of whether there were any injuries reported following a violent incident. It is important that restraint monitoring forms/body maps are clearly and comprehensively completed too and sent within 24hrs of the incident so as to ensure accurate monitoring and if required

appropriate management action. Recording of violent incidents on DATIX incident forms allows the Trust to monitor assault trends and review the adequacy of policies / procedures. It may also provide useful evidence in any legal or professional investigations, as a contemporary record of what occurred, what the antecedents and consequences were, and is acceptable in court

- 18.8 As part of debriefing, an assessment should be done to determine if a physical examination is necessary. If the person being held sustains an injury, then they should be seen as soon as practicable by a doctor following commencement of physical holding. Staff sustaining injuries should be supported in accessing Accident & Emergency Department if necessary or advised to contact Occupational Health (9am - 5pm, Monday to Friday)/ their own G.P as appropriate.
- 18.9 Immediately following the incident, or as soon as practicable the shift co-ordinator should brief the ward manager or designated senior staff member (as appropriate) regarding the incident. They will then assess the situation to identify action required to prevent a recurrence of the incident and to ensure the safety of all service users, and visitors within the ward or department. This may include increased observation, review of medication, requests for assessment from secure wards, discussion of the incident with the service user, etc.
- 18.10 If the service user is not detained, but restraint in any form has been deemed necessary, consideration should be given to whether formal detention under the Mental Health Act is appropriate, especially if restraint has occurred on a repeated basis.
- 18.11 The Duty Senior Nurse whether present or not at the incident should always be informed when a violent incident has occurred or restraint used and should attend the ward as soon as possible afterwards, in order to provide guidance / support or assistance in the review as necessary.
- 18.12 They should be made aware of the outcome of the post incident review and their assistance sought, especially if there is need for any additional staffing requirements over the following shifts.

19.0 Good Practice

19.1 Dress:

- Staff should always ensure that they are dressed appropriately for the role they are to carry out, e.g. loose comfortable clothing, flat shoes and a belt or waist band to carry pagers / keys / swipes / radios as appropriate. It is advisable to keep the wearing of jewellery to a minimum as it can increase the risk of injury to both staff and service users. For further guidance on this refer to the Trust Dress Code Policy.

19.2 Allocations:

- If a member of staff is allocated to the response team, then there is an expectation that it is they who will respond to any incidents. Any changes to the team or difficulties in responding, should be communicated to the duty senior nurse immediately. Any delays caused by re-allocating to another member of staff when the emergency call has gone out, puts others at unnecessary risk.
- As has already been mentioned, staff (bank/ permanent not trained in MAPA/SI holding skills and students on placement should **not** be allocated. If staff are to be swapped then it should be like for like, e.g., gender, experience, etc. Changing an experienced staff member for an inexperienced one is poor practice and potentially places all concerned at risk.

- These teams are allocated on a shift-by-shift basis by the clinical areas who each nominate one member of staff to attend psychiatric / fire / medical emergencies. It is essential for practical and health and safety reasons that only appropriately trained staff, eg., those who have completed the Trust's 5 Day holding skills course and are in date on the live register of practitioners should be allocated to the rapid response / emergency nursing teams.
- The use of staff untrained in MAPA/SI techniques on the response teams including bank staff or students, is therefore not acceptable practice. If for whatever reason wards are unable to allocate an appropriately trained member of staff, then they should communicate this to the DSN as soon as possible in order to look at alternatives.
- Staff who have had no MAPA/SI training, or who are trained in different models of holding techniques (not MAPA/SI) can assist through necessity, i.e. in an emergency if those trained are not available. They should however, do so in a safe and professional manner and accept guidance from staff who are MAPASI trained in the techniques as appropriate. Other staff may also assist by preparing medication, liaising with other disciplines, or by ensuring the wellbeing of the other service users.
- Wards should therefore only allocate appropriately trained staff for these teams and ensure they have adequate staff to respond, even at difficult times such as ward rounds. The DSN should document in their records as to who is allocated and co-ordinate any necessary changes to the team. This is to ensure that the team is appropriate to the age, size, gender and history of the service user and be best able to effectively address the range of situations they are likely to encounter. Any problems affecting a member of staff's ability to respond should be communicated to the DSNs as soon as possible.
- All staff allocated to the RRT/ENT must ensure that they have received a swipe / key / radio, etc., to access all areas of unit that they may be required to respond to in an emergency.

19.3 **Response Times:**

- Although there are geographic factors that may affect the time it takes for staff to respond to an incident, staff are expected to respond immediately when they are needed. This is the same for a phone request as it is for an emergency call.
- If for whatever reason staff are unable to do this, e.g. due to ill health / physical disability / inappropriately dressed, etc., then the reasons why should be documented in the Duty Senior Nurse notes. This should then be communicated to the relevant manager who should address the issue with the member of staff to prevent a recurrence in the future.

20.0 **Training**

- 20.1 It is essential that all nursing staff working in mental health inpatient settings attend the initial and subsequent MAPA/SI training courses/refreshers provided by the Trust in line with their TNA to ensure their skills are updated and any modifications to the techniques passed on. They are required to attend regular follow up refresher days within a year of completing the full course. It is good practice for staff who are trained in practical disengagement and holding skills to receive annual refresher training in order to

maintain their ability to apply the techniques safely and appropriately (BILD (2010 and RRN)

- 20.2 A 'Live' register of staff who have completed the relevant physical holding skills course and attended regular annual refresher training will be kept by Learning and Development department.
- 20.3 Staff are responsible for ensuring that they maintain themselves on the live register and attend the refresher courses and it is also the responsibility of their managers to ensure that staff are released to attend the relevant courses. It is acknowledged that the use of physical holding techniques varies widely depending on the clinical area and client group. Skills that are used infrequently, are sometimes forgotten when staff come to use them. Staff who require more frequent refresher training in order to address this, are actively encouraged to attend refresher courses earlier than 12 months. This has to be discussed/ agreed by the individual and their manager first.
- 20.4 Staff is required to attend annual refreshers yearly as per national guidance (RRN 2019 standard 1.61). Those who do not attend the appropriate holding skills refresher course within 14 months of the initial course/refresher, will be required to attend another initial course in its entirety (5 Day for Acute / PICU / Forensic / CAMHS & 3 Day for MHCOP). .

21.0 Governance

21.1 Chief Nurse:

- The Chief Nurse is the nominated director who takes leading responsibility at a board level for the Trust restrictive intervention reduction strategies. In addition, they should produce annual report on restrictive interventions including Physical holding skills (Appendix 1).

21.2 Director of Nursing:

- Oversee the functioning of the MAPA/SI team Leads in restrictive practice

21.3 Matron for Restrictive Practice and MAPA/SI

- Coordinates MAPASI training across the Trust
- Ensures training standards are maintained in line with RRN standards and restrictive practice
- Promotes least restrictive practice across the Trust

21.4 Training Department:

- Keep accurate record of staff training in Physical Holding Skills on ELFT Learning Academy
- Ensure training dates are communicated for staff to update as required.

21.5 Directorate Management Teams:

- Directorate monthly forum to review all restrictive interventions including physical holding skills overall and in particular the number of prone restraints;
- Have a system of testing alarms and check response times.

21.6 Lead Nurses:

- Borough Lead nurses to discuss restrictive interventions in supervision with Matrons including overall all physical holding skills and in particular prone restraints as well as seclusion among others.

21.7 Matrons/Ward Managers:

- New staff are inducted into their role in emergencies and on how to summon assistance and make response calls;
- Communication systems allow team members to be informed of risks associated with service users;
- Review and discuss ward statistics related to restrictive interventions including physical holding skills in particular prone restraints.
- Ensure staff are up to date with their training in line with their TNA.

22.0 References

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Appendix 1

AUDIT TOOL:

Policy Title:	Policy on Use of Physical Restraint
Audit Procedure:	<ol style="list-style-type: none"> 1. Use the locality DSN book/ file to identify the most recent 10 incidents of restraint to have taken place. 2. Obtain the following for each incident of restraint: <ul style="list-style-type: none"> • Incident Reporting Form (from ward incident files) • Service User's Notes (including fluid balance chart & physical observation chart); • DSN book/folder. 3. Examine the documentation above using audit tool below. 4. Use one form per incident of restraint. 5. Please use comments boxes to record reasons for standards not being met. 6. All completed audits using this tool should be sent to the Director of Nursing for Policy & Practice and copied to the Assurance Department and relevant audit lead.
Sample/ sources of evidence:	<ul style="list-style-type: none"> • DSN Book/File for the locality; • The health records of the relevant service users identified in the 10 most recent incidents of restraint from the Locality DSN book/ file; • Ward incident files.
Frequency:	Annual
Responsibility for completion:	Director of Nursing

Auditor Initials:	Date of Audit: Location:

Details of Restraint:		
i)	Date/time that restraint took place:	
ii)	Was there a prolonged or violent struggle?	
iii)	Was enforced medication or rapid tranquillisation used?	
iv)	Was the service user suspected to be under the influence of alcohol or illicit substances?	
v)	Does the service user have a known physical condition that may inhibit cardiopulmonary function? (i.e. asthma, obesity)	
vi)	Was the service user pregnant at the time of the restraint? (If 'Yes' see question 4)	
vii)	Date/time of first recorded medical assessment following restraint:	

Standards to be measured		Yes	No	N/A	Comments
1a	The incident of restraint must be recorded in the locality DSN book/ folder.				
1b	The incident of restraint must be recorded using the Trust Incident form and a copy stored on the ward.				
1c	The incident of restraint must be recorded in the service user's notes.				
2a	Evidence that a medical assessment took place within 2 hours of the commencement of the restraint must be recorded in the service user's notes. <i>(If 'Yes', go to 3, if 'No' go to 2b)</i>				
2b	If a medical assessment could not be performed, the reasons why (ie: service user refused or doctor not available) must be clearly documented in the service user's notes, stating what alternative actions have been taken.				
3	Evidence of physical monitoring checks post restraint during the following 24-hour period must be recorded on the:				
a)	Physical observations chart				
b)	Fluid balance chart <i>(If "No" to either a) or b), go to 3c)</i>				
3c	If any of these checks could not be performed, the reasons why must be clearly documented on the charts.				
4	<u>Pregnant women only:</u> If the subject of restraint is a pregnant woman, there must be an explicit care plan to address this situation.				

Appendix 2

This is a guide to de-briefing using the COPING model with suggested questions in italics.

Control	<p>Check that staff/ service users are physically and emotionally in control and ready for debriefing. Conducting debriefing when people are not ready may traumatise them more. <i>We may ask:</i></p> <ul style="list-style-type: none"> • <i>Are ready to talk about the incident?</i>
Orient	<p>Orientate yourselves with basic facts about the incident from the staff and service users' perspective. Gather as much information about the antecedents and the incident.</p> <p><i>We may ask:</i></p> <ul style="list-style-type: none"> • <i>Can you tell me what happened? (Avoid being judgemental)</i>
Patterns	<p>Check for patterns:</p> <p><u>For service users; of the behaviour/ triggers in the service user. Apart from recorded patterns, the individual may be aware of other patterns.</u></p> <p><i>We may ask :</i></p> <ul style="list-style-type: none"> • <i>What caused the behaviour?</i> • <i>Has this happened before?</i> <p><u>For staff, check for patterns in responses to the behaviour</u></p> <p><i>We may ask:</i></p> <ul style="list-style-type: none"> • <i>Can we identify patterns in the responses?</i> • <i>What worked and what did not work so well?</i>
Investigate	<p>Investigate alternatives:</p> <p><u>For the service user; to the behaviour.</u></p> <p><i>We may ask:</i></p> <ul style="list-style-type: none"> • <i>What can you suggest that might prevent this from happening in future?</i> <p><u>For staff; to the responses:</u></p> <p><i>We may ask :</i></p> <ul style="list-style-type: none"> • <i>What can we do to strengthen things that worked well and improve those that did not work so well?</i>
Negotiate	<p>Investigate future approaches:</p> <p><u>For the service user; expectations and or behaviour.</u></p> <p><i>We may ask :</i></p> <ul style="list-style-type: none"> • <i>Do we need to agree on the actions you and the staff will take?</i> <p><u>For staff; changes that will improve future interventions:</u></p> <p><i>We may ask :</i></p> <ul style="list-style-type: none"> • <i>Do we need to agree on priorities for improvements?</i> • <i>If so, what are they?</i>
Give	<p>Give support:</p> <p><u>For Service users; control and support:</u></p> <p><i>We may ask :</i></p> <ul style="list-style-type: none"> • <i>What help and support do you require to make these changes?</i> <p><u>For staff; support and encouragement:</u></p> <p><i>We may ask :</i></p> <ul style="list-style-type: none"> • <i>What help and support do you need to make these changes?</i>

Appendix 3 - Police Use of Restraint in Mental Health & Learning Disability Settings

Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings

In Summary

- This Memorandum of Understanding (MoU) between National Police Chief's Council, Mind, Royal College of Psychiatrist, RCN and Faculty of Forensic and legal Medicine provides clarity on the role of the police service in responding to incidents within mental health and learning disability settings.
- Health providers have a duty to undertake, implement and review risk assessments for all the services they provide. The police do not have specific powers to restrain a patient for the purposes of medical treatment regardless of whether the treatment is in the patient's best interests.
- Police services and health providers should develop or review existing protocols to take account of this MoU. There should be timely joint reviews of incidents where the police use force or where the police did not attend an incident despite the agreed local protocol being properly used.

Over-Arching Ethos

- Each situation should be properly judged on its individual merits.
- Police officers should NOT be called to undertake restrictive practices, connected to purely clinical interventions (e.g. taking of fluid samples, injections, etc.) unless exceptional factors apply.
- The police service should ensure an appropriate response to allegations of crime and to requests for immediate support in connection with risks of serious injury or damage, where healthcare providers' internal mechanisms have been unsuccessful and safety is then compromised.

Examples Requiring a Police Response

- An immediate risk to life and limb
- Immediate risk of serious harm
- Serious damage to property
- Offensive weapons
- Hostages

Police Attendance Protocol

Step 1 – Decide RVP

At the time healthcare staff request the police to attend, a suitable rendezvous point (RVP) should be agreed. This is where the most senior police officer present can meet with the most senior member of health staff before police deployment onto the ward takes place. Depending on the circumstances and urgency of the situation, an RVP may not be suitable.

Step 2 – Incident explained

Police and health staff meet at the RVP. Health staff will explain the incident, which should include any specific risks associated with the patient (e.g. the patient's legal status; whether the patient has already been restrained by healthcare staff; whether tranquilisation has been administered and the effect this has had; highlighting any dangers and relevant health related issues). An assessment of available/sufficiently trained staff should also be made.

Step 3 – Police/Health roles established

If further deployment is necessary both Health care/Police leads will work together to decide how best to resolve the incident. Police will consider the use of specialist officers/public order trained/hostage negotiator etc., where relevant. Throughout the incident health staff will remain responsible for the patient's health and safety.

Step 4 – Police handover

Police will regain control of the ward/patient/situation using appropriate tactics. If police restraint is used, police will hand-over the patient to healthcare staff as soon as control is regained. There should be sufficiently trained healthcare staff to enable this to happen (unless exceptional circumstances, e.g. health staff injured/unavailable).

Step 5 – Determine need for Criminal Investigation

If a criminal act is alleged or the police determine that a criminal offence has been committed, a police investigation should be instigated. If a patient is suspected to be responsible for a crime, it will be an exceptional set of circumstances where police will consider arresting and removing the patient from the health setting. The crime will be recorded by police and a statement obtained from relevant witnesses. A short statement/CPS approved pro-forma will also be obtained from a suitably qualified health practitioner in relation to the patient's mental state at the time of the offence.