Prevention and Management Violence and Aggression (PMVA) Policy

(Reducing Restrictive Interventions, Positive and Proactive Care)

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1 INTRODUCTION

1.1 RESTRICTIVE INTERVENTION STATEMENT

The Trust is totally committed to providing high quality, person centred care that maintains the dignity of, and respect for our patients, ensuring that restrictive Interventions used within inpatient areas is reduced.

This document promotes the development of therapeutic environments, and reducing all forms of restrictive practice so that they are used as a last resort only, and then for the shortest possible time.

All aspects of risk management are to be implemented, taking account of the person’s wishes and best interests, operating within a framework of continual monitoring, reviewing and reducing any necessary restrictive practice.

The policy is developed using the following frameworks

The Department of Health launched Positive and Proactive Care: reducing the need for restrictive interventions in April 2014


http://www.cdc.gov/violenceprevention/overview/publichealthapproach.html

These frameworks are implemented via Trust level policies and procedures with assurance being derived from internal audits and inspections and external review from Monitor and Care Quality Commission (CQC). The Trust’s lead for this work is Director of Nursing and Partnerships.

Six key actions have been identified to ensuring improved care:

• Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restrain on any surface, not just on the floor
• If restrictive intervention is used, it must not include the deliberate application of pain
• If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate risk
• The use of seclusion is permitted under the guidance as detailed in the MHA Code of Practice (2015). However, as the purpose of seclusion is to contain exceptional emergency situations which compromise standards of safety, it is possible that seclusion could be used in relation to a patient who is not subject to detention under the MHA 1983. In these circumstances common law powers would be used to seclude the patient, but in using these powers, staff must only use a degree of physical or medical intervention, which is sufficiently enough to bring the emergency to an end. An immediate review of the patients legal status would be required once the immediate risks had been reduced
• People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of their care and support, and
• Individualised support plans, incorporating behaviour support plans must be implemented for all people who use our services. Plans must clearly demonstrate the steps to be taken for the purpose of restrictive intervention reduction planning (DH 2014)

This policy is underpinned by the 2015 NICE Guideline 10 Violence and aggression, the short term management in mental health, health and community settings and the Department of Health publication Positive and proactive care, embedding the human rights based approach described as PANEL- Participation, Accountability, Non-discriminatory, Empowerment and Legality within all areas.

The trust ethos is to reduce restrictive interventions and if necessary ensure restraint is carried out using least restive technique, for the shortest time possible. The philosophy is to improve care, ensuring a robust leadership, assurance and accountability strategy which is transparent and routinely monitored.

2. Definitions

Mental Capacity Act Code of Practice states that someone is using restraint if they: “Use force or threaten to use force to make someone do something that they are resisting or restrict a person’s freedom of movement whether they are resisting or not.”

Work-related violence - The Health and Safety Executive (HSE) defines it as any incident in which a person is abused, threatened or assaulted in circumstances relating to their work. This can include verbal abuse or threats as well as physical attacks.

Violence and aggression – refers to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

Restrictive Intervention – Interventions that may infringe a person’s human rights and freedom of movement, including observation, seclusion, manual restraint, and rapid tranquillisation.

Positive Behavioural Support Plan (PBS) – “A framework that seeks to understand the context and meaning of behaviour in order to inform the development of supportive environments and skills that can enhance a person’s quality of life” “Any person who can reasonably be predicted to be at risk of being exposed to restrictive interventions must have an individualised Behaviour Support Plan.” Department of Health 2014.

Physical Assault The intentional application of force to the person of another without lawful justification resulting in physical injury or personal discomfort.’

Non-Physical Assault: - the use of inappropriate words or behaviour causing distress and/or constituting harassment.

De-escalation – A set of verbal and nonverbal skills which if used selectively may
reduce the level of arousal.

Rapid Tranquillisation - Rapid Tranquillisation is the use of medication to calm the patient, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression, thereby allowing a thorough assessment to take place and allowing comprehension and response to spoken messages throughout the intervention.

3 PURPOSE

The purpose of this policy is to set out the arrangements for managing the risks associated with the reduction, prevention, and management of work related violence and aggression, both in clinical and non-clinical settings ensuring that the risk of its reoccurrence is minimised.

4 SCOPE

This policy applies to all staff, patients and visitors. It covers both physical and non-physical violence and aggression, including:

- Physical violence and assault
- Self-harm
- Antisocial, offensive or disruptive behaviour
- Verbal abuse
- Threatening language or behaviour
- Harassment
- Damage to personal or Trust property

A significant proportion of this policy applies particularly to staff working in the Trust’s Mental Health and Learning Disability In-Patient Services, where specific legal and practice requirements must be implemented as set out in documents such as NICE Guideline on Violence and Aggression 2015, The Mental Health Act Code of Practice 1983 (amended 2015). The detail of some of these requirements is further set out in a number of associated Trust polices listed in Section 12, with which staff must be familiar.

5 RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

5.1 Trust responsibilities

- The Trust Board recognises its duties with regard to reducing restrictive interventions and the prevention and management of violence and aggression by safe and proper means demonstrating the least restrictive option, in order to safeguard staff, patients and others as far as is reasonably practicable.
- The Board of Directors delegates to the Chief Executive overall responsibility for the effective implementation of this policy, which in turn is delegated to the Executive Directors of the Trust.
- The role of Director responsible for PMVA is the Director of Nursing and Quality.
5.2 Security Management Director (SMD) - Executive Director of Finance

The role of the Executive Director of Finance in this Trust is also the SMD, whose role is to promote security management work from the non-executive function at board level, to support the Local Security Management Specialist (LSMS) in their role, challenge, scrutinise and ensure accountability in respect of security management work and facilitate access to competent legal advice when required.

5.3 Local Security Management Specialist (LSMS)

The LSMS will:

- Develop a strong interface with clinical services to help promote a culture that focuses on early recognition, prevention and de-escalation of potential aggression with the focus on reducing the risk of its recurrence.
- Promote awareness and support implementation of evidence based best practice, from an overall security management perspective.
- Take forward security management work locally according to statutory requirements and national standards and guidance issued by NHS Protect.
- Provide advice and support to Managers and staff following a serious assault.
- Monitor incident reports of violence and aggression, promoting the use of sanctions, notification to the police and prosecutions as appropriate.
- Work with the PMVA Team and Managers to promote continuous improvement with regard to security management and organisational learning. Work collaboratively with the police to facilitate any required investigation processes.
- Provide the Quality Assurance Sub Committee with an annual report and forward work plan to tackle security management issues with an emphasis on the prevention and management of workplace violence.

5.4 Directors

Through their managers the Directors will:

- Make arrangements for the effective implementation and monitoring of the policy.
- Promote a culture which focuses on PMVA by early recognition, prevention and de-escalation of potential aggression, using techniques that minimise the risk of its recurrence.
- Support the use and implementation of individual Positive Behavioural Support Plans where necessary.
- Promote a positive reporting and learning culture to facilitate continuous improvement with regard to violence and aggression.
- Influence the design of buildings via the Head of Estates and Facilities so that full account can be taken of known environmental factors associated with positive risk management.
- Assess their areas of responsibility and produce risk assessments as required under the Management of Health and Safety at Work Regulations 1992, where violence is identified as a hazard. The risk assessment must be produced in liaison with the Health and Safety Lead.
- Following the Risk Assessment, agree local procedures as required and
communicate these to the associated staff.

- Advise and instruct staff on the policy requirements via local induction arrangements and on-going communication mechanisms, such as staff meetings, supervision, post-incident reviews etc.
- Facilitate and monitor the attendance of staff on mandatory PMVA Training.

5.5 Head of Education

The Head of Education is responsible for the implementation of the Mandatory Risk Management Training Policy and associated Training Needs Analysis, providing reports on compliance to the individual care groups. The responsibility also includes the management of the PMVA team and the training programme.

5.6 Prevention and Management of Violence & Aggression (PMVA) Team

The PMVA Team will:

- Promote awareness and a culture using evidence based best practice, which focuses on PMVA by early recognition, prevention and de-escalation of potential aggression, using the least restrictive interventions/practices that minimise the risk of its recurrence.
- On-going education must aim to facilitate a shift in the emphasis from secondary and tertiary prevention to a focus on prevention through organisational learning.
- Oversee, coordinate, and take responsibility for, the planning and provision of training according to national guidance and local risk assessments. Any training in PMVA within the Trust must only be provided in consultation and agreement with the PMVA Team.
- Maintain comprehensive training records of all training delivered. It is an NHS Protect requirement that these are kept for a minimum of 5 years.
- Provide advice and support to Managers on risk assessments in order to identify and plan for training, which is fit for purpose, appropriate to role, evaluated from lessons learnt.
- Work with managers to facilitate effective implementation and monitoring of this policy.
- Where needed or appropriate work with staff and patients to review incidents and be where possible be available for de-brief.
- Support and advise areas on individual patient needs providing bespoke training as identified within a behavioural support plan.
- Where the need for an intervention has been identified. The team will work with areas where required to provide advice on the management of the intervention using the least restrictive option.
- Audit the use of Positive Behavioural Support Plans on an annual basis, as recommended by the Department of Health (2014).
- Work with the Head of Estates and Facilities on design of buildings so that full account can be taken of known environmental factors associated with positive risk management.

5.7 The Resuscitation Service

The resuscitation service will:
• Support and advise areas to plan physical healthcare of patients during and after restrictive interventions
• Provide advice and support to both patient areas and the PMVA team around the physical healthcare of patients during and post restrictive interventions.

5.8 Managers

Managers will:

• Advise and instruct staff on the policy requirements via local induction arrangements and on-going communication mechanisms.
• Facilitate an understanding of the legal and practice requirements which must be implemented as set out in this policy and associated polices.
• Facilitate and monitor the attendance of staff on mandatory PMVA training.
• Maintain accurate staff training records.
• Promote an environment where all staff demonstrate and encourage respect for equality and diversity and recognise the need for privacy and dignity.
• Promote a culture which focuses on PMVA by early recognition, prevention and de-escalation of potential aggression, using techniques that minimise the risk of its recurrence.
• Promote a positive reporting and learning culture to facilitate continuous improvement with regard to the provision of safer and therapeutic services.
• Ensure all incidents of violence and aggression are reported via the Electronic Incident Form (IR1)
• Any incidents requiring physical intervention must have a Restraint/Physical Intervention Monitoring Form and Body Restraint Chart completed and filed within the patient’s clinical record. See Appendix A.
• Facilitate timely post-incident patient debrief which will not only provide support and understanding, but will enable the team and patient to work in partnership to create or evaluate Positive Behavioural Support Plans. By working in partnership with patients, teams will be able to prevent the reoccurrence of violence or implement the least restrictive interventions by learning from previous incidents.
• Facilitate timely post-incident staff support, to limit wherever possible the effects of exposure to distressing workplace events.

5.9 All staff

All staff are required to:

• Promote a culture which focuses on Prevention and Management of Violence & Aggression (PMVA) by early recognition, prevention and de-escalation of potential aggression, using techniques that minimise the risk of its recurrence.
• Ensure the implementation of Positive Behavioural Support Plans where appropriate.
• Implement the policy and agreed measures to manage risks.
• Demonstrate and encourage respect for equality and diversity and recognise the need for privacy and dignity.
• Participate in the identification of both environmental and clinical violence and aggression hazards and the production of risk assessments.
• Take reasonable steps to protect themselves and others from harm.
• Attend mandatory training on PMVA
• Report all incidents and participate in post-incident reviews.
• Seek advice and support as required in a timely manner).

6 PROCEDURE/IMPLEMENTATION

All those involved in the management of disturbed/violent behaviour should:
be familiar with:

• The relevant sections of the Mental Health Act 1983 (amended by the Mental Health Act 2007) and its Code of Practice 2015
• The Mental Health Act Code of Practice, chapter 26 - Safe and Therapeutic Responses to Disturbed Behaviour which outlines Primary, Secondary and Tertiary Strategies
• The principles underlying the common law doctrine of ‘necessity.’
• The requirements of the relevant articles of the European Convention on Human Rights, including Article 2 (right to life) and Article 3 (the right to be free from torture or inhuman or degrading treatment or punishment). Article 5 (the right to liberty and security) and Article 8 (the right to respect for private and family life) and the principle of ‘proportionality.’
• The Health and Safety at Work etc. Act 1974, which places duties on both employers and employees, and applies to the risk of violence from patients and the public.
• The Management of Health and Safety at Work Regulations 1992, which places specific duties on the employer to ensure suitable arrangements for the effective planning, organisation, control, maintenance and review of health and safety (these duties include ensuring that risk assessments are undertaken and implemented).
• The Mental Capacity Act 2005: Deprivation of Liberty Safeguards - Code of Practice (MOJ 2008)
• Receive regular training on the above.
• Ensure that a comprehensive record is made of any intervention necessary to manage an individual’s disturbed/violent behaviour, including full documentation of the reason for any clinical decision.
• Ensure or contribute to ensuring that all aspects of the management of disturbed/violent behaviour are monitored on a regular basis, and that any consequential remedial action is drawn to the attention of those responsible for implementing it.
• Be aware of the obligations owed to a patient while their disturbed/violent behaviour is being managed, and of parallel obligations to other patients affected by the disturbed/violent behaviour, to members of staff, and to any visitors.
• Ensure or contribute to ensuring that any patient who has exhibited disturbed/violent behaviour should not be the subject of punitive action by those charged with providing them with care and treatment, and that where the disturbed/violent behaviour is thought to warrant criminal sanction, it is drawn to the attention of the proper authority.
6.1 Duty of Care

By law, staff have a duty of care to patients, themselves and others. This will be provided by ensuring suitable treatment and care that is in the patients’ best interests. Treatment must be necessary to preserve or improve health and be in accordance with practice accepted at the time by a responsible body of opinion appropriate to the staff involved. Staff must be skilled in the particular form of treatment being utilised.

6.2 How the Trust carries out risk assessments for the prevention and management of violence and aggression (Refer to The Trusts Security Policy for further detail)

- Risk assessment for the prevention and management of violence and aggression is an on-going and dynamic process that reflects changing environmental and patients.
- Environmental factors which affect aggression and violence are risk assessed as part of the two yearly (minimum standard) Workplace Security Inspection / Security Risk Assessment, as described in the Trust Security Policy.
- The process and monitoring arrangements are described in the Security Policy.

These risk assessments are reviewed by Managers every two years or when circumstances change e.g. change of building use or design, change in patient group, need identified through review of incidents.

- Patient risk assessment for violence and aggression is a core component of the clinical risk assessment and risk management process, carried out by clinical staff and teams using approved clinical risk assessment tools and informing where required a patients Positive Behavioural Support Plan. See Clinical Risk Assessment and Management Policy.
- Advice and support on risk assessment can be sought from the PMVA Team, the LSMS and the Health and Safety Lead as appropriate.

6.3 Timescales for review of risk assessments

- Patient

For patient risk, assessment, due to the diversity of clinical services provided in community and hospital settings, timescales for review will vary considerably depending on the identified risks.

Patient risk assessment is a dynamic and continuous process, and review timescales may vary from e.g. a daily review in an inpatient setting to a 6 monthly review, depending on identified risk and patient need. The timescales for review will be determined by the relevant clinical staff and clinical team.

A clinical risk assessment must be completed and documented within the clinical record at:

- the point of referral
- at each subsequent review for all patients (those subject to Care Programme Approach or otherwise)
- when prompted by a change of circumstances e.g. admission, discharge,
change in personal circumstances etc.
- movement between services, shared care, etc.
- Environmental (Refer to Trust Security Policy for further detail)
- See above for environmental risk assessment.

6.4 How action plans and Positive Behavioural Support Plans are developed as a result of the risk assessments

- Environmental (Refer to the Trusts Security Policy for further detail)

Actions required to mitigate a risk identified by the Workplace Security Inspection / Security Risk Assessment are to be agreed with the Manager, and Security Advisor.

The action plan is to contain the following information;
- Who has overall responsibility for the action plan (if not the Manager)?
- What the risk is?
- What is required to mitigate the risk?
- Who is responsible for the required action?
- When the action is to be completed?

The manager is to forward a copy of the action plan to the Security Advisor with the Risk Assessment

- Patient – see 6.3 above

Advice and guidance can be obtained from the PMVA Team and the LSMS as appropriate.

6.5 How are action plans and Positive Behavioural Support Plans are followed up

- Environmental (Refer to Security Policy for further detail)

The completion of an action plan is the responsibility of the Manager of the area it applies to.

The Security Advisor will request an update on the action plan near the completion date, and an exception report will be presented to the Health Safety & Security Forum if required.

- Patient (as above)

6.6 Arrangements for making sure lone workers are safe

Where staff are working alone or in remote locations, they should follow the guidance and instruction within the Lone Working Policy.

6.7 Environment

The NICE Guideline 10 Violence and Aggression,(2015) the short term management in mental health, health and community settings recommends that
the environment should be improved or optimised wherever possible, e.g. enhancing décor, simplifying ward layout and ensuring easy access to outdoor spaces and privacy.
Assessment of the environment should form part of the health & safety risk assessment carried out in each area on a regular basis. The PMVA team must be consulted with for any plans for new buildings or refurbishment in applicable areas.

6.8 Workplace stress

Where risk assessment identifies violence and aggression as a hazard that may affect the health and wellbeing of staff, the policy for Healthy Workplaces: staff support and stress at Work should be referred to, in order to proactively identify measures to reduce stress.

- The consequences of violence can be far reaching for staff, patients and others alike and include:
  - Physical/psychological injury or death of staff or patient.
  - During the incident and for some time afterwards, reduced numbers of staff available to work with patients.
  - Short-term reduction in staff due to sickness.
  - Increase in workplace stress.
  - Reduced morale.
  - Reduction in permanent staff leading to reduced quality of communication.
  - Lack of confidence in staff (in themselves and by patients).

Advice and support can be sought from the Human Resources Department as appropriate.

6.9 On admission to a Mental Health or Learning Disability Service

Primary prevention-

For primary prevention to be effective, it is essential to understand the cause rather than simply address some underlying symptom. This requires proactive intervention from the outset by engaging with the individual to identify triggers and jointly agreeing supportive interventions.

- All patients should be assessed for immediate and potential risk of; absconding, suicide, self-harm, aggressive and threatening behaviour towards others, physical violence, drug or alcohol abuse, and, self-neglect. Individual care plans including Positive Behavioural Support (PBS) plan if required should be developed. The Positive Behaviour Support (PBS) plan should include any identified/known triggers for these behaviours, actions to be taken should any of these occur, and any known physical health conditions that may be exacerbated by restrictive interventions, and may impact on the post incident physical health monitoring.
- Secondary intervention- relies on the need for effective observation, an awareness of warning signs, early intervention, engagement and positives communication. This level of prevention relies upon conflict resolution and de-escalation skills
- Patients’ behaviour should be seen in context. Staff should not categorise behaviour as disturbed without taking account of the circumstances under
which it occurs. While it is an important factor in assessing risk, it should not be assumed that a previous history of disturbance means that a patient will necessarily behave in the same way in the immediate future.

- Particular care needs to be taken to ensure that negative and stigmatising judgements about certain diagnoses, behaviours or personal characteristics do not obscure a rigorous assessment of the degree of risk which may be presented - or the potential benefits of appropriate treatment to people in severe distress.

6.10 On Admission to Other Services

During the admission process, all patients should be observed for any behaviour which may indicate that there is a heightened risk of violence, aggression or abuse. If so, individual Positive Behavioural Support Plans should be developed and advice sought from the PMVA team if required.

6.11 Advance Statements and Advance Decisions

- Patients identified to be at risk of disturbed/violent behaviour should be given the opportunity to have their views and wishes recorded in the form of an advance statement.
- They should be encouraged to identify as clearly as possible what interventions they would and would not wish to be used. This should be subject to periodic review. See Policy on Advance Statements and Advance Decisions

6.12 Restrictive Interventions

Tertiary prevention

In some areas it may be necessary to avoid a situation escalating. Knowledge of the service user’s history and associated risk factors will help inform necessary and proportionate staff responses.

Any form of restraint: physical, mechanical, environmental or pharmacological constitutes restrictive practice and all services have a duty of care to minimise its use.

In certain circumstances the presenting risk may merit the need for restrictive intervention to be utilised in order to prevent harm from occurring. It is vital therefore that when any restrictive procedures are used, deploying staff are fully aware of the risks involved. These risks and associated precautions must be addressed in training syllabi which places them within legal, ethical and professional context.

- Rapid tranquillisation, physical intervention, seclusion and observation should be used only where de-escalation and other strategies have failed to calm the patient.
- These interventions are management strategies and are not regarded as primary treatment techniques. They should always be used in conjunction with further efforts at de-escalation, and must never be used as punishment or in a punitive manner.
• Any such intervention must be used in a way that minimises the risk to the patient’s health and safety and that causes the minimum interference to their privacy and dignity, while being consistent with the need to protect the patient and other people.

• When determining which interventions to employ, clinical need, safety of patients and others, and, where possible, PBS and statements made by patients who are subject to compulsory powers under the Mental Health Act 1983 (MHA) about their preferences for what they would or would not like to happen if a particular situation arises in future, should be taken into account. This includes legally binding advance decisions to refuse treatment. See Section 6.11 above and Chapter 9, Code of Practice Mental Health Act 1983 (amended by the Mental Health Act 2007)

6.13 Physical intervention

• Managing aggressive behaviour by physical intervention using the least restrictive approach should be undertaken only as a last resort in an emergency when there is a real possibility that harm would occur if no intervention is carried out.

• The most common reasons for needing to consider such interventions are:
  o Physical assault
  o Dangerous, threatening or destructive behaviour
  o Extreme and prolonged over-activity that is likely to lead to physical exhaustion and risk to health
  o Attempts to abscond (where the patient is detained under the MHA)

• The purposes of intervention where de-escalation has failed are to:
  o Take immediate control of a dangerous situation
  o End or reduce significantly the danger to the patient or others around them
  o Contain or limit the patient’s freedom for no longer than is necessary

• Any physical intervention used must be:
  o Reasonable, justifiable and proportionate to the risk posed by the patient
  o Using the least restrictive approach at that moment in time, which should be reduced as the patient de-escalates
  o Used for only as long as is absolutely necessary
  o Involve a recognised technique that does not depend on the deliberate application of pain
  o Be carried out by staff who are appropriately trained and compliant with the training
  o Any physical intervention in a community setting must be fully risk assessed; ensuring compliance with the legal framework that intervention is being carried out under.

• A single member of staff should lead and control the situation and the patient should be approached where possible and agreement sought to stop the behaviour. Where possible an explanation should be given to the patient of the consequences of refusing the request from staff to desist. The special needs of patients with sensory impairments should be considered - approaches to deaf or hearing-impaired people should be made within their visual field.
• During physical intervention one team member should be responsible for protecting and supporting the head and neck, where required. They should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.

• A number of physical skills may be used in the management of a disturbed/violent incident. Every effort should be made to utilise skills and techniques that do not use the deliberate application of pain, which has no therapeutic value and could only be justified for the immediate rescue of staff, patients and/or others.

• It is important that restraint through the use of physical intervention is seen within the overall spectrum of approaches for dealing with violence and aggression. Disengagement from a violent or potentially violent situation is preferable. Occasions may occur when the safety of self or others may supersede this.

• Staff will develop a clear understanding of factors that may contribute to disturbed behaviour and dealing with violence and aggression through local induction procedures, advice and instruction from Managers on the policy and through their attendance on mandatory PMVA Training.

• Staff likely to be involved in restraint through the use of physical interventions must be suitable trained by attending the relevant course as set out in Section 9 of this policy.

• Violence that occurs very suddenly and without time to de-escalate or summon help may require immediate physical intervention. The use of such intervention is acceptable in law providing the amount of force is reasonable to stop the attacker, and/or stop injury to the person being attacked or injury to the attacker.

Clinical Holding
A definition of Clinical Holding as taken from the Mental Capacity Act is ‘The use of restrictive physical interventions that enable staff to effectively assess or deliver clinical care and treatment to individuals who are unable to comply.’

Clinical holding may be defined as the proactive holding of part of the body to allow a procedure to be carried out, e.g. 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 interventions are planned interventions and therefore must be care planned accordingly.

Clinical holding interventions should not routinely be incident reported (IR1) unless something untoward occurs (e.g. an injury to patient or staff).

Clinical Holding should not routinely require a full Early Warning Score (EWS) to be completed, unless there is a clinical need.
6.14 Physical care and observation of the patient /The Early Warning Score (EWS)

(See also section 7.5 patients brought in by the police who may have been restrained)

6.15 During restraint/physical interventions

Verbal de-escalation should continue throughout the intervention, and negotiations with the patient to comply with requests to stop the behaviour should continue where appropriate.

Physical monitoring should commence during any restraint, however is of particular importance:

- During and following a prolonged or violent struggle
- If the patient has been subject to rapid tranquillisation
- If the patient is suspected to be under the influence of alcohol or illicit substances.
- If the patient is clinically obese
- If the patient has a known condition which may inhibit cardiopulmonary function e.g. Asthma

At the point of restraint and every 5 minutes during the restraint the following observations should be recorded:

- Respiratory rate
- Central Nervous System (CNS) (Alert Voice Pain Unconsciousness) (AVPU) level
- Oxygen saturations(O2 saturations)
- Pulse

If it is not possible to monitor O2 saturations and pulse, respiratory rate and CNS (AVPU) must be recorded as a minimum and rational documented as to why O2 saturations and pulse could not be recorded.

These observations must be recorded on the physical observation chart and EWS calculated and recorded.

It is also important to monitor for any verbal or non-verbal signs of pain or discomfort.

Physical observations that cause a concern must be reported immediately to a Doctor and the clinician in charge of the restraint must assess whether releasing the restraint is a viable option at this time. If it is unsafe to release the restraint the clinical team and the Doctor should reassess the restraint.

If after release from restraint observations do not improve further medical assistance should be sought via the ambulance service particularly if:

- The patient is struggling to breathe
- There is noted flushing and redness to the face and neck
- There is marked expansion of the veins in the neck
• Changes in behaviour
• Reducing level of consciousness

**Care of other patients**

A member of staff should take the lead in caring for other patients and moving them away from the area of disturbance.

Staff not involved in the physical intervention should leave the area quietly.

**6.16 After restraint**

Once the restraint has been released Every 15 minutes for the first hour and every 30 minutes for the next three hours the following observations must be recorded

- Respiratory rate
- CNS (AVPU)

These observations must be documented on the physical observations chart and an EWS calculated They can be taken without cooperation from the patient therefore must be taken in every event

The following observations should be taken only if there is clinical indication of deterioration or change in the patients physical condition and only then, if it is safe to do so

- O2 saturations
- Blood pressure
- Pulse
- Temperature

These observations must be documented on the physical observations chart and an EWS calculated

If at any time there is cause for concern for the patients physical health a Doctor must be contacted.

Rationale for the level of physical observations taken should be recorded in the nursing notes, not on the chart.

**6.17 Seclusion**

Seclusion is the supervised confinement of a patient in a specifically designed and approved room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others. It has a place to play in the spectrum of least restrictive interventions available to support the management of violence and aggression. See *Management of a Secluded or Segregated patient Policy* for further information.

**6.18 Rapid tranquillisation**

Rapid Tranquillisation should only be considered once de-escalation and other
strategies have failed to calm the patient, and should be considered as a management strategy and not a primary treatment technique. See *Rapid Tranquillisation Policy and Guidelines*.

Physical intervention may be used in order to administer medication to an unwilling patient where there is legal authority, whether under the Mental Health Act 1983 (amended by the Mental Health Act 2007) Mental Capacity Act 2005 or otherwise, to treat the patient without consent.

6.19 **Observation**

Increased levels of observation may be used both for the short-term management of disturbed behaviour and to prevent suicide or serious self-harm. See *Policy for The Care of In-Patients who are Identified as Posing a Significant Risk to Themselves or Others*.

6.20 **Mechanical restraint**

The use of mechanical restraint is not permitted.

This might include strapping or tying a patient to an object, fastening trays to chairs to prevent patients getting out, placing chairs facing walls to prevent movement, hooking clothes over chairs, commodes or other objects to prevent movement. The Trust does not support any of these forms of approach.

6.21 **Incidents where dangerous weapons are present**

Staff should not attempt to physically disarm any person who is acting in a hostile manner with any kind of dangerous weapon. Urgent Police assistance should always be requested.

6.22 **Calls for police assistance**

Please see appendix E for advice and guidance on calling the police.

6.23 **Debriefing**

Tertiary prevention recognises the need for thorough post incident review procedures in order to ensure lessons are learned from incidents and that action is taken to prevent the risk of re-occurrence.

Debrief must;

- Evaluate the physical and emotional impact on all involved including witnesses.
- Identify if there is a need, and if so provide counselling or support for any trauma that might have resulted.
- Help patients and staff to identify what led to the incident and what could have been done differently to ensure lessons are learnt from each incident.
- Determine whether alternatives including less restrictive interventions were considered.
- Determine whether service barriers or constraints make it difficult to avoid the
same course of action in future.

- Where appropriate recommend changes to the service philosophy, policy, care environment, treatment approaches, staff education and training.
- Patients should not be compelled to take part in debrief, they should be offered the right to talk about the incident independently.

If required the PMVA team can be available to assist in the debrief process.

6.24 **Defusing**

- This is the process of discussing an incident or series of minor incidents at the end of the working shift/day if staff-wish. The team manager or person in charge of the shift should initiate it.
- The purpose is to provide an immediate outlet for staff to voice their thoughts and feelings following a difficult period of working. It does not replace debriefing, which may still be held, depending on the severity of the incident and the feelings of those involved.

6.25 **Post incident management for staff**

- Any member of staff who has been involved in a violent incident should be offered these supportive processes when they have recovered their composure, and their right to this should be respected regardless of the manager's view of the incident.
- The review should acknowledge the emotional response to the event, promote relaxation and feelings of safety, facilitate a return to normal patterns of activity and begin to consider if there is a specific need for emotional support in response to any trauma that had been suffered.
- Ensure that all appropriate parties have been informed of the event and ensure that all necessary documentation has been completed.

6.26 **Staff issues**

- A review of whether staff require medical treatment, sick leave or temporary relief from duty must be carried out by the Manager and appropriate arrangements made. Staff may wish to be referred for counselling via the relevant Occupational Health Department or alternatively could choose to access the Staff Counselling Service.
- A review and assessment of working practices and security measures must be carried out and appropriate changes made where required. Where changes are required, but cannot be implemented, these must be reported to the Director/Senior Manager immediately.
- The Manager should discuss the issue of pursuing a prosecution against the assailant, and offer to accompany the member of staff to the police if necessary. Advice and support can be provided by the LSMS.
- If the member of staff requires sick leave, the Manager should establish how frequently the member of staff would like to be contacted. Staff may feel very isolated if they are away from work, and unable to discuss the events. Managers should also check how the staff are feeling when they return to work, and at intervals following the incident. See *Sickness and Absence Policy*.
- Advice and support can be sought from the Human Resources Department as
appropriate.

6.27 On-going review of incident and consideration of Duty of Candour

Once a situation has been deemed safe, consideration needs to be given as to the longer term care needs of the patient(s) involved. Options to be considered by the multi-disciplinary team are:

- The need to move a patient to another unit area to prevent a further occurrence. Use of a moving and handling risk assessment may be required.
- The need for the patient to be nursed in seclusion for a period of time. See Management of a Secluded or Segregated Patient Policy.
- The need for a patient to be transferred into a more suitable secure area.
- Review of treatment and medication aims and effectiveness.
- The need for the patient to be nursed on special observations. See Policy for the care of in-patients who are identified as posing a significant risk to themselves or others
- Consideration should be given to Duty of Candour.

6.28 Visiting

- Trust staff are responsible for the health and safety of any visitors who are on Trust premises. In the event that visitors are in the vicinity when an incident occurs they should be removed to a safe area immediately.
- Witnessing a violent incident can be distressing. Staff should offer support and reassurance, and explain why the visitors are being removed, and when it is safe for them to return to the area from which they have been removed.
- See Policy on the Visiting Patients on Inpatient Areas, and Policy for Children visiting In-Patient and Residential Units within the Trust.

6.29 Incident reporting and recording

Staff must report all incidents of restrictive interventions as soon as possible after the incident by completing and submitting an Electronic Incident Form (IR1) via the electronic Safeguard incident reporting system. See Incident Reporting Policy.

These incident reports are reviewed by the Local Security Management Specialist (LSMS), PMVA Team and Resuscitation Service and reviewed with the relevant Manager as appropriate.

It is a requirement that all incidents of physical and non-physical assault are reported - whether intentional or not.

Recording

Where restrictive interventions are used staff must:

- Record the decision and the reasons for it and complete a Restraint/Physical Intervention Monitoring Form and Body Restraint Chart. See Appendix A.
- Document and review every episode of restrictive intervention, which should include a detailed account of the restraint.
- Record the physical observations on the physical observation chart
- Document the debriefing discussion with the patient
- File the patient’s written account (where provided) of what happened

All the above will be kept in the patient’s clinical record.

Where patients are brought in by the Police, staff must establish if the Police have physically restrained the patient and the discussion with the Police should be recorded in the patient’s clinical record.

6.30 Responding to Complaints

Any complaint made against staff as a result of a violent incident will be dealt with quickly and fairly and investigated as per the “Policy and Procedure Relating to the Handling of Formal Complaints (including unreasonable persistent complainants)”. Staff are also encouraged to consult their own professional association or Trade Union for advice.

6.31 Pursuing criminal proceedings

Following a serious assault the process set out in Appendix B must be followed. The LSMS will provide advice and support to Managers and staff as required.

7 Special situations and considerations

7.1 Gender/sexual safety

There may be occasions where the staff team, confronted with an aggressive patient, face the potential problem of gender/sexual issues, such as an all-male team needing to manage a female patient or an all-female team having to manage a male patient.

On these occasions an attempt should be made to ensure there is a staff member of the same sex as the patient at the scene to observe the management of the situation.

There should be no attempt to change the responding nurse team into one of mixed gender unless it is safe to do so and the person stepping in is trained in physical interventions.

7.2 Patients with disabilities

Where it is known that a Patient has disabilities, including physical or sensory impairments and communication difficulties, they should have specific instructions in their PBS plan concerning the preferred method of dealing with incidents, which may require specific interventions. The PBS plan should set out the responsibilities that each member of staff has in relation to the actions required.

7.3 Pregnant Patients

Where it is known that a patient is pregnant, advice should be sought from the PMVA Team, Resuscitation Service, Obstetrics and Gynaecology, and special
provisions made where interventions may be required. The agreed interventions must be documented in the patient’s care plan.

7.4 Managing patients with HIV other communicable diseases

If staff are aware that a patient has a potentially infectious condition, the advice of the infection prevention and control team should be sought. Upon their guidance, protective clothing and equipment will be made available. Any special provisions to be implemented with patients should be clearly written up in their care plan.

If a member of staff or a patient is involved in an incident which involves a risk of infection, where the skin is broken, blood is spilt, or there has been direct contact with body fluids, then the Policy for Spillages of Blood and Other Bodily Fluids should be followed.

7.5 Patients brought in by the police who may have been restrained and searched

Where patients are brought in by the Police, staff must establish if the Police have physically or mechanically restrained the patient, and if so, or if staff are unsure a physical observation should commence. The discussion with the Police should be recorded in the patient’s clinical record and body map completed. Staff must establish if the patient has been searched prior to arrival at the unit, if not or staff are unsure they should follow the direction in the Trust Searching of a Person (Patient and Visitor) or their Property Policy.

7.6 Staff who undertake domiciliary visits or work alone

There are some staff within the Trust, who due to the nature of their work, will have to visit patients in their own homes or who may find themselves working alone. It is recognised that any staff who do work alone are particularly vulnerable, and the Trust has in place a lone working policy to which all managers and staff must adhere in all these circumstances. See Lone Working Policy.

7.7 Persons under 18 years of age on Adult Wards

In the exceptional circumstance that a person under 18 years of age is admitted to an adult ward, due consideration should be given to the involvement of parents or carers in the planning of care and treatment to maintain the therapeutic relationship. If a person under 18 years of age is admitted to an adult ward the PMVA team must be informed for any bespoke training to be considered.

8. TRAINING IMPLICATIONS

The Training Needs Analysis (TNA) for this policy can be found in the Trust's Mandatory Risk Management Training Policy

8.1 Prevention and Management of Violence & Aggression (PMVA) Training

All staff must have a comprehensive understanding of Prevention and Management of Violence & Aggression (PMVA).
The Trust provides 3 levels of training to ensure this:

- PMVA – Conflict Resolution – (Introduction face-to-face and then 3 yearly refresher by eLearning)
- PMVA – Disengagement (annual)
- PMVA – Comprehensive (annual)

An individual’s training matrix will identify at which level training should take place.

8.2 Life support

- All clinical staff involved in restraint or the administering and prescribing of rapid tranquillisation, or monitoring patients who have received rapid tranquillisation or restraint must receive training in Immediate Life Support (ILS) to a level equivalent to the Resuscitation Council ILS course. See the trusts Resuscitation Policy.
- With regard to persons under 18 years of age (see 6.7 above), from puberty a child is considered to be an adult in a life support situation.

8.3 Rapid tranquillisation

- All staff involved in rapid tranquillisation must be trained to the level of ILS. Prescribers and those who administer medicines must receive training in rapid tranquillisation including the properties, risks and titration of medications used in rapid tranquillisation. See the trusts Rapid Tranquillisation Policy and Guidelines

9 MONITORING ARRANGEMENTS

<table>
<thead>
<tr>
<th>Area for monitoring</th>
<th>How</th>
<th>Who by</th>
<th>Reported to</th>
<th>Frequency</th>
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<tr>
<td>Duties</td>
<td>LSMS Work plan and Security Report</td>
<td>Head of Health, Safety &amp; Security</td>
<td>Quality Assurance Sub Committee</td>
<td>Annual report and half yearly update report</td>
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<td>How the trust carries out risk assessments for the prevention and management of violence and aggression</td>
<td>Clinical Audit</td>
<td>Clinical Audit Manager</td>
<td>Clinical Policy Review Group (CPRG)</td>
<td>Annually</td>
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<td>Timescales for review of risk assessments</td>
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<td>How action plans are developed as a result of risk assessments</td>
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<tr>
<td>How action plans are followed up</td>
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<td>Arrangement for making sure lone workers are safe</td>
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<tr>
<td>How the trust trains staff, in line with the training needs analysis</td>
<td>Report</td>
<td>Head of Education</td>
<td>Individual care groups</td>
<td>Monthly</td>
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### Area for monitoring

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<th>Area for monitoring</th>
<th>How</th>
<th>Who by</th>
<th>Reported to</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit of Behavioural plans</td>
<td>Positive Support Report</td>
<td>PMVA team</td>
<td>Reducing restrictive interventions strategy group</td>
<td>Annually</td>
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### 10 EQUALITY IMPACT ASSESSMENT SCREENING

The completed Equality Impact Assessment for this Policy has been published on this Policy’s webpage on the Trust website.

### 10.1 PRIVACY DIGNITY AND RESPECT

#### Privacy, Dignity and Respect

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi’s review of the NHS, identifies the need to organise care around the individual, ‘not just clinically but in terms of dignity and respect’.

As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all patients with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).

#### Indicate how this will be met

There are no effects on the provision of privacy and dignity or respect within this policy.

### 10.2 Mental Capacity Act Statement

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individuals informed consent, or the powers included in a legal framework, or by order of the Court

Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.

#### Indicate How This Will Be Achieved

All individuals involved in the implementation of this policy should do so in accordance with the Guiding Principles of the Mental Capacity Act 2005. (Section 1)

### 11 LINKS TO ANY ASSOCIATED DOCUMENTS

- Clinical Risk assessment and Management Policy.
- Data Protection Policy
- Health Records Management Policy – Lifecycle of Clinical and Corporate Records
• Incident Reporting Policy
• Lone Working Policy
• Managing Sickness Absence Policy
• Mandatory Risk Management Training Policy and Training Needs Analysis
• Mental Capacity Act Policy
• Personal Harassment Policy
• Police Liaison Policy
• Policy and procedure for the searching of a person (patients or visitors) or their property
• Policy for children visiting inpatient and residential units
• Policy for Safer Manual Handling Operations
• Policy for spillage of blood and other body fluids
• Policy for the care of in-patients who are identified as posing a significant risk to themselves or others
• Policy for the Management of Serious Incidents
• Policy on Advance Statements and Advance Decisions
• Policy on the visiting of patients on the inpatient areas
• Healthy Workplaces: staff support and stress at Work
• Procedure for the Management of a Secluded Patient
• Rapid Tranquillisation Policy and Guidelines
• Resuscitation Policy
• Security Policy
• Whistleblowing (Disclosure of concerns on healthcare matters)

12 REFERENCES
• Care Quality Commission (2015) fundamental standards
• Department of Health (2004) Mental Health Policy Implementation Guide: developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health in-Patient settings
• Department of Health (2005) Delivering Race Equality in Mental Health Care: An action plan for reform inside and outside service, and the Government’s response to the independent inquiry into the death of David Bennett
• Health and Safety Executive (HSE) website provides further information and resources: http://www.hse.gov.uk/healthservices
• Health and Safety at Work etc. Act 1974
• Meeting needs and reducing distress Guidance on the prevention and
management of clinically related challenging behaviour in NHS settings

- Mental Capacity Act 2005
- Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- NHS Protect - http://www.nhsbsa.nhs.uk/Protect.aspx
- Positive and safe: reducing the need for restrictive interventions: Department of Health (20150
- Promoting Safer and Therapeutic Services – implementing the national syllabus in mental health and learning disability services (2005) NHS Security Management Service
- Self-harming over 8’s short term management and prevention and recurrence (2016
- Secretary of State Directions – Tackling Violence Against NHS Staff (2011)
- Tackling violence and antisocial behaviour in the NHS: Joint Working Agreement between the Association of Chief Police Officers, the Crown Prosecution Service and NHS Protect (2011)

13 APPENDICES

Appendix A - Restraint / Physical Intervention Monitoring Form and Body Restraint Chart
Appendix B - Action Following a Serious Assault
Appendix C - The Law
Appendix D - Reporting mechanisms
Appendix E – Requests for police assistance
APPENDIX A

RESTRAINT / PHYSICAL INTERVENTION MONITORING FORM

Name of Patient: M / F D.O.B:
Address:

Legal status:

ETHNIC ORIGIN

Asian or Asian British Bangladeshi □ Indian □ Pakistani □ Any other Asian background □
Black or Black British African □ Caribbean □ Any other Black background □
Mixed White & Asian □ White & Black African □ White & Black Caribbean □ Any other mixed background □
White British □ Irish □ Any other White Background □
Other ethnic group Chinese □ Any other ethnic group □ I do not wish to disclose this □

DETAILS

Date of restraint/physical intervention: Time: Hrs:

Rationale for use of restraint/physical intervention

Level of restraint/ physical intervention (number of staff involved)

Location where restraint/ physical intervention commenced (i.e. Seclusion room, Day room, Day unit, Main hospital)

Was the patient placed on the floor at any point throughout the procedure: Y / N
Was the patient placed in seclusion following the procedure: Y / N
Was the patient medicated during or following the procedure (oral or IM): Y / N
Any injuries to staff: Y / N Any injuries to patient: Y / N (if yes for either complete Incident form)
Medical Officer informed: Y / N  At:……………….. hrs  Name of
Dr:…………………………
Did Medical Officer attend the ward? Y / N  At:: ………………hrs

Outcome of restraint/ physical intervention (i.e. any change in legal status)

**LIST ALL STAFF INVOLVED IN RESTRAINT/PHYSICAL INTERVENTION:**

<table>
<thead>
<tr>
<th>Name update</th>
<th>Grade</th>
<th>Physical Interventions trained</th>
<th>Last update</th>
</tr>
</thead>
<tbody>
<tr>
<td>……………………</td>
<td>……..</td>
<td>Yes / No</td>
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<td>Yes / No</td>
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</table>

**DEBRIEFING**
Were the staff debriefed? Yes / No if no, why not?

Was the Patient Debriefed? Yes / No if no why not?

**DETAILS OF STAFF MEMBER COMPLETING FORM** (please print)

Name:  
Designation:  
Signature:  
Grade:  
Date:
BODY RESTRAINT CHART

DETAILS OF STAFF MEMBER COMPLETING FORM:
Name (please print)  Designation:  Grade:
Signature:  Date:

Staff Signatures

___________________

___________________

Staff Signatures

___________________

___________________

Staff Signatures

___________________

___________________

Time

Time

Time
**APPENDIX B**

**ACTION FOLLOWING A SERIOUS ASSAULT**

Serious Assault on a:
- Member of Staff
- Service user
- Visitor

Senior member of staff to:
- Contact Service Matron/Senior Manager on-call
- Contact Clinical Director (if Medic assaulted)
- Report to Police
- Inform Local Security Management Specialist (LSMS)

For any serious assault against a Medic, the Medic's decision-making responsibility will be immediately suspended, and responsibility temporarily handed to the Duty Consultant, who will make any immediate decisions required for the service user's care.

Arrangements will then be made for the service user's long-term care to be allocated to another Consultant via the pre-agreed Rota.

**Report to Police**

**Arrested by Police**
Criminal Justice System procedure to take its course.

Return to service only after full risk assessment by Consultant psychiatrist (new Consultant for service user if appropriate)

**Not Arrested**
Remain in Service
Clinical Review

Risk assessment by Consultant and victim informed of risk management process
Movement of staff if required
Change of Medic if appropriate
Senior Manager to raise the incident with Police at senior level if felt to be required
APPENDIX C

The Law

Powers to restrain – the law

- In all cases, the clinical needs of the patient and others must be taken into account.
- Any forcible intervention must be considered necessary on the basis of risk assessment (if alternative action or inaction would result in a greater risk) and must be **proportionate** to the perceived or actual harm likely to result if no such intervention is made.
- NHS staff have a duty of care to protect the public and a responsibility under health and safety legislation to maintain a safe environment (Health and Safety at Work etc. Act, 1974).
- The Human Rights Act (Article 2.1) indicates a positive obligation to preserve life and Article 2.2 allows the use of no more force than is absolutely necessary.
- Section 3(1) of the Criminal Law Act 1967 “a person may use such force as is reasonable in the circumstances in the prevention of crime, or in affecting or assisting the lawful arrest of offenders or suspected offenders or persons unlawfully at large” Staff should be reminded that the above should be carried out in the least restrictive way in the best interests of the patient.

Mental Health Act 1983 (amended by the Mental Health Act 2007) and its Code of Practice 2015

There is no specific guidance within the Mental Health Act itself on the management of violent and aggressive behaviour.

However Chapter 26 of the MHA Code of Practice (2015) specifically addresses safe and therapeutic responses to disturbed behaviour.

“26.5 Providers should have governance arrangements in place that enable them to demonstrate that they have taken all reasonable steps to prevent the misuse and misapplication of restrictive interventions. When restrictive interventions are unavoidable, providers should have a robust approach to ensuring that they are used in the safest possible manner. All mental health providers therefore should have in place a regularly reviewed and updated restrictive intervention reduction programme.”

The Code outlines a stepwise approach to primary, secondary, and tertiary interventions which may be considered for the management of patients whose behaviour may present a particular risk to themselves or to staff charged with their care.

- **primary preventative strategies** aim to enhance a patient’s quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbances
- **secondary preventative strategies** focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to encourage the patient to be calm (including on de-escalation,)
- **tertiary strategies** guide the responses of staff and carers when there is a behavioural disturbance. Responses should be individualised and wide ranging, if appropriate, possibly including continued attempts to de-escalate the situation, summoning assistance, removing sources of environmental stress or removing potential targets for
aggression from the area. Where it can reasonably be predicted on the basis of risk assessment, that the use of restrictive interventions may be a necessary and proportionate response to behavioural disturbance, there should be clear instruction on their pre-planned use. Instructions should ensure that any proposed restrictive interventions are used in such a way as to minimise distress and risk of harm to the patient. MHA Code of Practice 2015


**Mental Capacity Act 2005 and its Code of Practice**

The MCA is underpinned by a number of principles which staff have a legal obligation to observe. Please refer to the MCA Policy for greater clarification on this.

**Section 5** of the Mental Capacity Act 2005 allows staff to carry out interventions provided that:

- The member of staff has taken reasonable steps to establish whether the patient lacks capacity and
- They believe the patient lacks capacity in relation to the matter and
- It would be in their best interests for the act to be done

**Section 6** authorises restraint of a patient lacking capacity provided that the member of staff

- Believes it is necessary to restrain them to prevent harm to the patient
- The act is proportionate to the likelihood of them coming to arm and the seriousness of that harm

Please note this only authorises any action (including restraint) in the best interests of that individual rather than preventing harm to others.

**6.40** of the Mental Capacity Act Code of Practice states that someone is using restraint if they:

“Use force or threaten to use force to make someone do something that they are resisting or restrict a person’s freedom of movement whether they are resisting or not.”

It states that any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

(i) The person taking the action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and

(ii) 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.

**Section 6** does not authorise a deprivation of liberty and if any act restraint becomes or is likely to become a deprivation of liberty please immediately refer to the MCA/ DoLS policy.

**Common Law**

Common Law still authorises staff to prevent a breach of the peace described as “actual harm done either to a person or a person’s property in his presence or some form of violent
disorder or disturbance and itself necessarily involves a criminal offence.” R. (on the application of Laporte) v Chief Constable of Gloucestershire Constabulary 2006. Ordinarily this power would only exist if neither the Mental Health Act nor the Mental Capacity Act powers could be used.

**Human Rights Act**

The Human Rights Act, 1998 incorporated the European Convention on Human Rights into English Law. The Act states that it is unlawful for a public authority (which includes the Trust) to act in a way which is incompatible with a rights and freedoms guaranteed under the Convention.

Of particular relevance to this policy - as set out by the NHS Protect in the national programs, Conflict Resolution Training and Promoting Safer and Therapeutic Services – are:

**Human Rights in the Workplace**

‘In any environment where an employee is expected to use force in an occupational role, the use of force must be strictly controlled and competently managed by the organisation. Risk assessments must be carried out and appropriate training provided.’

**Article 2 - Right to life**

‘This states a positive obligation to preserve life. Authorities must not only refrain from taking life intentionally but also take appropriate action to safeguard life.’

‘A violation of Article 2 can result not only from those who committed the act, but from the fact that training and preparation is inadequate. If authorities know there are problems and fail to address them, and such a failure leads to a subsequent death that could have been prevented, a violation of Article 2 will occur.’

**Article 3 - Prohibition of torture**

‘This prohibits torture and inhumane or degrading treatment. The provision aims to protect individuals from physical and mental ill treatment. Everyone is entitled to the protection of Article 3 regardless of their own conduct.

**What is torture?**

- **Torture** - Deliberate inhumane treatment causing very serious and cruel suffering
- **Inhumane Treatment** – Treatment that causes intense physical and mental suffering
- **Degrading Treatment** – Treatment that arouses in a victim a feeling of fear and inferiority capable of humiliating and debasing the victim and possibly his/her physical or moral resistance.

**Article 5 – Right to liberty and security of person**

‘Article 5 states that no one shall be detained if detention is not authorised by law. Care staff have a duty of care legally, morally and ethically to protect vulnerable persons.’

**Article 8 - Right to respect for private and family life**

‘Article 8, which protects the right to physical integrity, requires that action that interferes with physical integrity should be in accordance with established law and guidelines; that it should
be for a legitimate purpose; and, that it should be necessary for and proportionate to that purpose.

For restraint/physical intervention to be considered proportionate, it must be the least intrusive measure possible in the circumstances. Proportionality requires both that any form of restraint/physical intervention should be a last resort only; and, that where there is recourse to this, it is the minimum necessary, and applied for the shortest time necessary to ensure safety.'

‘Implications for practice

- Organisational planning around the use of force must occur to eradicate as much as possible the chance of loss of life.
- Training for staff to recognise and deal with life threatening situations must be adequate.
- Training for staff in methods of restraining violent individuals must be safe and compliant with the convention standards and the health and safety legislation.’

**Treatment withdrawal**

The withholding of NHS treatment from violent and abusive patients will always be a last resort but will only be appropriate where violent or abusive behaviour is likely to:-

a) Prejudice any benefit the patient might receive from the care or treatment OR

b) Prejudice the safety of those involved in giving the care or treatment OR

c) Lead the member of staff offering care to believe that they are no longer able to undertake their duties properly (this might include incidents of racial or sexual abuse) OR

d) Result in damage to property inflicted by the patient or as a result of containing them OR

e) Prejudice the safety of other patients present at the time.

It **will not** be appropriate to withhold treatment where:-

- a patient requires emergency treatment
- is mentally ill and may be under the influence of drugs/alcohol
- has become violent or aggressive as a result of an illness or injury
- is under the age of 16 (except in exceptional circumstances)
- is not competent to take responsibility for their actions.

Any decision to withdraw treatment should be discussed and documented by the multi-disciplinary team, and approved by the Clinical Service Manager or Assistant Director.

The Trust will support clinical teams and staff in consideration of the withdrawal of treatment for patients where there has been evidence of wanton, deliberate aggression and violence.

Clinical teams and staff will be supported in their consideration of the need to withdraw treatment from patients where there has been an appropriate risk assessment undertaken. The team must ensure a comprehensive risk assessment has been completed for each individual patient.
The reasons why the withdrawal of treatment is considered the best option should also be documented and alternatives to treatment offered. The Trust's LSMS must also be involved in these considerations so that the appropriate legal guidance and duty of care considerations are incorporated. This also will ensure that the Trust is supporting teams in this difficult area. Teams must consider alternative options of treatment delivery, which may include different provider organisations in serious cases.
### Reporting Mechanisms

#### Health, Safety & Security Forum

The Health, Safety & Security Forum is to:

- Discuss and review the incident reports, trends and themes around violence and aggression identified reporting and facilitate learning and improvement through appropriate action.
- Monitor risk assessments of the physical security of premises and assets and take an organisational overview of these, making recommendations as appropriate.
- Report to the Risk Management Sub Group through its minutes on a bi-monthly and by exception basis, through the standing agenda item.

#### Quality Assurance Sub Committee

The Risk Management Sub-Group is to receive reports on:

- Key operational risk areas and assurances by the Local Security Management Specialist (LSMS) or nominated deputy.
- Monthly Premises Risk Assessment Report

#### Reducing Restrictive Interventions Strategies Group

The key responsibilities of the RRI strategy group is to

- To review National guidance in relation to the use of restrictive interventions and advise the Trust on any required actions to achieve compliance.
- To lead on the introduction of the “Safe wards “initiative.
- To Review the impact of the proposed changes to policing and mental health and make recommendations in relation to any practise /policy changes which will result from these changes.
- To review incidents where Police assistance has been requested by clinical staff.
- To review use of restraint within the Trust to identify any themes or trends.
- To review incidents where police assistance has been requested by clinical staff.
- To lead on the review of any Trust wide polices or procedures which can lead to restrictions being imposed on patients.
- To oversee the audit programme around Prevention and Management of Violence & Aggression (PMVA) within the Trust.
- To review any restrictive practices in place within the Trust and maintain a data base for what restrictive practices are in place, where and review arrangements.
- To review data in relation to the use of seclusion, restraint and rapid tranquilisation to identity trends and make recommendations to the clinical services.
- To bench mark the Trust data in relation to use of seclusion, rapid tranquilisation, and restraint against other Mental Health and Learning Disability providers.
• To identify any trend in relation staffing levels and the use of restraint, rapid tranquillisation or seclusion, and link into the clinical staffing review group.
• To consider the challenges posed to clinical staff in relation to the care of patients who present with extreme levels of violence and provide management guidance.
• To consider environmental risks in relation to patient safety and make recommendations for suitable and proportional risk management measures.

**People Committee**

The people committee is responsible for receiving from the Head of Education reports on Mandatory Training compliance and for taking appropriate action as required.
Requests for Police Assistance
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POLICE ASSISTANCE

When making a request for police assistance, it is useful to consider the following;

The central principle is that police will respond to incidents when they involve the core duties of the police, which are….

(A person commits a breach of the peace by using or threatening to use, unlawful violence).

Consideration is likely to be given to the immediacy of any threat or risk. The police will prioritise all requests for assistance and will attempt to identify if the response should be immediate or if a less urgent response is appropriate.

For example, if a crime has already occurred and there is no danger to anyone, an investigation could commence at a later time.

It is crucial therefore, to consider why we are asking for police assistance. If the situation falls within one of the core duties as above and there is some urgency or immediacy, the police will provide assistance.

Prior to making contact with the police, it is good practice to risk assess the circumstances and to record the important points that should be highlighted to the police when making a request for assistance.

The process of risk assessing may help to clarify if there is a need for police to attend or not.

Equally, if the threat(s) appear to change or to reduce – a fresh assessment should be conducted and appropriate actions taken.

If a request for assistance has already been made to the police, they should be updated as to any change in circumstances as soon as possible.

**Concern for the welfare of a patient**

Police will carry out a check when a report is made to them about a person/patient if it is an emergency and there is a genuine concern that something of a sufficiently serious nature has, or is about to take place involving that person/patient.
Where the circumstances suggest that a welfare check is made on a person/patient and there are no significant or serious risks associated, then the police should not be requested to assist.

Instead, we should consider:

- Would it be appropriate to ask a friend/carer or family member to check on the welfare of the person and to provide feedback?
- Can telephone or text messaging contact be established? Is this appropriate in the circumstances?
- Consider if the patient should be reported to the police as a missing person. *This course of action should be considered when the person is considered to be vulnerable.*
- Should a welfare check be made by Trust staff?
  If this is deemed to be the most appropriate response, a risk assessment should be conducted and recorded.

**Patients absent without leave (AWOL)**

Section 18 of the Mental Health Act 1983 (MHA) provides a power for any patient who is absent without leave to be re-detained and returned to the hospital by:

- An AMHP (approved mental health professional)
- Anyone on the staff of a hospital
- A constable
- Anyone authorised by hospital managers

Forcible entry to premises cannot be made under this section and a warrant obtained under Section 135(2) MHA would be required if consent to enter premises is not provided.

S135(2) allows a magistrate to issue a warrant on application by an AMHP, a constable or anyone authorised by hospital managers, in order to re-detain someone who is liable ‘to be detained’ or who is already absent without leave – as defined by Section 17 of the MHA.

**Emergency circumstances: the need to save life or limb**

Section 17 of the Police and Criminal Evidence Act 1984 (PACE) enables a police constable to enter and search any premises for the purpose of saving life or limb or preventing serious damage to property.
Therefore, in order to use this power in relation to locating a patient, the police would need to form a genuine belief that there is a significant risk to life or limb.

Police assistance with mentally ill people in the community or in healthcare settings

The partnership agreement that the Trust has with South Yorkshire Police recognises that it is the core business of the Trust to manage the patients in its care. It equally recognises that there will be exceptional circumstances when assistance from the police is required.

There is an expectation that where any foreseeable risk or incident is identified in relation to a patient, the Trust will make appropriate arrangements for the management of that person. Staff, including managers should consider all appropriate options for managing the patient.

The threshold for requesting police assistance should be set to a high level.

Healthcare professionals have available to them statutory and common law powers to detain and/or restrain patients to prevent them harming themselves or others, to prevent crime and to prevent a breach of the peace. These powers mirror the powers of the police under common law and under Section 3 of the Criminal Law Act 1967. The Mental Capacity Act also provides protection from liability for those professionals who have assessed a lack of capacity and are using the least restrictive means to act in a person’s best interest.

The central principle is that police will respond to incidents when they involve the core duties of the police, which are:

- To prevent and detect crime
- To keep the Queen’s peace
- To protect life and property

(A person commits a breach of the peace by using or threatening to use, unlawful violence).

Consideration is likely to be given to the immediacy of any threat or risk. The police will prioritise all requests for assistance and will attempt to identify if the response should be immediate or if a less urgent response is appropriate. For example, if a crime has already occurred and there is no danger to anyone, an investigation could commence at a later time.

It is crucial therefore, to consider why we are asking for police assistance. If the situation falls within one of the core duties as above and there is some urgency or immediacy, the police will provide assistance.

Prior to making contact with the police, it is good practice to conduct a risk assessment of the circumstances and to record the important points that should be highlighted to the police when making a request for assistance.
The process of risk assessing may help to clarify if there is a need for police to attend or not.

Equally, if the threat(s) appear to change or to reduce – a fresh assessment should be conducted and appropriate actions taken. If a request for assistance has already been made to the police, they should be updated as to any change in circumstances as soon as possible.

Health service providers have legal obligations to ensure that sufficient numbers of trained staff are available to restrain patients for medical intervention or to isolate them for their own or another’s safety where this is necessary, in a safe and compassionate way.

It is becoming more common for patients to present under the influence of “legal highs” which can dramatically affect their behaviour, including increased strength and violence. It is important for hospitals to be able to rapidly intervene when faced with such behaviour.

Mental Health staff receive specialist training in the control and restraint of mentally ill patients, police officers’ training relating to control and restraint is not as specific.

Police should respond to calls from mental health facilities when they relate to police core duties. When there is a serious risk of harm to any person or serious damage to property, Police will attend to assist the nursing staff to regain control.

Throughout any incident the responsibility for an individual’s health remains with the Health Trust. It is essential that there is always medical support at any incident of prolonged restraint and health staff will guide officers as to the best course of action, considering the patient’s health.

Restraint of a person who has already been sedated or tranquilised increases the risk to the health of that person, there must be appropriate resuscitation equipment available as well as suitably trained members of medical staff.

Where no significant threat of harm or commission of a crime is present, police will not attend to assist in restraining patients who are receiving treatment or assessment within their premises, either as a compulsory or voluntary patient.

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**The Mental Health Act Code of Practice emphasises that:**

*All hospitals should have a policy on the recognition and prevention of disturbed or violent behaviour as well as risk assessment and management, including the use of de-escalation techniques, enhanced observation, physical intervention, rapid tranquillisation and seclusion.*

*The Code of Practice states all hospitals should have a policy on training staff who work in areas where they may be exposed to aggression or violence, or who may need to become involved in the restraint of patients.*
Physical intervention
(see section 26 of the 2015 Code of Practice for the Mental Health Act 1983)

Managing aggressive behaviour by using physical interventions should be done only as a last resort in an emergency when there seems to be a real possibility that harm would occur if no intervention is made.

• The most common reasons for needing to consider such interventions are:
  o Physical assault
  o Dangerous, threatening or destructive behaviour
  o Self-harm or risk of physical injury by accident
  o Extreme and prolonged over-activity that is likely to lead to physical exhaustion; and
  o Attempts to abscond (where the patient is detained under the Act)

• The purposes of intervention where de-escalation has failed are to:
  o Take immediate control of a dangerous situation
  o End or reduce significantly the danger to the patient or others around them
  o Contain or limit the patient’s freedom for no longer than is necessary

• Any physical intervention used must be:
  o Reasonable, justifiable and proportionate to the risk posed by the patient
  o Used for only as long as is absolutely necessary
  o Involve a recognised technique that does not depend on the deliberate application of pain
  o Be carried out by staff who have received appropriate training

• A single member of staff should lead and control the situation and the patient should be approached where possible and agreement sought to stop the behaviour. Where possible an explanation should be given to the patient of the consequences of refusing the request from staff to desist. The special needs of patients with sensory impairments should be considered - approaches to deaf or hearing-impaired people should be made within their visual field.

• During physical intervention one team member should be responsible for protecting and supporting the head and neck, where required. They should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.

• A number of physical skills may be used in the management of a disturbed/violent incident. Every effort should be made to utilise skills and techniques that do not use the deliberate application of pain, which has no therapeutic value and could only be justified for the immediate rescue of staff, patients and/or others.

• It is important that restraint through the use of physical intervention is seen within the overall spectrum of approaches for dealing with violence and aggression. Disengagement from a violent or potentially violent situation is preferable. Occasions may occur when the safety of self or others may supersede this.
• Staff will develop a clear understanding of factors that may contribute to disturbed behaviour and dealing with violence and aggression through local induction procedures, advice and instruction from Managers on the policy and through their attendance on mandatory Managing Work Related Violence Training.

• Staff likely to be involved in restraint through the use of physical interventions must be appropriately trained by attending the relevant course

• Violence that occurs very suddenly and without time to de-escalate or summon help may require immediate physical intervention. The use of such intervention is acceptable in law providing the amount of force is reasonable to stop the attacker, and/or stop injury to the person being attacked or injury to the attacker.

• Disengagement from a violent or potentially violent situation is preferable, but also recognises that at times safety of self or others may supersede this. Where staff have not been trained in physical intervention, they should only be involved in extreme circumstances where they, or others are in immediate danger.

The following guidance should be used:

• Wherever possible, restraining patients on the floor should be avoided. If the floor is used, this should be for the shortest period of time and for the primary reason of gaining control of the situation.

• In exceptional situations where the patient is in a prone position (face down) this should be for the shortest possible period of time to bring the situation under control and the patient moved into the supine position (face up). The process of breathing must not be impeded. Pain must not be inflicted.

Vulnerable parts of the body e.g. neck, chest and sexual areas should be avoided. Hold only long bones e.g. forearms, upper arms and legs. Monitor for signs of distress or injury and terminate the intervention as appropriate.

Staff trained in physical intervention should take over as soon as is practicable.

Extract from the POLICY AND PROACTIVE CARE FOR REDUCING RESTRICTIVE INTERVENTIONS which was issued in July 2015.

Restraint during Transportation

Arrangements for transferring patients between the community and hospital or other healthcare settings; between different hospitals and healthcare settings; or transfers to emergency departments for treatments following an illness or injury to the patient, should not normally involve a request for police assistance.

If a patient’s behaviour is challenging, staff should attempt to use de-escalation techniques to manage the patient. If this is unsuccessful and physical restraint is necessary, this should be by the
least intrusive means possible to manage the patient and should always be in accordance with Trust policies.

There should not be an automatic request for police assistance to manage challenging patients, such requests should only be made once risk assessing has taken place which has considered all other options.

If a patient is violent and needs to be transferred in an NHS ambulance with Police assistance, then the safest and least restrictive method is to utilise Velcro limb restraints ("Fastwrap" or similar) on limbs and then lay the patient on the ambulance trolley in the recovery position. They can be kept safely secure by means of the seatbelts attached to the trolley. They can now be monitored by both ambulance staff and the accompanying police officer. It is important to use the restraint for only as long as is defined in the training.

Using the above method, there should never be an instance where Police and ambulance staff consider that a mentally ill person is too violent to travel by ambulance and Police transport is necessary. However, if the decision is made, a member of the ambulance clinical staff must accompany the person in the Police vehicle in order to maintain constant observation and comply with the Mental Health Act Codes of Practice.

It is vital that officers recognise the high risk associated with locking a violently unwell person into a small van cage. Using Velcro limb restraints in the center of a van and placing the patient under observation by both ambulance staff and Police is always safer.

Under normal circumstances, unless the individual’s behavior is so violent or unpredictable there should be the availability of appropriate vehicles and staff to manage non-compliant behaviour.

The Mental Health Act Code of Practice 2015 advises that:

"Persons who have been sedated before being conveyed should always be accompanied by a health professional who is knowledgeable in the care of such persons, is able to identify and respond to any physical distress which may occur and has access to the necessary emergency equipment to do so”

MHA CoP 17.7

Detained person en-route to S136 suite

Contact received from police that a person detained under Section 136 of the Mental Health Act 1983 is en-route to the S136 suite:
• Obtain full details of detainee/patient
• Obtain as much detail of the incident giving rise to the detention as is possible
• Obtain expected time of arrival at the suite
• Enquire if there are any specific risks associated with this person
• How are they presenting now?

On arrival at the S136 suite:

• Complete a thorough handover with the accompanying escorts (police, ambulance, contractor)
• The detaining police officer will identify any risks identified to inform the risk assessment/decision making process of the clinician.
• Enquire about/research risk factors, record accurately and clearly
• Agree a timescale for accompanying escorts to be released
• The handover should be completed within an hour of the patient’s arrival at the S136 suite

For guidance relating to Section 135 Mental Health Act 1983 (as amended), please refer to the Trust website and the policy document entitled; Section 135 Mental Health Act 1983 and the 2015 Code of Practice to the Mental Health Act 1983.