

## Procedure for the positive and safe support for people who may present with behaviour that challenges.

The key messages the reader should note about this document are:

1. The importance of providing services that promote a safe and therapeutic culture for everyone.
2. Recognise, prevent, and manage behaviour that challenges; Ensuring management strategies employed before, during and after episodes of conflict behaviour are based within a legal and ethical framework.
3. Safeguarding the people who use our services through adopting a Human rights approach to the use of restrictive practice.
4. Recognising the impact of traumatic experiences and how they may lead to trauma responses expressed as behaviour that challenges staff and services.
5. Reducing incidents of restrictive practice through positive and proactive care, learning lessons and post incident reviews.

This policy/procedure may refer to staff as qualified/registered/professional or other such term to describe their role. These terms have traditionally referred to individuals in a clinical role at band five or above. Please note that the use of these terms **may or may not** include nursing associates or associate practitioners (band 4). For clarification on whether a nursing associate or associate practitioner is an appropriate person to take on the identified roles or tasks in this policy/procedure please refer to the job description and job plan for the individual, or local risk assessment.

## DOCUMENT SUMMARY SHEET

ALL sections of this form must be completed.

<b>Document title</b>	Procedure for the positive and safe support for people who may present with behaviour that challenges.
<b>Document Reference Number</b>	C-0021
<b>Key searchable words</b>	Challenging behaviour, restrictive intervention, physical restraint, post incident support, positive and safe care, and mechanical restraint.
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<b>Approved by (Committee/Group)</b>	Mental Health Legislation Operational Steering Group
<b>Date approved</b>	08/09/22
<b>Ratified by</b>	Policy & Procedure Group
<b>Date ratified</b>	19 October 2023
<b>Review date</b>	19 October 2026
<b>Frequency of review</b>	Three yearly

### Amendment detail

Version	Amendment	Reason
4.0	Change of title of this procedure	Transferred into new template and title of document has changed from Procedure and Guidance on the Therapeutic Management of Challenging and Violent Behaviour
4.1	Updated 1.5.8 and Appendix 5 added to the Procedure.	To make clear the governance in the use of mechanical restraint including a safeguarding alert. Changed the name of the DON and removed reference to the RRIWG.
	Extension granted from 29/08/2021 to 28/02/2022 on 09/09/2021.	The Policy and Procedures Group approved the extension request on 9 September 2021.
4.1	Extension agreed from 28/02/2022 to 31/08/2022.	Extension granted by the Policy and Procedures Group on 17 March 2022.
5	Procedure updated to include Human rights considerations, roles and responsibilities of police officers and definition of negligible force. Along with refresh of existing elements of the procedure to ensure they reflect current legislation and best practice guidance.	Implementation of the Mental Health Units (Use of Force) Act 2018 Statutory guidance
5.1	Appendix updated. Ratified as a minor change by the Policy and Procedures Group on 19 October 2023.	A link to new procedure C-0078 – Sensory Processing Practice Guidance for Weighted Equipment added to appendix.

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## 1.1. Description of Procedure

Leeds and York Partnership NHS Foundation Trust (LYPFT) aim to provide a safe and therapeutic culture within our services for all people. Occasionally, there are circumstances when a service user may present with distressing and/or dangerous behaviour which challenges our ability to deliver good care safely. This procedure is intended to give staff guidance on how such challenging behaviour can be prevented and managed.

LYPFT are committed to providing person centred strategies to minimise distress and reduce reliance on restrictive practice. This procedure is intended to promote non-coercive intervention and collaborative ways of working to reduce both the incidents of challenging behaviour and the restrictive interventions adopted to manage such behaviours.

Restrictive practices can be recognised as clinical decisions which stops someone from doing something they want to do or make them do something they do not want to do. They are a wide range of activities, some deliberate and some less so, which restrict people liberty and other rights, such as blanket rules or restrictions, personal searches, observations, and restrictive interventions. (Skills for Health 2014)

Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently. We recognise restrictive interventions as an umbrella term that includes physical restraint, seclusion, rapid tranquillisation, and mechanical restraint.

LYPFT recognises that person centred, therapeutic services are most effective for promoting the health and wellbeing of everyone in our organisation.

This procedure is recovery focused and trauma informed and provides a framework which helps services to develop individual care and support for those who present with behaviour that challenge.

As a modern compassionate healthcare service, we will only use restrictive interventions in situations where there is a real possibility of harm to the person, staff, the public or others and that risk cannot be safely managed in a less restrictive manner. Any restrictive practices used will consider, with reference to the team psychological formulation, the possible risk of re – traumatisation to service users and this will determine whether a particular intervention is safe to use.

Service users must always be treated with dignity and respect. Care should also be given to avoid negative and pre-conceived judgements based on a person's diagnosis, behaviour, or personal characteristics.

Initial assessment should pay due regard to cultural issues. Such awareness is imperative in understanding behaviour and responding accordingly.

The results of an initial assessment will form the basis for a Positive and Safe Care Plan.

Discussion should be had with services users regarding how challenging behaviour is managed in the service and the mutual expectations placed on everyone within the service should be explained.

## **1.2. Promoting a positive and safe culture within care settings.**

The Positive and Safe Working Group (PaSWG) represent the organisational commitment to reducing restrictive practice. The membership is a trustwide collaborative who provide a forum to review clinical practice, support quality improvements initiatives and identify training needs through a co-ordinated trustwide strategic agenda set out in the PaS work plan. The work plans aim is to enable the culture change necessary within LYPFT to reduce the use and severity of restrictive interventions across trust.

The PaSWG have subgroups that report into and hold responsibilities on its behalf these include the Seclusion oversight Group and the Reducing the Use of Restrictive Practice - Service user and carer working/reference group. This group's membership includes service users/carers with lived experience of restrictive practice or have cared for a person who has had experience of restrictive practice. The PaS working group reports the use of restrictive interventions through the production of a quarterly report to the Mental Health Legislation Operational Steering Group (MHLOSG) and Tier 2 clinical governance groups, alongside an annual report to the Executive Team.

The physical and therapeutic environment of a service can have a significant impact on levels of agitation, frustration, and boredom.

The impact a physical environment can have on an individual's emotional wellbeing and their ability to engage in therapeutically must be given during any service development and estate change. Consideration should be given to how the environment can provide psychological safety for service users to prevent trauma responses being triggered.

Clinical services must ensure they work as a therapeutic team by using a positive and encouraging approach which has strong effective leadership at its core and allows staff to regulate their normal emotional responses to behaviour that challenges. Staff anxiety and their own trauma experiences can accentuate a service user's anxiety and self-control ability, as well as hindering their own ability to respond in the most effective and socially skilled way. Similarly, frustration and anger has the capacity to amplify patient anger, or alternatively trigger catastrophic loss of self-esteem, with either of which responses can trigger further or more extreme conflict behaviours.

LYPFT has agreed the implementation of Safewards as the preferred model for inpatient services. Safewards provides a framework for understanding the sources of conflict, or behaviours that challenge, and the interventions that staff typically use to contain them. This understanding of the connection between the conflict and containment behaviours informs the implementation of ten evidence based Safewards interventions, which when used together have proven significantly effective at reducing conflict behaviour of service users and containment behaviour of staff.

Oppressive environments and use of unnecessary blanket restrictions can have a negative impact on how people behave and are inconsistent with a human rights-based approach. All blanket restrictions must be implemented within the framework of the [blanket restriction standard operating procedure](#)

### 1.3. Human Rights and Restrictive Practice

Restrictive practice impacts on an individual's liberty and other rights, they should be clearly identified and must always be legally and ethically justifiable.

The Human Rights Act (1998) (HRA) places a legal duty on public services and all those who work for them, to respect and protect human rights across their actions, decisions, policies, and services.

NHS Trusts such as LYPT are public services which means that all LYPFT staff must respect and protect human rights in everything they do within their role.

The legal duty under the Human Rights Act has three parts:

- **RESPECT** people's human rights. To not restrict them or try to breach them. Staff should avoid interfering with someone's rights unless it is absolutely necessary to protect that person or others from harm.
- **PROTECT** people's human rights. By law, staff must step in and take positive action to protect people from harm. This could include protecting a person from harm by another person such as a family member or carer.
- **FULFILL** people's human rights. This means investigating when things have gone wrong and putting measures in place to stop it from happening again.

British Institute of Human Rights

Decisions to use restrictive practice that restricts an individual's 'non-absolute' rights such as article 5, right to liberty, and/or article 8, right to respect for private and family life, home, and correspondence, must meet a three-stage test,

**Lawful** – There must be a law which allows staff to take that restrictive action (such as the Mental Health Act or Mental Capacity Act) and this information must be made accessible to the person (or their family, carer, or advocate if capacity is an issue).

**Legitimate** – There must be a good reason for the restrictive practice (for example to protect that person or others from harm). A good reason could never solely be that there is no time or resource to do something differently.

**Proportionate** – Other less restrictive interventions have been considered, but there is no other way to protect the person or other people.

All decisions of restrictive interventions must be transparent and have established clear lines of accountability. As many of these decisions will involve assessing whether the person involved has the mental capacity to make a specific decision any planned restrictive intervention must include a capacity assessment documented on the Mental Capacity Assessment on Care Director, and an associated Best Interest decision if appropriate.

Restrictive practice that amounts to a restriction of article 3, right to be free from inhuman and degrading treatment, can never be justifiable as we all have absolute protection from serious abuse and neglect.

Restrictive practice may be inhuman and/or degrading if it leads an individual to be very frightened or worried, experience a lot of pain, feel worthless or hopeless or experience extreme humiliation. It may also trigger distressing trauma experiences which may be expressed as behaviours that challenge.

What amounts to inhuman and degrading treatment is subjective, it will depend on each individual and how the treatment affects them, consideration of the following would assist in determining if a restrictive intervention could amount to a restriction of someone's article 3 rights:

- A person's age and gender.
- Their mental health/ how the restriction has impacted on this.
- Their mental capacity to understand what is happening to them.
- How long they have been experiencing the restriction.
- Their thoughts and feeling towards the intervention.
- Impact of previous experiences on current treatment.
- Consideration of the person's psychological formulation which will highlight psychological/emotional vulnerabilities.

Where there are concerns about the potential disproportionate restriction on someone's human rights colleagues can seek support and guidance from the Safeguarding Team, Mental Health Legislation Team, Professional Practice lead for Reducing Restrictive Practice and the PaSWG.

#### **1.4. Positive and Safe (PaS) / Positive Behaviour Support (PBS) Plans**

Service users who have an identified risk of or who are exhibiting behaviour that may lead to a restrictive intervention being used must have a care plan in place to direct staff to proactively manage the behaviour with a graded response.

Individual clinical teams can develop a PaS/PBS plan framework or model to best suit the need of the service, however, they must contain the following as a minimum standard:

- a) An outline of the problem/challenging behaviour
- b) Service user and/or carer involvement and perspective
- c) **Primary**- Preventative strategies
- d) **Secondary**-Proactive identification and management of early escalation
- e) **Tertiary**- Reactive emergency/crisis management
- f) Post incident review
- g) Regular identified review dates

### **Outline of the problem/challenging behaviour**

Key areas that assist in understanding an individual's presenting behaviour include, recognising triggers or predictors and identifying contextual factors such as personal issues, physical and/or mental health and learning disability conditions, communication skills, inability to influence the world and identified patterns to the behaviour and the impact on the individual.

On admission service users should be assessed for immediate and potential risks of behaviour that challenges. Be aware that risks may not be immediately apparent. Assessment should take account, but not exclusively, of the following.

- History of challenging behaviour,
- History of experiencing personal trauma
- Presenting mental state
- Presenting physical state
- Current social circumstances

After this initial assessment there needs to be understanding of the persons difficulties, with PaS/PBS plans developed to address the issues raised in this formulation.

### **Patient and/or carer involvement**

Positive engagement is an integral part of helping someone manage the escalation of behaviour that may be challenging; enabling them, and where appropriate their carers, to actively participate to their full potential in their care and negotiate the level of engagement that will be most beneficial for them.

Patients and/or family and carers are to be encouraged, in a way that is useful to them, to develop advanced statements regarding how they wish to be supported in a crisis and how staff should respond to behavioural disturbances. This should include involving them in identifying their own trigger factors and early warning signs and detail how staff can offer early support, including interventions that would avoid escalation of challenging behaviour.

### 1.4.2 Primary- Preventative strategies

This refers to everything that is put in place that reduces the likelihood of the conflict behaviour happening. This involves an understanding of the function of the behaviour that challenges and an awareness of which situations/triggers might lead to the expression of distress in this way. Prevention strategies aim to remove or reduce triggers and events that evoke or maintain the conflict behaviour for the person.

Preventative strategies are the key to effective PaS/PBS plans as such proactive interventions should make up most of any plan. Most challenging behaviour is preventable; once challenging behaviour is evident any reactive strategy used is not going to prevent the behaviour.

Interventions should be designed to support personal development and the learning and maintenance of new skills.

Teaching communication skills, alternative coping strategies, self-soothing techniques and looking after their physical health, making sure there are meaningful and interesting things to do, and good social networks are all examples of proactive working.

The following factors should be taken into consideration in helping a service user feel calm and relaxed and reducing the chances of behaviour that challenges occurring:

- The care environment.
- Communication that is honest, respectful, compassionate, and consistent.
- Access to preferred activities, objects, and people.
- Feeling in control of one's destiny/ access to timely information.
- Management of social factors.
- Feeling well and happy.
- Interaction styles – how do you talk to the person?

### 1.4.3 Secondary- Proactive identification and management of early escalation

Proactive refers to the strategies that are put in place before the behaviour occurs, or during its early stages. It involves effective observation and active engagement by staff to identify precursor behaviour or early warning signs that someone's emotional wellbeing is altering. These can often be subtle and difficult to identify. Guidance on interventions that help the service user calm should be offered, this should be based on individual assessment and be specific to the person and the identified challenging behaviour.

Interventions and guidance should include, but not exclusively.

- Distraction.
- Verbal de-escalation.
- Access to self-soothing techniques.

- Change of environment.
- Increased support through within eyesight or arm's length observation.
- PRN medication (**not rapid tranquillisation**).

### 1.5.1 Tertiary- Reactive emergency/crisis management

The reactive element of a positive and safe care plan describes what you should do, or how you should react, in response to immediate and high-risk challenging behaviour. Reactive strategies manage escalated behaviour as safely and quickly as possible, to keep the person and those around them safe. They should only be used when proactive interventions are no longer maintaining safety of the service user, staff, and others within the environment or if the risk posed is deemed so serious and imminent that proactive interventions would be ineffective.

PaS/PBA plans should always be designed to be least restrictive, highlighting restrictive interventions to be a last resort to managing any conflict behaviour. Any plan should contain a hierarchy of reactive strategies from least to most restrictive, with guidance on how staff can provide a graded response.

Reactive responses should be individualised and respectful of any advance statements. Verbal de-escalation should continue throughout with staff making attempts to identify and clarify the source of the conflict and reach an agreement on how this can be resolved.

Staff should immediately make the environment as safe as possible for themselves, the service user, and others. This may include removing other service users from the area or moving the individual to a quiet area, maintaining a suitable distance from the person and/or establishing support of other staff through activating alarms. Should the number of staff required to maintain safety need to be increased then this should be escalated to the CTM/Nurse in Charge and staffing escalation protocols be followed.

Staff must be mindful of their own non-verbal and verbal communication and how this can influence a situation. Be careful not to show signs of anxiety and frustration; attempt to understand the individual's viewpoint and the reason behind the behaviour rather than focussing on the consequence of said behaviour can help, as can maintaining an open, relaxed, and non-threatening body posture and keeping verbal communication calm, empathic and respectful.

#### 1.5.61 Restrictive interventions

Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:

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

Restrictive interventions must **NEVER** be used to punish or for the sole intention of inflicting pain, suffering or humiliation.

Where a person restricts a patient's movement, or uses (or threatens to use) force then that should:

- Be used for no longer than necessary to prevent harm to the person or to others.
- Be a proportionate response to that harm.
- Be the least restrictive option.

Mental Health Act code of practice 2015, pg. 290

The most common reasons for requiring the use of restrictive interventions are.

- Physical assault.
- Dangerous, threatening, or destructive behaviour.
- Self-harm or risk of physical injury by accident.
- Extreme and prolonged over-activity which may lead to physical exhaustion.
- Attempts to escape or abscond.

Any restrictive intervention must be justifiable both legally and ethically, in that it is.

- Used for no longer than is necessary to prevent harm to the person or to others.
- Proportionate response to the harm.
- The least restrictive option to safely manage the situation.

Consideration must be given to the choice of restrictive intervention and should be guided by such factor as.

- PaS/PBS plans.
- Service user's advanced statement.
- The physical health and other impacting factors of the service user.
- History of previous trauma.
- Appraisal of the immediate environment.

### 1.5.2 **Physical restraint**

“Physical restraint refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person” MHA Code of Practice 2015 chapter 26 pg. 295.

Any physical restraint must only be conducted by staff that are trained by the LYPFT PMVA department and are in date with their PMVA compulsory training requirements.

Staff should only use methods of physical restraint for which they have received training for.

The PMVA team hold responsibility to work with clinical services to conduct a training needs analysis and risk assessment for each service area. This will detail the types of physical restraint which may be used in each specific clinical area.

The exception to this would be unforeseen emergency situations where there is not the opportunity to assemble a team of appropriately trained staff; in these circumstances any person can use such force as is reasonable, under section 3 of the Criminal Law Act 1967, to aid the safety of the persons present.

Assistance of appropriately trained staff must be sought as soon as is practical to allow them to take control of the situation.

It is important to work together as a team, understanding each other's roles and having an identified lead person; this may not necessarily be the most senior person present as it may be more useful for it to be the person who has the better relationship with the service user. If there is a head person present, they would usually adopt the lead role.

The lead person has specific responsibility for the 3 C's

- **Care-** Protection of the service user's head and neck, if required, ensuring the airway is not compromised and monitoring of vital signs through an A-E assessment
- **Communication-** Clearly explain to the service user what is happening, continuing to offer reassurance and explore a resolution to the situation through effective de-escalation. Verbal communication between team members should be kept to a minimum and focused on the resolution of the emergency ensuring the service user is not excluded from discussions. It is important that team members do not talk over each other, give conflicting or repetitive comments/requests; this can be confusing and disorientating and could lead to further conflict arising.
- **Co-ordination-** Leading the team through the physical restraint and directing the graded response to the presenting situation.

Any physical restraint must be the minimum level required to manage the situation safely, this requires the team to use their judgement and escalate/de-escalate a graded response, as necessary. The team must ensure the level of force used is justifiable, appropriate, and proportionate to the situation and for the shortest time possible.

Wherever possible we must avoid taking service users to the floor; however, if the risk dictates this as necessary, the team must plan to take the service user into the supine (face up) position.

LYPFT understand that in an exceptionally volatile situation the struggle to regain control may lead to an emergency and unplanned descent to the floor in a prone position (chest down) as failure to do so would cause injury to either staff or service user or may lead to the service user falling, unsupported to the floor.

If this happens the service user should be either released from holds or, if not safe to do so, be repositioned into the supine position as soon as it is safe to do so.

It is important to remember that physical restraint can lead to a physical health emergency at any time, staff must remain vigilant for this throughout any physical restraint.

Physical restraint must never impact on a service user's physical wellbeing and individual consideration and extra care should be given to impacting factors such as pre-existing health considerations, cardiopulmonary disorders, and restriction in mobility, obesity, and pregnancy.

Continual monitoring of the service user's physical health should be made guidance on this can be found in A-E Physical Assessment Checklist (appendix 1), all members of the team should be familiar with this and be competent in interpreting their visual observations and informing the lead person of any concerns they may have.

A record of all physical observations taken during physical restraint must be entered onto the incident reporting system (Datix) and in the clinical notes.

Any service area where the use of physical restraint is foreseen must have immediate access to emergency resuscitation equipment and be familiar with the response to a medical emergency protocol, for their service area this can be located in the [Resuscitation & Physical Health Emergencies Procedure](#).

Any physical restraint should not routinely be used for more than 10 minutes. Duration of 10 minutes or more is to be considered a prolonged restraint and after this time the team must consider alternative management, such as seclusion or rapid tranquillisation, to attempt to bring the prolonged restraint to an end as soon as it is safe to do so.

LYPFT does not recognise that pain compliance techniques have any place in the therapeutic management of challenging behaviour and does not support their use in any circumstances, outside of situations where there is an immediate risk to life.

### **Planned physical restraint for clinical intervention**

Physical restraint may be required to aid a vital clinical intervention, such as the administration of medication (other than rapid tranquillisation), nasogastric feeding, obtaining a blood sample and assisting in personal hygiene needs. This may be referred to as a **planned physical restraint for clinical intervention** to distinguish it from an unpredicted emergency or crisis incident management.

The enforcement of clinical interventions via the use of physical restraint must be avoided wherever possible. However, it may be necessary if the continued lack of cooperation with a clinical intervention would result in significant and immediate harm occurring, and/or there is a risk of harm to service user or staff whilst carrying out such intervention.

The MDT should weigh up the risk of not receiving the clinical intervention against the risk of conducting the intervention under physical restraint, including the risk of trauma.

Where the physical restraint for clinical intervention can be reasonably predicted or is ongoing there should be clear instructions, through a Positive and Safe care plan. These instructions should ensure that any pre-planned intervention is used in a manner which minimises distress and risk of harm to the service user and is justifiable within a legal and ethical framework. There should be clear review period.

The use of planned physical restraint to conduct a clinical intervention should first be carefully considered by the MDT and documented and justified in clinical notes. Where necessary, guidance should be sought from both the professional practice lead for reducing restrictive practice and the Mental Health Legislation Team, to ensure there is a legal authority to treat without consent, alongside the PMVA department as additional training may be required.

### 1.5.3 **Rapid Tranquillisation**

Rapid tranquillisation refers to the use of medication to calm or lightly sedate a service user to reduce the presentation of agitated and aggressive behaviour and the risk of harm to self and/or others.

Rapid tranquillisation should only be considered when a service user's risk behaviour is not being successfully contained by other therapeutic interventions. Its aim is to reduce immediate risk and not to treat any underlying mental illness. The use of oral rapid tranquillisation should always be considered before the use of intra-muscular (IM) injection.

It may be necessary to physically restrain to administer rapid tranquillisation, it is important to ensure that the correct legal authority is in place.

Wherever possible, staff should avoid placing a service user in the prone position to administer intra-muscular rapid tranquillisation. Support, education, and training on alternative intra-muscular injection sites is provided by the PMVA team through ward-based sessions, PMVA and SCiP training.

The prescriber should indicate the preferred injection site clearly and details on how this will be administered should be included in the tertiary section of the Positive and Safe Care/PBS plan.

Further guidance on rapid tranquillisation can be found in [Guidelines for the pharmacological management of psychiatric emergencies/behavioural emergencies using rapid tranquillisation \(RT\) - MM0005](#)

### 1.5.4 **Seclusion**

Seclusion refers to the supervised confinement and isolation of a service user, away from other service users, in an area from which they are prevented from leaving. (MHA Code of Practice 2015)

It can never be used as a planned reactive strategy, e.g., in a PASC/PBS plan.

It is important to recognise the use of physical restraint; low stimulus environments and quiet areas of the ward in the management of a crisis situation are for the sole aim of separating service users from others to aid de-escalation. Ongoing use of such restrictive interventions, even if the service user has agreed or requested it, may meet the definition of seclusion and as such should be afforded the same procedural safeguards of the [Procedure for the use of Seclusion and Long Term Segregation \(C-0022\)](#)

### 1.5.5 **Mechanical restraint**

Mechanical restraint is defined as “the use of a device (e.g., belt or cuff) to prevent, restrict or subdue movement of a person’s body, or part of the body, for the primary purpose of behavioural control”.  
(26.75 MHA Code of Practice 2015).

Mechanical restraint should never be used for the routine management of behaviours that challenge but LYPFT recognise that an exceptional circumstance may arise where the use of a mechanical restraint device is deemed to be the safest and least restrictive option in the management a service user’s challenging behaviour.

[Guidelines on the use of mechanical restraint](#) must be always followed.

### 1.5.6 **Roles and responsibilities of police officers during an incident**

In exceptional circumstances, where a therapeutic intervention has been attempted and/or staff have been injured and/or are unable to gather sufficient wider support from other clinical services, police officers may be requested to assist clinical staff to manage the ongoing risk to safety. It is important that everyone is aware of the role of the police and LYPFT staff in managing the incident properly and safely, [The College of Policing 'Memorandum of Understanding' – The Police Use of Restraint in Mental Health and Learning Disability Setting](#) sets out detailed guidance on the clinical oversight expected during an incident. It is important to understand that LYPFT staff retain overall responsibility for the patient and their safety and wellbeing and must intervene if they consider there is a risk to the patient.

Examples of incidents that may require a police response include:

- An immediate risk to life and limb.
- An immediate risk of serious harm.
- Serious damage to property.
- Possession of an offensive weapon.
- Hostage situations.

The police should not be expected to assist LYPFT staff in responding to a patient who is presenting with a clinical management issue (including their transfer from one service to another), unless those exceptional or aggravating factors apply.

The Mental Health Units (Use of Force) Act 2019 provides direction that any police officer going into a mental health unit on duty to assist staff who work in

that unit, must wear and operate a body camera at all times when reasonably practicable. However, there may be special circumstances that justify not wearing or operating a camera, it is for the police officer(s) to determine in line with current College of Policing guidance on the use of body cameras whether special circumstances apply.

## 1.6 **Post incident management**

Immediately after an incident the nurse in charge should take the lead for managing the immediate ongoing risks to ensure the safety and wellbeing of all service users and staff; facilitating a return to normal patterns of activity as soon as possible. Guidance on this process can be found in appendix 3

Following any physical restraint staff must continue to monitor the service user for signs of emotional or physical distress for as long as is clinically necessary.

The nurse in charge must assess whether the service user requires a review from a doctor, either regarding the emergency which preceded the restrictive intervention or for the intervention itself.

The nurse in charge and/or doctor must assess the need to monitor the service user's physical observations (MEWS) following physical restraint. When considering the frequency and duration of observations the following should be taken into consideration:

- Level/type of manual restraint.
- Duration of manual restraint.
- Service user appears asleep or sedated.
- Manual restraint has resulted in harm to service user.
- Illicit drug or alcohol have been consumed.
- Pre-existing physical health problem identified.
- If Rapid tranquillisation has been administered MEWS must be complete at least hourly until there are no further concerns.

Decisions need to be clearly communicated to the team and documented in the care notes.

If it is not possible to take physical observations due to risk factors, or because the service user is sleeping or refusing then a visual A-E assessment should be completed (see appendix 2).

When a restrictive intervention has been used everyone involved should have appropriate support and the opportunity to reflect on what happened.

Service users must be given the opportunity to explore their understanding of the incident and their experience of the restrictive intervention; it is important that they are helped to understand what has happened and why. Staff should assess

whether the restrictive intervention has had a traumatising impact on the service user and must offer therapeutic support if this is the case. Staff to be aware that they may see some continued distress as a trauma response because of the restrictive intervention.

The aim is to learn through mutual understanding which aspects of the interventions helped, did not help, or could be dealt with differently next time. It is important that this does not become an opportunity for staff to justify the need/or choice to use a restrictive intervention. Service users and their family members should be given the choice in who they talk to, ideally someone who was not involved in the restrictive intervention.

Individuals with cognitive and/or communication impairments may need help to engage in this process. Consideration should be given to the fact that, due to the nature of their impairment, some service users are not able to get involved in this process. In this event ways of assessing the effects of any restrictive interventions on their behaviour, emotions and clinical presentation should be fully explored and recorded as part of their positive and safe/ PBS plan.

The service user's account of the incident and the subsequent discussions of their thoughts and feelings regarding the use of restrictive interventions should be recorded in their notes.

Service users should not be compelled to engage in any post incident debrief but they should have their right to talk to about the incident to an independent advocate, family member or staff member explained to them.

Staff members involved in managing behaviour that challenges and restrictive interventions should have the opportunity to discuss their experience with other staff not involved in the incident.

Exposure to challenging situations may contribute to work related stress, trauma, generate negative feelings and impact on a staff member's ability to regulate their own emotional responses to stressful situations. Staff should have access to a safe forum to explicitly acknowledge and actively manage their feelings.

Access to Critical Incident Staff Support Pathway (CISSP) could be considered at this point. The service is a voluntary team of staff specifically trained to offer Post-incident Peer Support Meetings to colleagues and teams involved in critical incidents.

The pathway offers confidential, practical, emotional, and social support at times of work-related crisis in the form of group or individual debriefings in the days and weeks following the event. A critical/traumatic incident can hold the potential to overwhelm one's usual coping mechanisms, potentially resulting in psychological distress and possible impairment of normal adaptive functioning.

Access to the pathway is via direct contact with the People Wellbeing Lead.

Any staff involved in the use of restrictive interventions must have access to clinical supervision, the agenda for supervision must always include the opportunity to discuss and reflect on incidents.

It is important to consider the support offered for any witnesses to incidents this may include but is not limited to other service users, visitors, and colleagues.

Acknowledgement of the psychological impact of traumatic incidents should be part of all service's response to incidents.

Post incident reviews (PIRs) are a distinctively separate aspect of post incident management. Once everyone has had the opportunity to reflect on the immediate emotional impact of an incident it is important to learn lessons from all aspects of the situation to reduce its reoccurrence and/or the need of restrictive interventions in the future.

A PIR should occur within 72hrs of an incident occurring, unless due to unexpected high levels of ward activity it needs to be delayed. It is imperative that everyone involved is given the opportunity to recover their composure to be able to make an objective and positive contribution to the review process. It may be helpful to establish local ground rules for such reviews to enable them to take place in a blame free context where everyone's contribution is valued.

It should be facilitated by someone not directly involved in the incident and aims to establish:

- Any warning signs of an impending crisis.
- What de-escalation strategies were used.
- How effective they were.
- What could have been done differently then and in the future.
- Whether alternative, less restrictive interventions were considered.
- Determine whether service barriers or constraints make it difficult to avoid the same course of actions in future.
- Do any changes need to be made to reduce risk of reoccurrence, such as service philosophy, policies, care environment, treatment approaches, psychological formulation, staff education and training?

It may be useful to use a reflective model such as Gibbs (1988) to aid in this process- see appendix 4. Details of discussions along with any recommendations for changes should be recorded in the service users care notes. Local arrangements for the communication of any PIR to the wider team should be made.

Patients, their family, carers and independent advocates must be supported to raise any concerns regarding the use of any restrictive intervention, this may be

through discussion with the MDT or through the [complaints management procedure](#).

## 1.7 **Reporting incidents of restrictive interventions**

It is important that there is openness and transparency about how often restrictive interventions are used, the types of interventions and the reasons why. Robust data collection has many organisational advantages, such as informing restraint reduction plans, recognising issues at an individual patient level and identifying disproportionate or inappropriate use.

The PaS working group will take a leadership role in identifying any disproportionate or inappropriate use of RI. Holding teams to account and supporting them to learn and take action to implement quality improvement initiatives to eliminate such incidents.

Recording restrictive interventions also helps LYPFT to meet their obligations under the Public Sector Equality Duty, by demonstrating that they understand how they use of restrictive interventions on different groups sharing protected characteristics under the Equality Act 2010.

All incidents of restrictive interventions must be recorded within the service user's care notes and on the electronic incident reporting system (Datix) within 24 hours of the incident occurring.

Alongside completing the mandated fields within Datix, information provided within the 'description and action taken by staff' section (of a Datix form) should include:

- The reason for using the specific type of restrictive intervention.
- Why a less restrictive alternative strategy was unsuccessful/discounted.
- The type of intervention used.
- The consequence/outcome of the intervention.

An incident in which the police were called to assist must also record:

- The reason for police involvement.
- Time and route police were contacted.
- Time police attended.
- Action taken by attending police, specifically the use of prone or mechanical restraint.
- Log number provided by the police.
- Whether the incident was recorded by their body worn camera, and if not, why not.

All above are mandated, drop down, fields on the electronic incident reporting system (Datix).

Clear and accurate reporting of the use of restrictive interventions is essential to evaluate a service user's progress and the success of any PaS/PBS plan. It can

assist in understanding the reason behind its use and help develop proactive strategies to avoid it happening again.

CTMs must regularly monitor the use of restrictive interventions within their service. This can assist in identifying reoccurring themes or 'hot spots,' allowing the early development of proactive interventions. This may involve support from the PaS working group and/or the PMVA department.

CTMs should provide a narrative for any data reports submitted by the Positive and Safe Working Group on the use of restrictive interventions, this will assist in the group having a more in depth understanding of the use of restrictive interventions and any actions already taken.

Any injury sustained, by staff or patient, during a restrictive intervention must be incident reported via the electronic incident reporting system (Datix) within 24 hours of the incident occurring. All injuries will be reviewed at ward level and by the PMVA team, any actions taken because of the review will be communicated via the positive and safe working group.

Training relating to understanding the relevant definitions and terminology, and guidance about what must be recorded following an incident of restrictive interventions is part of PMVA initial training.

The quality of data reporting on the use of restrictive interventions is subjected to ongoing monitoring by the professional practice lead for reducing restrictive practice and information services, any quality improvement requirements identified will be escalated to the Datix user group and positive and safe working group.

The PMVA department review all Datix reported incidents of physical restraint on an ongoing basis, and where required, will liaise with the service areas to provide support, guidance, and additional training.

The positive and safe working group will collate and review the aggregated data on the use of all restrictive interventions quarterly, to allow the identification of emerging themes, and monitor the use of restrictive practice on people who share protected characteristics under the Equality Act 2010. This will then be reviewed by the MHLOGS.

### 1.7.2 **Negligible Force**

There are an extremely limited set of circumstances where physical restraint would not be required to be recorded via Datix, the Mental Health Units (Use of Force) Act 2019 refers to such circumstances as negligible force.

Physical restraint can only be considered negligible where it involves light or gentle and proportionate pressure. This would be recognised within LYPFT as a friendly come along, standing hold of the arms.

Any negligible use of force must also meet all the following criteria:

- It is the minimum necessary to carry out therapeutic or caring activities (for example, personal care or for reassurance)
- It forms part of the patient's care plan
- Valid consent to the intervention, as part of the delivery of care and treatment, has been obtained from the patient and where appropriate a member of their family or carer has been consulted, particularly a person with parental responsibility if the child is not Gillick competent. Where the patient lacks capacity to consent to the intervention a best interest decision would need to be made and clearly documented.

Any use of force that meets the above criteria must be included in the patient's PaS/PBS plan and be recorded within care records. This should be regularly reviewed at a ward level with a continued aim to reduce the requirement for physical holding as part of any care and treatment.

The use of force can never be considered as negligible in any of the following circumstances, even if the patient consents:

- Any use of rapid tranquillisation.
- Any form of mechanical restraint.
- The patient verbally or physically resists the contact of a member of staff.
- Where the physical restraint involves the use of a wall, floor, (or another flat surface) and is disproportionate.
- A patient complains about the physical restraint either during or following the use of force.
- Someone else complains about the physical restraint. This does not have to be a formal complaint and can include another patient telling a member of staff they are hurting a patient.
- The use of force causes an injury to the patient or a member of staff. In this context, this would include any type of injury or other physical reaction including scratches, marks to the skin and bruising.
- The use of force involves more members of staff than is specified in the patient's care plan.
- During or after the use of force a patient is upset or distressed.
- The use of force has been used to remove an item of clothing or a personal possession.

After applying the above guidance, if staff are still unsure as to whether the use of force was negligible or not, they should seek advice from a more senior member of staff. If there is still uncertainty the incident should be recorded.

Mental Health Units (Use of Force) Act Statutory guidance 2021

## 1.8 **Training**

Education and training are central to promoting and supporting a positive and safe culture, it is imperative that staff have timely access to compulsory training programmes and complimentary specialised service-based education, support, and training programmes.

All clinical areas where there is an identified risk of the use of restrictive interventions to support service users who may present with challenging behaviour should have a risk assessment and TNA which identifies the level of PMVA training staff should receive. The PMVA department is responsible for conducting an annual review of the TNA and training content in consultation with service areas, staff, and the positive and safe working group. They are responsible for ensuring all training is provided by certified training providers with restraint reductions network national training standards accreditation.

The PMVA department and the positive and safe working group are responsible for ensuring that all compulsory training programmes are in line with LYPFT's procedure(s), practice development and current legislation. Training must reinforce a culture of prevention through positive engagement and using a hierarchical response of primary, secondary, and tertiary interventions.

Staff, along with their line manager, are responsible for ensuring they attend the correct level of initial training as soon into their induction period as is practically possible. Refresher/update training should be undertaken on an annual basis.

Due to the complexity of supporting people who may present with behaviour that challenges staff must ensure they are compliant with the following training to compliment the PMVA programme:

- Essential life support (ELS)/ Immediate Life Support (ILS).
- Equality and Diversity.
- Mental Capacity Act/Deprivation of Liberty Safeguards, Mental Health Act.

The following priority training is also recommended:

- Trauma informed care.
- Human Rights Act training.

Information of compulsory training can be found in the [Compulsory Training Procedure](#).

## 2 Appendices

(Or the link to the relevant document(s) on staffnet)

### Appendix 1

[A-E Physical Assessment Checklist](#) - For reference on how to interpret physical observation checks during physical restraint.

### Appendix 2

[Visual A-E Assessment Tool](#)

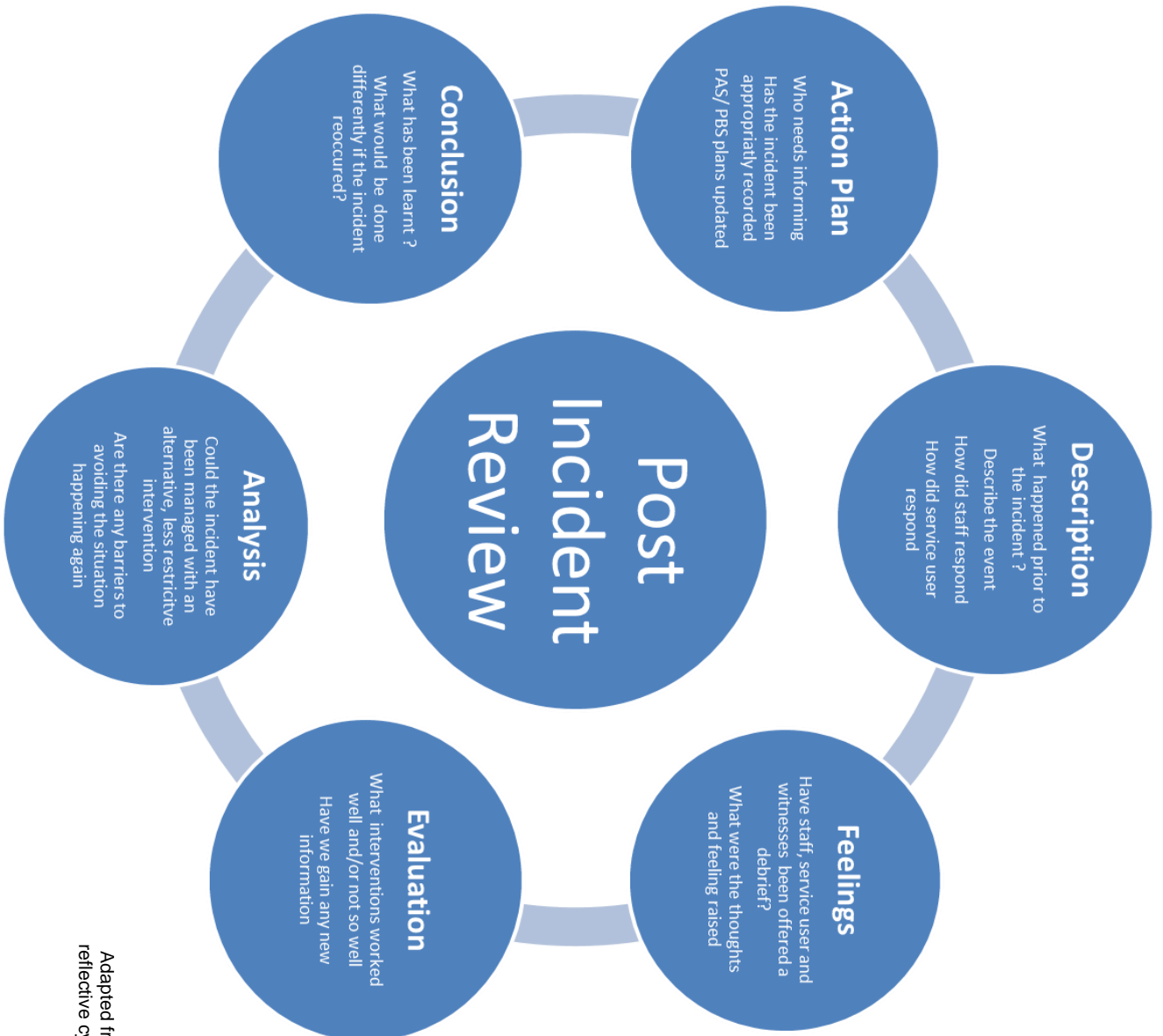
## Appendix 3

### Post Incident Guide

Your responsibilities are to manage the immediate risks and safety of service users and staff and to start planning ongoing support measures.

- **Is everyone ok?**
  - Has anyone been injured?
  - Have I offered first aid?
  - Have I offered access to A&E?
  - Have I offered time out?
  - Have I offered the opportunity to talk about the incident?
  - Have I offered the opportunity for individuals to go off duty/move area?
  - Who can support you with this?
  - Have I arranged support for other service users on the ward?
  
- **Is the environment secure?**
  - Do you need more staff support?
  - Do you need police assistance?
  - Do you need to organise repairs?
  - Are all service users accounted for?
  - Do we need to isolate an area, i.e., to preserve evidence?
  
- **Have you notified the right people?**
  - All staff in the locality?
  - Appropriate Senior Staff
  - Appropriate Medical staff
  - Police- To report assault/incident
  - Has a DATIX form been completed?
    - For the incident
    - For any service user injury
    - For any staff injury
  - Have statements been requested? (If applicable)
  
- **Who can help you?**
  - Senior nursing staff
  - MDT
  - Chaplaincy
  - PMVA Team
  - Occupational Health- Self referral system
  - Mental Health Legislation team
  - Professional practice lead for reducing restrictive practice/ PaS working group
  - Other staff members
  - Staff wellbeing/Critical Incident Staff Support Pathway (CISSP)

Appendix 4



Adapted from Gibbs reflective cycle (1988)

## PART B

### 3 IDENTIFICATION OF STAKEHOLDERS

The table below should be used as a summary. List those involved in development, consultation, approval, and ratification processes.

Stakeholder	Level of involvement
Positive and Safe Working Group members	Consultation
Resuscitation Team	Consultation
PMVA Team	Consultation
Ethics committee	Consultation
Trauma informed care council	Consultation
Mental Health Legislation Operational Steering Group	Approved 8 <sup>th</sup> September 2022
Policy & Procedure Group	Ratification

### 4 REFERENCES, EVIDENCE BASE

Mental Health Act (2003) Code of Practice (2015) Department of Health, 2015

Violence and aggression: short-term management in mental health, health, and community settings (NG 10), National Institute for Health and Care Excellence, 2015

Meeting needs and reducing distress: Guidance on the prevention and management of clinically related challenging behaviour in NHS settings, NHS Protect, 2013

Skills for Care & Skills for Health, A positive and proactive workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health, (Leeds, 2014) [www.skillsforcare.org.uk](http://www.skillsforcare.org.uk) [www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk)

## 5 ASSOCIATED DOCUMENTATION (if relevant)

Procedure for the Observation & Engagement of People using the Services of Leeds & York Partnership NHS Foundation Trust.

Guidelines for the Pharmacological Management of Psychiatric Emergencies/Behavioural Disturbances using Rapid Tranquillisation (RT) in Adults & Older Adults.

Procedure for the Therapeutic clinical Management of Challenging, Violent & Aggressive Behaviour.

Resuscitation & Physical Health Emergencies Procedure

Procedure for the use of Seclusion and Long-Term Segregation

## 6. EQUALITY IMPACT

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender, and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I have not identified any potential negative impacts for any of the nine protected groups.

Signed: E Oldham-Fox

Print name: Emma Oldham-Fox

Job title: Professional Practice Lead for Reducing Restrictive Practice

Date: 10/10/22

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email; [diversity.lypft@nhs.net](mailto:diversity.lypft@nhs.net).

**CHECKLIST** To be completed and attached to any draft version of a procedural document when submitted to the appropriate group/committee to support its consideration and approval/ratification of the procedural document. This checklist and is part of the working papers.

	Title of document being newly created / reviewed:	Yes / No/
<b>1.</b>	<b>Title</b>	
	Is the title clear and unambiguous?	yes
	Is the procedural document in the correct format and style?	yes
<b>2.</b>	<b>Development Process</b>	
	Is there evidence of reasonable attempts to ensure relevant expertise has been used?	yes
<b>3.</b>	<b>Content</b>	
	Is the Purpose of the document clear?	yes
<b>5.</b>	<b>Approval</b>	
	Does the document identify which committee/group will approve it?	yes
<b>6.</b>	<b>Equality Impact Assessment</b>	
	Has the declaration been completed?	yes
<b>7.</b>	<b>Review Date</b>	
	Is the review date identified?	yes
	Is the frequency of review identified and acceptable?	yes
<b>8.</b>	<b>Overall Responsibility for the Document</b>	
	Is it clear who will be responsible for co-ordinating the dissemination, implementation, and review of the document?	yes
<b>Signed by the Chair of the Committee / Group approving</b>		
If you are assured this document meets requirements and that it will provide an essential element in ensuring a safe and effective workforce, please sign and date below and forward to the chair of the committee/group where it will be ratified.		
Name	<i>Janet Smith</i>	Date <i>12/10/2023</i>
<b>Signed by the chair of the Group/Committee ratifying</b>		
If you are assured that the group or committee approving this procedural document have fulfilled its obligation, please sign, and date it and return to the procedural document author who will ensure the document is disseminated and uploaded onto Staffnet.		
Name	<i>Cath Hill</i>	Date <i>19/10/2023</i>