NHS
Mersey Care
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Community and Mental Health Services

TRUST-WIDE CLINICAL POLICY

POLICY FOR THE SUPPORT OF SERVICE USERS WHO MAY PRESENT WITH BEHAVIOURS OF CONCERN

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TRUST-WIDE CLINICAL POLICY

2019 – Version 3

Striving for perfect care and a just culture

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Further information about this document:

Document name	**The support of service users who may present with behaviours of concern – SD18**
Document summary	**This policy and procedure provides clear guidance for supporting service users who may present with behaviours of concern within Mersey Care NHS Foundation Trust. It allows the Trust to demonstrate that the use of restrictive practices meet and uphold the guiding principles of the Mental Health Act Code of Practice (2015) and that they remain proportionate, least restrictive, last for no longer than is necessary, take account of service user preference wherever possible and provide a safe and therapeutic environment for service users, staff and visitors.**
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To be read in conjunction with	**Mental Health Act 1983 Code of Practice (2015)** **NICE Guidance NG10 (May 2015)** **SD48 - Reducing Restrictive Practice** **SD11 - Rapid Tranquilisation** **SD04 - Supportive Observation**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

Version History:		
SD18 v2	Ratified by Corporate Document Review Group	May 2015
SD18 v3	Ratified by Executive committee	September 2019

SUPPORTING STATEMENTS

this document should be read in conjunction with the following statements

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/ adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/ adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

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1. PURPOSE AND RATIONALE

1.1 To ensure a consistently safe and effective approach to supporting people who may present with behaviours of concern using least restrictive practice.

1.2 Mersey Care NHS Foundation Trust is one of three Trusts in England that incorporates a range of high secure, medium secure, low secure and psychiatric intensive care mental health services, in addition to a range of adult, older peoples and learning disability services. Mersey Care NHS Foundation Trust comprises of four clinical divisions; namely the Secure Division, the Local Division, the Specialist Learning Disability Division and Community Services Division. This policy applies to all areas of the Trust.

1.3 Mersey Care NHS Foundation Trust is committed to reducing the need for restrictive interventions as set out in the Trusts Reducing Restrictive Practice policy SD48 and 'Positive and Proactive Care (DH April, 2014). The guidance and policy are aimed at promoting the development of therapeutic and trauma informed environments and minimising all forms of restrictive practices.

1.4 Mersey Care NHS Foundation Trust is required to provide effective therapeutic care in safe conditions that promote recovery. The Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the 'protected characteristics' of age, disability, gender, race, religion or belief, sexual orientation and gender reassignment. The Act also requires regard to socioeconomic factors, pregnancy/maternity and marriage/civil partnership.

1.5 The Trust focuses on the prevention of behaviours of concern through promoting a positive culture through compassionate leadership and organisational learning. The Trust believes that all people have the right to be treated with dignity and respect and is committed to, the elimination of unfair and unlawful discriminatory practices.

1.6 Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line with a Human Rights based approach and the FREDA principles of Fairness, Respect, Equality, Dignity, and Autonomy. Mersey Care NHS Foundation Trust is also aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote human rights in everything they do.

1.7 The Trust believes that mental health practitioners can often prevent an individual service user who is distressed, over-aroused and presenting with behaviours of concern, from deteriorating further by the use of skilled interventions. Appropriate training and support for employees who have direct and regular contact with service users has to be provided to enable these skills to be generated.

1.8 The Trust is committed to ensuring that the workforce adopts the 'No Force First' framework approach (graded approach) that details how such practice is developed and maintained and which underpins effective approaches to care.

1.9 The application of this policy is intended to minimise the risk of behaviours of concern and consequential risks of injury to any service user, employee or member of the public.

2. OUTCOME FOCUSSED AIMS AND OBJECTIVES

2.1 Restrictive practices are monitored and reduce over time. Restrictive practice reduction strategies are implemented across all Mersey Care services and lead to improvements in safety, participation, quality of life outcomes and experience of service users and staff.

2.2 All staff are capable and knowledgeable of supporting patients who may present with behaviours of concern and are committed to reducing restrictive practices which is evidenced in clinical practice across the organisation.

3. SCOPE

3.1 This is an organisational policy applicable to all staff and clinical services across the Trust. However, due to the diverse nature of the services within the Trust, local procedures will reflect the inherent operating differences within each service.

3.2 Mersey Care NHS Foundation Trust has a responsibility to provide training and personal safety support to all staff in all divisions.

3.3 Divisional Chief Operating Officers have the responsibility for ensuring that local provision and procedural arrangements are in place to ensure the framework detailed within this policy is delivered.

4. DEFINTIONS – BEHAVIOURS OF CONCERN & AGGRESSION

4.1 Behaviours of concern also known as challenging behaviour has been clearly defined in a multidisciplinary document published by the Royal College of Psychiatry. "Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion".

4.2 There are now two clear legally based definitions of assault used in the NHS to ensure a consistent approach throughout:

- Physical assault
- Non-physical assault

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 harassment.

(NB: Secretary of State Security Directions require that **all** incidents of physical assault be reported – **whether intentional or not**)

5. PRINCIPLES

5.1 Mersey Care NHS Foundation Trust is committed to "Promoting the Human Rights of service user's, carers and staff". Service users must always be treated with dignity and respect regardless the degree of behaviours of concern and with due regard to an individual's race, ethnicity, age, religion, gender, sexual orientation, mental, physical, learning disability or transgender status.

5.2 Mersey Care NHS Foundation Trust believes that behaviours of concern with the potential to cause harm directed towards staff, service users or the public is unacceptable, however the Trust are sensitive to the particular past experiences, trauma and symptoms that the service users may be experiencing, or have experienced and how they may impact on their behaviours. As a result while the Trust is committed to take every reasonable step to prevent harm or injury to staff, unfortunately at times harm may occur. During these times appropriate support will be provided as described in the Trust Policy and Procedure for the support of people who experience abuse, discrimination and violence HR9.

5.3 Mersey Care NHS Foundation Trust is committed to providing trauma informed care environments for the people we serve to support their recovery. The Trust recognises that exposure to traumatic events, especially as children, heighten service users' health risks. The Trust acknowledges the need to understand service users life experiences in order to deliver effective care which can improve service user engagement, treatment adherence, health outcomes, and provider and staff wellness (see Appendix 7, Characteristics of a trauma-informed care environment).

5.4 All services will actively implement the positive and safe guidance set out in the National Institute for Clinical Excellence (NICE) Guidelines on Violence and aggression: short term management in mental health, health and community settings, NG10 (May 2015).

5.5 During any incident with the potential to cause harm, skilled practitioners must provide care for service users using contemporary, proportionate, least restrictive and evidence-based approaches.

5.6 The Trust is committed to the Policy and Procedure for the support of people who experience abuse, discrimination and violence (HR09) and will actively support any member of staff who is assaulted or threatened with an assault, which arises out of the course of their work.

6. DUTIES AND RESPONSIBILITIES

6.1 **Board of Directors.** The trust board is the executive sponsor of Reducing Restrictive Practice and is responsible for ensuring that a policy is in place that governs the support of services users who may present with behaviours of concern via its governance arrangements and that all staff working in the trust are aware of, and operate within the policy.

6.2 **Medical Director.** The Medical Director is the Executive Director of the policy and is responsible for ensuring that all medical staff are aware of, and operate within the policy and procedure for the support of service users who may present with behaviours of concern.

6.3 **Executive Director of Nursing and Operations.** The Executive Director of Nursing and Operations is responsible for ensuring mechanisms are put in place to ensure nursing and allied health professionals within the services are aware of and comply with the requirements of the policy and procedure for the support of service users who may present with behaviours of concern.

6.4 **Clinical Director for the Centre of Perfect Care.** The Clinical Director for the Centre of Perfect Care is the Trusts appointed responsible person for the purposes of the Mental Health Units (Use of Force Act) 2018.

6.5 **Associate Director of Nursing & Patient Experience (Secure Division and Specialist LD Services)** is accountable for the delivery, content and provision of PSS training for the workforce.

6.6 **Trust Lead for Reducing Restrictive Practice.** The Trust Lead for Reducing Restrictive Practice is responsible for developing the Personal Safety Service Training syllabus, reviewing the Trust policy SD18 and will chair the Trust Reducing Restrictive Practice Implementation Group and the Personal Safety Service/Curriculum Development Group.

6.7 **The Reducing Restrictive Practice Curriculum Group.** The Reducing Restrictive Practice Curriculum Group operates within the Trusts governance arrangements to ensure that training is planned developed and implemented in accordance with the national training standards (The Restraint Reduction Network Training Standards 2019) national policy, legal/ethical frameworks, and the Human Rights agenda.

6.8 **Reducing Restrictive Practice Implementation Group.** The Reducing Restrictive Practice Implementation Group operates within the Trusts governance arrangements to ensure the continuous development of innovative approaches to reduce restrictive practices, implementation of the Trusts Reducing Restrictive Practice Programme and to ensure compliance with the MHA code of practice, relevant guidance and evidenced best practice.

6.9 **Reducing Restrictive Practice Monitoring Group**. The Reducing Restrictive Practice Monitoring Groups within the Divisional governance structures of the Trust have the responsibility to ensure that the use of restrictive practices is reported on to their governance boards in line with agreed governance structures. They also have the responsibility to support and advise on the use of restrictive practice within their Division and to ensure compliance with the MHA code of practice, relevant guidance and evidenced best practice.

6.10 **Divisional Chief Operating Officers**. The Divisional Chief Operating Officers are responsible for ensuring that all managed staff members are aware of and operate within the policy and procedure for the support of service users who may present with behaviours of concern and are responsible to ensure that staff are trained within their service areas to make certain that there is always an adequate collective staff response to manage risks of behaviours of concern that could be reasonably predicted.

6.11 **Associate Medical Directors.** Associate Medical Directors have the responsibility to monitor the use of restrictive practice within their division and chair or nominate a deputy for the Divisional Reducing Restrictive Practice Monitoring Group.

6.12 **All staff**. All staff within the Trust in front-line supportive relationships with service users have a responsibility to provide care in accordance with this policy and procedure. It is the responsibility of all staff to ensure that they are up to date with their mandatory personal safety training (i.e. H.R Policy and Procedure for Learning and Development for Staff within Mersey Care HR05).

6.13 **Medical Staff**. A doctor should be able to attend an incident of physical restraint in a timely manner (i.e. within 60 minutes).

6.14 **Nurse in Charge of the Ward**. The nurse in charge of the ward is responsible for ensuring the service user is offered the opportunity to be de-briefed following an incident involving the use of physical restraint, the staff involved and any other service users who may have witnessed the incident.

7. POLICY

7.1 Clinical, Organisational and Environmental Risk Assessment

7.1.1 Assessment and the management of risk is an essential part of the care and treatment provided for service users and is an integral part of the Care Programme Approach (CPA). It is essential that on admission/referral or initial contact a clinical risk assessment is carried out and a risk management plan is put into place. This should be in collaboration with the service user and their carer/family wherever possible. The risk assessment process is designed to be comprehensive with the potential risk of behaviours of concern to cause harm being just one element that is considered as part of the assessment and will support positive, collaborative risk taking aligned with the Trust values.

7.1.2 Only clinical risk assessment tools formally approved for use by Mersey Care NHS Foundation Trust staff can be used. These are listed and described in the **Portfolio of Clinical Risk Assessment Tools**, which can be found on the Trust's website. (See policy SA10 'Use of Clinical Risk Assessment Tools').

7.1.3 Risk assessments and risk management plans must be regularly reviewed with the service user and their carer whenever possible. Plans should record known triggers to aggressive/violent behaviour based on current observations, previous history and discussion with service users and their carers/families.

Changes in levels of risk should be recorded, communicated and risk management plans changed accordingly.

Service users can make ***Advance Statements*** under the Policy and Procedure for the Use of Advance Statements & advance decisions (SD19), identifying how they would like to be cared for at a time when they do not have capacity.

7.1.4 The approach to risk assessment must be multi-disciplinary and reflect the care setting in which it is undertaken. Any risk factors relating to a service user must be communicated appropriately across care settings.

7.1.5 The physical and therapeutic environment can have a strong mitigating effect on the levels of latent agitation, frustration and boredom that can be experienced by service users. It is good practice for ward managers to undertake environmental and organisational risk assessments at least once every twelve months, or sooner if there is a significant change to the facility. This should include an assessment of: the physical environment; safety and security issues; access to meaningful and purposeful activity; access to fresh air outdoors where possible; and adequate staff to service user ratios (see Good Practice Guidelines for Ward Design and Organisation, Appendix 5). The Personal Safety Service will assist in this process on request.

7.1.6 Each service will have a local procedure that describes how to summon help in an emergency and which determines the need for alarm systems. The procedure will be based on an evaluation of the risk assessment process. The procedure must be disseminated to all staff who are required to familiarise themselves with its content.

7.1.7 Collective responses to alarm calls should be agreed before incidents occur, consistently applied and be periodically rehearsed.

7.1.8 The Trust's Personal Safety Service who provides training will also provide advice, support and practical help to individual service areas in the prevention and management for the support of people who may present with behaviours of concern. The service will provide a timely response according to the risks presented (See referrals flowchart, Appendix 10)

7.2 Prevention

7.2.1 All inpatient wards will embed the Trust's No Force First key philosophy, 6 key ward based interventions and consider the implementation of the evidence based toolbox interventions based on the profile of incidents on the ward, outlined within the Trust Guide for Reducing Restrictive Practice.

7.2.2 A wide range of appropriate occupational, social and recreational activities will be provided for the service user group taking into account an individual's abilities, level of functioning and resources available.

7.2.3 Positive and Proactive Care advocates the use of PBS Plans for anyone likely to be subjected to a restrictive intervention. Based on an explicit analysis of the function of behaviours described as *challenging*, a PBS plan incorporates both primary and secondary *preventative* strategies, which must always be employed prior to considering the use of more restrictive interventions.

7.2.4 A detailed procedure for the development of PBS plans operates within the Trust's SpLD Division, however, the guidance contained within it can be adopted within any clinical setting. http://sharepoint.merseycare.nhs.uk/sites/SpecialistLD/Policies%20and%20Procedures/27.21%20Positive%20Behavioural%20Support%20Plans.pdf

7.2.5 Mersey Care NHS Foundation Trust is committed to preventing the occurrence of behaviours of concern with the potential to cause harm through proactive leadership (See Appendix 6, Violence Reduction Strategies to minimise the use of coercive interventions).

7.2.6 All staff will demonstrate a positive attitude when communicating with service users. Staff must never use language that could be construed as supporting negative stereotypes. This would include verbal or non-verbal responses that could be interpreted as carrying aggressive, threatening, sarcastic or disrespectful intent. Staff will demonstrate self awareness, compassion and understanding towards behaviours of concern and the values set out by the Trust. If staff encounter compassionate fatigue or witness staff using communication that is not aligned to the values of the Trust this must be escalated accordingly.

7.2.7 Conflict between staff and service users, carers and the public can arise and must be dealt with promptly in a fair, safe, equitable and constructive manner. All clinical staff, but particularly matrons have a responsibility to ensure that any concerns are dealt with promptly and that local resolution of any difficulties is facilitated. The input of advocates and/or PALS (Patient Advisory Liaison Service) can be sought if other avenues have proven unsuccessful.

7.2.8 Open, clear and effective communication between staff members, service users, relatives and their advocates (especially those with visual, hearing, cognitive impairment or whose first language is not English) minimises misinformation and confusion arising. Each clinical area/service will avoid this by producing unambiguous collaborative care plans that encourage co-operation and cohesion. These plans should also include guidance on de-escalatory interventions that take account of communication difficulties.

7.2.9 A gender sensitive approach must be considered by staff when managing people who may present with behaviours of concern. Staff must consider history of abuse, spiritual, religious and cultural needs, beliefs and behaviours when considering interventions. Staff will receive appropriate equality and diversity training to help them facilitate this approach.

7.2.10 The Trust's Personal Safety Service will provide learning packages that will enable practitioners to gain greater competence to prevent violence and aggression occurring. Training will include methods of preventing, anticipating, de-escalating and managing

behaviours of concern by developing greater awareness of their own verbal and non-verbal behaviours. (See also section 8, Staff Training).

7.2.11 Risk assessments and risk management plans / positive behavioural support plans will be regularly reviewed with the service user and with consent, their respective carers/families whenever possible, unless there are capacity issues, in this case a best interest's assessment and or post incident review could determine this. Plans will record known triggers to behaviours of concern as well as the service user's strengths (i.e. what worked/helped). Assessments are based on previous history, current observations and discussion with service users and their carers/families. Changes in levels of risk should be recorded, communicated and risk management plans changed accordingly. Consideration should be given to communicating changes in risk to the service user. (See on the use of Clinical Risk Assessment, SA10).

7.3 Approaches for personal safety

7.3.1 As indicated at section 3.1 procedural arrangements for the effective management of behaviours of concern will be established at local level that will include details on how to summon help and support should a crisis occur.

7.3.2 The choice of intervention must be guided by clinical need and the obligations owed to the service user (i.e. advance statements, physical, cultural, religious, gender and previous trauma), other service users affected by the disturbed behaviour and to members of staff and any visitors.

7.3.3 The physical intervention selected must amount to a proportionate and reasonable response to the risk posed and for the least amount of time required.

7.4 De-escalation techniques

7.4.1 Support of people in distress requires management utilising a compassionate, measured, flexible and reasonable response. Where possible, attempts at de-escalation need to be employed prior to other interventions being used (see Appendix 8, Verbal De-escalation Techniques).

7.5 Observation

7.5.1 Observation is a core healthcare worker skill and should be used to help recognise, behaviours of concern through timely interventions (refer to the Supportive Observation Policy, SD04).

7.6 Implementation and Monitoring of Physical Interventions

7.6.1 Staff who are expected to engage therapeutically on a continuous and direct basis with service users who pose a potential risk, will require Personal Safety training. It is the responsibility of the service manager to risk assess appropriate Personal Safety training (Refer to flow chart) in relation to course outlines of who must receive mandatory training in the use of physical intervention (see Section 8, staff training). All ward based nursing staff will routinely require full Personal Safety training but this may also include other disciplines. Wherever possible, Personal Safety Coordinators will make reasonable adjustments as required by the Equality Act 2010, to ensure that training is successfully undertaken.

7.6.2 All staff who employ physical interventions must receive mandatory Basic Life Support training (BLS) (see Section 8.1.3, Staff Training).

7.6.3 Wherever possible staff must use the physical intervention techniques taught by the Personal Safety Service approved by the Reducing Restrictive Practice Curriculum Group. However, we recognise that the initiation of physical intervention will often not follow any set pattern. The actions of staff must be ethical, reasonable, proportionate and safe and in accordance with law, the Human Rights Act and its principles.

7.6.4 Physical intervention should be avoided if at all possible. However, where physical interventions are utilised it should be brought to an end at the earliest opportunity. Debriefing should be provided for the service user, staff, other service users and other individuals involved / impacted by the intervention. Were appropriate, with service user consent the carer should be made aware of any physical intervention.

7.6.5 At all times a doctor should be available (within 60 minutes) to attend an alert by staff members when physical intervention, rapid tranquillisation and/or seclusion are implemented (see Appendix 1, Physical Care and Observation during Physical Intervention). Where the expectations of this policy are not adhered to then a separate adverse incident report must be completed**.** The clinical team must review this incident as soon as practically possible.

7.6.6 There are real dangers with physical interventions in any position (i.e. positional asphyxia). To avoid prolonged physical intervention an alternative strategy, such as rapid tranquillisation or seclusion, where available, should be considered. (Refer to NICE Guideline NG10, May 2015).

7.6.7 When physical intervention occurs a graded approach to the number of staff employed to maintain safety should be taken (minimum 2). Where a three person team is required, one member of this team will be responsible for protecting the service users head and neck. A team member should be nominated to take responsibility for leading the team through the restraint process. All staff involved in the intervention and the immediate vicinity has responsibility to ensure that the service user's airway and breathing are not compromised and that vital signs are monitored (see Appendix 1, Physical Care and Observation during Physical Intervention). If additional staff are available, it is good practice to ask them to write down events as they occur (i.e. times, movement from and to, what was said and advice of any concerns). The Trust advocates through its personal safety training programme that physical intervention involving one member of staff should be avoided.

7.6.8 Unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position on any surface, not just the floor (MHA Code of Practice, 2015).

7.6.9 When using physical restraint, staff should avoid taking the service user to the floor, but if this becomes necessary:

- Use supine (face up) position if possible or
- If the person ends up in the prone position (face down), use it for the shortest time possible

7.6.10 The physical restraint procedure will be discontinued immediately if:

- The person's facial colour becomes overly red, pale or ashen;
- The person appears to be gasping for breath or shows signs of other breathing difficulties (including very rapid breathing);
- Blue colouration of hands, feet or other body parts (indicates reduced blood circulation);
- The person appears to be in pain or distress during the intervention;

- There are any signs of injury including any sort of bleeding especially from the head area;
- The person begins to vomit or if there is any evidence of seizure activity.

Should any of the above concerns become apparent, the person in charge will immediately seek medical advice.

7.6.11 Under no circumstances during physical interventions should pressure be applied to the neck, thorax, abdomen, back, pelvic area or obstructing the mouth or nose. The overall physical and psychological well being of the service user should be continuously monitored throughout the whole process (see Appendix 1, Physical Care and Observation during Physical Intervention).

7.6.12 During a physical intervention positive communication (ideally from the staff member with the best rapport with the service user) should continue throughout the process. It is essential that staff attempt to de-escalate and reassure the service user and provide advice, support and guidance to alleviate the situation, with the aim of ceasing the intervention at the earliest possible opportunity.

7.6.13 There may be extraordinary situations where pain or discomfort is unavoidable for service users, i.e. the need to employ a breakaway technique with a individual who presents with a high level of intent and potential to cause serious harm / immediate risk to life and where less intrusive techniques would prove unsuccessful, or where its use is deemed the only way to resolve an emergency (such as impending death or grievous bodily harm) when alternative interventions have been considered and proven ineffective. Any pain compliant technique should only be used for the minimum of time necessary to achieve the intended outcome which is breakaway and summon assistance. This principle is supported by Criminal Law Act 1967, The Use of Reasonable Force and the Mental Health Act Code of Practice, (1983, updated, 2015). The deliberate infliction of pain or discomfort can **NEVER** be used to get a service user to follow an instruction where there is no risk to life, or desist from verbally aggressive behaviour.

7.6.14 Medical history and ongoing current conditions, pregnancy, age, gender, religious beliefs, culture, language, disability or previous trauma should be taken into consideration and recorded in the service user's care plan / positive behavioral support plan.

7.6.15 Lifting of service users whilst in restraint is not taught within the Personal Safety Service syllabus, this procedure is only conducted within the Secure Division Level 3 Response team. Service Users must not be manually handled without the correct training and equipment, this also fits with the Health & Safety Act (1974) and Management of Health and Safety regulations (1999) Manual Handling operations regulations (1992) as amended (2002).

7.6.16 In the event of a service user commencing to spit at staff whilst dealing with challenging interventions staff may wear PPE (masks / glasses / aprons) which must be accessible within all clinical areas. Under no circumstances should the service users breathing be compromised.

7.6.17 Following a physical intervention involving a service user which results in their injury, or a complaint by the service user or observer about the physical intervention, consideration should be made as to whether a Safeguarding referral should be submitted (refer to the Policy for Safeguarding Adults from Abuse, (SD17).

7.7 Mechanical Restraint and Protective Equipment

7.7.1 On occasions the use of handcuffs is required for security purposes for the transfer of restricted service users in secure settings to other secure or non-secure settings. The use of mechanical restraint in these circumstances should be informed by an assessment of the risks posed by the service user, as well as their presenting physical and mental condition and the

need to maximise their dignity. Escorting staff should alert medical staff to any identified risks if the restraints were to be removed; however, if requested by medical staff, they should be removed only whilst medical treatment is carried out following consultation with the duty manager / bronze command.

7.7.2 In Secure Division areas with the exception of services at Whalley and the STAR unit the use of additional protective equipment (refer to glossary) is available for use in extreme circumstances – for instance if a service user became armed. Access to such equipment would be afforded only as a last resort to contain and control a given situation. A local security procedure will be in place identifying the criteria for deployment and the command structure under which it is deployed. These local frameworks will address training requirements and the need for effective audit and post-incident review of practice.

7.7.3 Serious incidents using weapons may occur in local services. In these areas protective equipment is not available. In these circumstances the procedure at 7.11.3 below should be followed.

7.8 Seclusion

7.8.1 Seclusion is as defined in Chapter 26 of the Mental Health Act Code of Practice (1983), is "the supervised confinement and isolation of a patient, away from other service users, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others".

7.8.2 Seclusion must only be used as a last resort and should only be used for the shortest possible time.

7.8.3 Staff employing seclusion must receive mandatory Basic Life Support training (BLS). (Refer to section 8 - Staff Training).

7.8.4 The implementation of seclusion must be applied in accordance with the Trust Seclusion Policy (SD28).

7.9 Rapid tranquillisation

7.9.1 Medication, skilfully given (in the context of good clinical care and milieu), can safely and effectively be used to support people who present with behaviours of concern. Staff must utilise the Trust-wide Clinical Policy for the Use of Rapid Tranquillisation (SD 11) and have undertaken the appropriate training.

7.9.2 Staff involved in the administration, prescribing or monitoring of service users in receipt of parenteral rapid tranquillisation must have received training in the provision of Immediate Life Support (ILS), or have the direct support of colleagues trained to that level. (Refer to section 8 Staff Training).

7.9.3 After the use of intramuscular (I/M) or intravenous (I/V) rapid tranquillisation, vital signs must be monitored in accordance with the Trust-wide Clinical Policy for the Use of Rapid Tranquillisation (SD 11).

7.10 Police Involvement and links to the Criminal Justice System

7.10.1 All services will establish local working partnerships with the Police and the Criminal Justice System. This will be facilitated with input from the Trust Criminal Justice Liaison Service and the nominated Trust Mental Health Liaison Police Officers.

7.10.2 Local protocols must be compliant with the Mental Health Units (Use of Force) Act 2018 and the Memorandum of Understanding - The Police Use of Restraint in Mental Health & Learning Disability Settings and will be formulated outlining the criteria for summoning the police to a violent incident, the methods of achieving that assistance, the potential use of C.S incapacitant spray and Tasers and the subsequent care of those affected by its use.

7.10.3 Staff should refer to the support of people who experience abuse, discrimination and violence (HR 09) for guidance around the bringing of criminal proceedings against service users, visitors or members of the public who have assaulted staff and other service users (i.e. Assault may be physical or non-physical).

7.11 The Use of Weapons

7.11.1 Local procedures will dictate what specific action should be taken if a weapon is used during an aggressive or violent incident (see section 3.1).

7.11.2 Where weapons are involved the staff who assumes control of the situation should ask for the weapon to be placed in a neutral location rather than handed over.

7.11.3 Where potential weapons may be available the aggressor, if possible, should be isolated or relocated to a safer environment. Staff should vacate an area where such an immediate risk is posed and secure the service user concerned if it is safe to do so. On no account should an attempt to physically disarm a service user be attempted (excepting those circumstances covered at section 7.11.4)

7.11.4 If safe to do so, maintain dialogue whilst waiting for additional support either via the deployment of the High Secure Response Team (Secure Division with the exception of services at Whalley and the STAR unit) or from the police.

7.12 Incident Reporting, Post Incident Support and Clinical Review

7.12.1 Any incidents of 'behaviours of concern' should be recorded as per Policy for the Reporting, Management and Review of Adverse Incidents (SA 03).

7.12.2 For all incidents, the member of staff in charge should ensure that a member of staff involved in the incident completes the relevant electronic incident report. Incident reports completed using DATIX (All Divisions except High and Medium Secure automatically selects the incident classification. Within High and Medium Secure incidents are recorded on PACIS from which staff will enter an initial classification using the Mersey Care Adverse Incident Classification Matrix (See policy SA03).

7.12.3 For all class A, B or C incidents (DATIX) or moderate/major incidents (Ulysses), the member of staff in charge should ensure that a debriefing session takes place as soon as is practical. This does not constitute a review but an opportunity for the staffing/clinical team to share their initial reactions to the incident. Service users if the incident occurred in an inpatient area will be offered support/debriefing as appropriate. A practitioner with appropriate skills should facilitate debriefing. Staff support/counselling services should also be offered to staff were unwanted/distressing psychological symptoms persist. Arrangements made with Mersey Care Staff Support Services to facilitate this (Contact details on Mersey Care NHS Website, Policy HR13, or can be contacted via Occupational Health).

7.12.4 Staff support systems and mechanisms to review practice, both internally and externally as determined by collective and individual need should be utilised when appropriate to promote a culture of learning around such issues.

7.12.5 Risk managers routinely supply incident data to facilitate the examination of and proactive management of emergent risks in service areas.

7.12.6 Learning from incidents takes place using the Trust's Root Cause Analysis (RCA) system (see policy SA03). Additionally, all physical intervention incidents are reviewed at MDT meetings, so that care plans of individual service users can be reviewed and amended accordingly.

7.13 Complaints

7.13.1 Service users who wish to complain about their care during physical intervention must have their concerns fully considered and acted upon accordingly (refer to the Management of complaints/concerns policy, SA06).

7.13.2 Staff with concerns about the care a service user has received has a responsibility to make their concerns known. Such concerns should be raised through the normal line management structures. Any outstanding concerns can be raised in accordance with the procedures laid down within the Public Interest Disclosure Act 1998 and the Trust Freedom to Speak Up (Whistleblowing) Policy, HR06.

7.14 Clinical Audit and Monitoring

7.14.1 Monthly review of challenging incidents should take place to identify trends, including data related to the protected characteristics of age, disability, gender, race, sexual orientation, religion/belief, and gender reassignment. The data obtained should be used to inform training and develop preventative strategies.

7.14.2 The Department of Health (DH) Positive & Proactive Care: Reducing the need for restrictive interventions, the National Institute for Health and Clinical Excellence clinical guide NG10 standards (2015) and the Restraint Reduction Network will provide a benchmark for current education, training and clinical practice. A self assessment tool for compliance with NICE guidance has been disseminated to Chief Operating Officers within each division by the Clinical Audit team to track compliance. The Personal Safety Service will assist in developing action plans and or meeting compliance if approached.

7.14.3 The clinical audit team will audit compliance with Department of Health (DH) Positive & Proactive Care: Reducing the need for restrictive interventions / NICE guidance within the review period of this policy (i.e. SD18). Results from the audit will be disseminated to all stakeholders for recommendations to be made regarding future education, training and practice.

7.14.4 Compliance with the requirements of this policy will be monitored by the Trust Lead for Reducing Restrictive Practice and a detailed report provided to the Trust Quality Assurance Committee.

8. STAFF TRAINING

8.1 Training Frequency

For the training requirements related to this policy (i.e. course type, frequency and who needs to attend) please refer to the Trust's Policy, Induction & Mandatory Training (HR28). This policy outlines the mandatory Personal Safety training course staff are required to undertake, with regard to the duration and frequency.

8.1.2 **Life Support Training**

Training will be made available for identified staff involved in the administration, prescribing or monitoring of service users in receipt of parenteral rapid tranquillisation to Immediate Life Support level. (ILS - Resuscitation Council UK). This should cover airway management, cardio-pulmonary resuscitation (CPR) and use of automated defibrillators. (Please refer to Trust Resuscitation Policy, SD07).

8.1.3 Staff who employ physical intervention techniques or utilise seclusion will require Basic Life Support training annually (Refer to BLS – Resuscitation Council UK) (Refer to Trust Resuscitation Policy SD07).

8.2 Non-Physical Approaches and Physical Skills Training

8.2.1 Validated training for staff in Personal Safety will be available for all employees. Programmes should be tailored to the specific needs of the service and its service users to ensure its appropriateness and acceptability, particularly concerning age, disability, gender, race, sexual orientation, religion/belief, transgender and maternity issues.

8.2.3 Personal Safety training including the use of non-physical and physical intervention techniques (e.g. de-escalation & breakaway training) will be provided through induction and on-going training by the Trust Personal Safety Service.

8.2.4 The level and frequency of training provided will be determined based on the risks presented and the job role. Those staff considered most at risk of physical/non-physical assault are described as 'Frontline staff' as put forward in Appendix 10 - Personal Safety Service Courses.

8.2.5 The Trust will focus on meeting the Department of Health Positive & Proactive care aims and the National Restraint Reduction Network Training Standards. All delivery of Trust Personal Safety techniques/ training courses will only be undertaken by Trust employed approved Personal Safety Co-ordinators (i.e. Personal Safety Co-ordinators/Advisors) specialising in meeting the needs of staff and service users in each division. All approaches and physical interventions taught will be subject to an on-going process of audit and validation by the Reducing Restrictive Practice Curriculum Group.

8.2.6 **Non-Physical Interventions**

Training in the use of non-physical approaches – Personal Safety training including verbal de-escalation, is a mandatory requirement thereafter two yearly updates, for all staff in direct or indirect contact with service users, except for those staff working in High Secure Services who require yearly updates as per the Local Security Framework. Training in non-physical approaches must be accessed before undertaking training in physical interventions. The training courses have been developed to reflect the staffs' role, the perceived risk and level of exposure to that risk (See Appendix 10 - Personal Safety Service Courses).

8.2.7 **Physical Interventions**

All staff who are expected to engage therapeutically on a direct basis with service users who pose a potential risk (i.e. frontline staff) will receive training according to the risks posed due to the staffs' role and the risks presented. For example: Lone workers will receive training on how to breakaway from an assailant whilst staff in inpatient areas where physical intervention may be required will receive team training. Such training will not exclusively deal with physical intervention skills but will incorporate the use of non-restrictive approaches and restraint reduction initiatives. This standard will apply to all inpatient nursing staff.

8.2.8 **A Combined Approach**
Training courses will combine non-physical and physical approaches unless the need for a specific training course has been identified by the Personal Safety Service in conjunction with services (e.g. service user specific referral). Courses have been identified for the following staff groups:

8.2.9 **Personal Safety Training Course (1 day) Clinical/Non-clinical staff** The emphasis is in maintaining personal safety (i.e. non-physical approaches) as well as specific 'breakaway techniques' (i.e. physical approaches) which can be deployed to escape an assailant and raise the alarm in an emergency.

8.2.10 **Team Work Skills (4 day)** The emphasis is on "Personal Safety & Team Work Skills", will be provided with this training as soon as practically possible (depending on service needs/requirements), but no later than within three months of starting their employment or moving to the area where these skills are required.

8.2.11 **Team Work Skills Refresher Training Course (2 days)** Training records will be considered out of date where they exceed the specified mandatory update which is 12 months in the Organisational Training Needs Analysis.

8.2.12 **Individual staff** are responsible for keeping their mandatory training up to date. Mandatory training requirements must be met or planned to be met before any other training or development requirement is fulfilled. (See the Trusts Learning & Development Policy for Staff within Mersey Care, HR 05)

8.2.13 All staff within clinical areas must maintain mandatory annual refresher training within a 12 month period.

8.2.14 Where Frontline inpatient staff exceed the time specified to undertake a refresher course the staff member will be assessed on a individualised basis as to whether they need to access the (four day) team work skills course.

8.2.15 Response team training utilising Personal Protective Equipment,' is only applicable to the Secure Division with the exception of services at Whalley and the STAR unit and is governed by local security policies therein.

8.2.16 Staff who cannot complete training due to disability, pregnancy, medical or psychological problems should be referred to occupational health for an access to work assessment. A risk assessment should be carried out by their direct line manager to ascertain whether this person will be able to continue working in this particular environment.

8.2.17 Where the Trust continues to use Agency staff then the Senior Clinical Nurse for Reducing Restrictive Practice managing the Personal Safety Service will liaise with the Trusts Bank Co-ordinator to ensure that such individuals have received training appropriate for the respective services in which they will work.

8.2.18 All bank staff will receive training through the Personal Safety Service and will be subject to the same conditions as Trust employees.

8.2.19 Only in exceptional circumstances and as a last resort will employees, bank or agency staff who have not received such training be expected to apply physical interventions.

These circumstances will be in line with common law provision and will be at the direction of the practitioner with responsibility for managing the situation.

8.2.20 Clinical/Non staff working within the Trust who have indirect contact with service users must access a Personal Safety Course ('A') every two years except for those staff working in High Secure Services must access training yearly as per the Local Security Framework.

9. Local Procedure

9.1 Chief Operating Officers within all areas of the Trust will identify an appropriate individual to ensure that the key elements of this policy (Section 3) are adopted within local procedures.

9.2 Where specific procedural deviation is required in respect of this policy, it is the responsibility of the Divisional Chief Operating Officer to identify these areas for consideration by the Integrated Governance Committee on behalf of the Trust.

10. Development and Consultation process

10.1 This policy has been developed by the author drawing on existing policies and procedures within the respective services and consultation with service users and staff. The document also draws on the best practice advocated by current professional guidelines and legislation referenced below. Given the national developments that are on-going in this field, it is essential that the first review of this policy will take these aspects into account. The Trust will also need to ensure a wider consultation of these issues is undertaken that incorporates more fully the views of service users and carers.

11. Reference Documents

Ashcraft L, Anthony WA: (2008), Eliminating seclusion and restraint in recovery orientated crisis services. Psychiatric Services 591198-1201, 2008.

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Department of Health (2015), Code of Practice; Mental Health Act 1983, The Stationary Office. London.

Equality Act (2010).

Equality and Human Rights Commission (2019), Human rights framework for restraint: principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions.

Felitti VJ et al (1998), Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. American Journal of Preventative Medicine.

Health and Safety Executive (1999), Management of Health and Safety at Work Regulations.

Huckshorn K. A: (2005), Six core strategies to reduce the use of seclusion and restraint planning tool. National association of state mental heath program directors. Alexandra, Va.

Human Rights Act (1998), The Stationary Office. London.

Manual Handling Operations Regulations (1992), as amended (2002).

Menschner C, Maul A (2016), *Key Ingredients for Successful Trauma Informed Care Implementation*.

Mental Health Units (Us of Force) Act (2018).

Memorandum of Understanding (2017), - The Police Use of Restraint in Mental Health & Learning Disability Settings.

MIND (2013), Mental Heath Crisis Care: physical restraint in crisis.

NICE Clinical Guidance 1 (2009), Psychosis and schizophrenia: management.

NICE Clinical Guidance 10 (2015), Violence and aggression: short-term management in mental health, health and community settings

NICE Clinical Guidance 11 (2015), Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges

NICE Quality Standard QS154 (2017), Violent and aggressive behaviours in people with mental health problems.

National Institute for Mental Health in England (2004), Mental Health Policy Implementation Guide.

Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists (2007), Challenging behaviour: a unified approach, Clinical and service guidelines for supporting people with learning disabilities who are at risk of receiving abusive or restrictive practices.

12. References and Associated Documentation

SD03 Lone Working
HR09 Support of people who experience abuse, discrimination and violence
SA03 Reporting, management and review of adverse incidents
HR06 Freedom to Speak Up (Whistleblowing) Policy
SA10 Use of Clinical Risk Assessment
SD11 Use of Rapid Tranquillisation
SD28 Seclusion
SD48 Reducing Restrictive Practice
HR05 Learning and Development
SD17 Safeguarding Adults from Abuse
SD19 Advance Statements & advance decisions
SA06 Management of complaints/concerns
SD07 Resuscitation

SD18 Policy for the support of service users who may present with behaviours of concern

SD04 Supportive observation
HR13 Prevention and management of workplace stressors
HR10 Equality and Human Rights

13. Glossary

Advance Decision: A written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future.

Advance Statement: a document that contains the instructions of a person with a mental health problem. It sets out their requests in the event of a relapse, an incident of disturbed/violent behaviour etc. Furthermore it makes explicit the treatment that they do not want to receive and any preferences that they may have in the care they receive.

Antecedents: events which precede an incident of disturbed/violent behaviour.

Breakaway: a set of physical skills to help separate or breakaway from an aggressor in a safe manner. They do not involve the use of restraint.

Common Law: this 'judge made' law is distinguished from statute law which comprises Acts of Parliament. The common law refers to principles identified by judges, which have evolved to meet the needs of particular cases or particular developments in society.

Exceptional Circumstances: circumstances that cannot reasonably be foreseen and as a consequence cannot be planned for.

Frontline Staff: Nurses on wards/community teams, medical staff on wards/community teams. Psychologists/occupational therapists and other relevant professionals on wards/community teams. Clinical staff in A&E mental health liaison services. Other staff based on training needs analysis and risk assessment.

Functional assessment: An assessment of the function of behaviour that challenges, including functional analyses and other methods of assessing behavioural functions.

Indirect patient / service user contact: Non-clinical staff who may come into contact with service users through working in areas in which service users also have access e.g. porters, admin staff etc.

Mechanical Restraint: a method of physical restraint involving the use of authorised equipment applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part/s of the body of the individual concerned.

Milieu: environment, including the physical environment, policies and procedures, atmosphere, etc.

Personal Safety Service: The Personal Safety Service is a dedicated Trust team who provide advice, support and training for the Divisions on this agenda.

No Force First: Trust initiative to reduce conflict and the use of restrictive practices.

Positional Asphyxia: a condition in which a person experiences severe breathing difficulties or respiratory failure during or after being physically restrained. Most often occurs when the person is being restrained in the prone (face down) position or hyperflexion (bent over forwards).

Rapid Tranquillisation: the use of medication to calm/sedate the service user, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression thereby allowing a thorough psychiatric evaluation to take place. Although not the overt intention, it is recognised that in

attempting to calm/sedate the service user, rapid tranquillisation may lead to deep sedation/anaesthesia.

Response Team/Protective Equipment Team: a specialist group of staff trained in physical intervention skills that wear and use specialist protective equipment e.g. helmets, body armour, shields. These staff would respond as a last resort and/or be utilised in high risk situations, when all other management strategies have been unsuccessful or in a situation where a weapon is being used. Secure Division areas only.

Seclusion: Defined in Policy SD28 as per chapter 26.103 of the Code of Practice, and is held to be "Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others".

14. Appendices

Appendix 1: Physical Care and Observation during Physical Intervention
Appendix 2: Personal Safety Service Referral Flowchart
Appendix 3: Mental Health Units (Use of Force) Act 2018
Appendix 4: Department of Health – Positive and Proactive Care
Appendix 5: Good Practice Guidelines for Ward Design and Organisation
Appendix 6: Violence Reduction Strategies
Appendix 7: Characteristics of a trauma-informed care environment
Appendix 8: Verbal De-escalation Techniques
Appendix 9:The Restraint Reduction Network Training Standards (2019)
Appendix 10: Personal Safety Service Courses
Appendix 11: Equality & Human Rights Analysis

Appendix 1: Physical Care and Observation during Physical Intervention

Situations requiring the use of physical intervention constitute a medical emergency and should be treated as such by mental health service providers.

On admission, or at least within 24 hours of admission, service users should have a basic physical examination and their physical condition and needs assessed, with particular attention to conditions which may impact on cardio-pulmonary function or muscle and joint impairment, e.g.

- Asthma
- Heart disease
- Obesity
- Arthritis
- Propensity for using illicit drugs and/or alcohol
- Women who are pregnant

Where an older person is assessed the Single Assessment Process should be followed and particular attention given to the older person's level of frailty.

Any physical condition which may increase the risk to the service user of collapse or injury during restraint should be clearly documented in the service user's records and an appropriate care plan formulated. This should be communicated to all multidisciplinary team members.

At all times, a doctor should be quickly (within 60 minutes) available to attend an alert by staff members when physical intervention, rapid tranquillisation and/or seclusion are implemented. Any injuries must be reported through the Trusts reporting system.

Any person subject to restraint should be physically monitored continuously during restraint (with special attention to pallor or discolouration) and level of consciousness and at least every 2 hours post restraint for a period of 24 hours. This check should include:

- Care in the recovery position where appropriate
- Pulse
- Blood Pressure
- Respiration
- Oxygen saturations
- Temperature
- Level of consciousness.
- Fluid and food intake and output

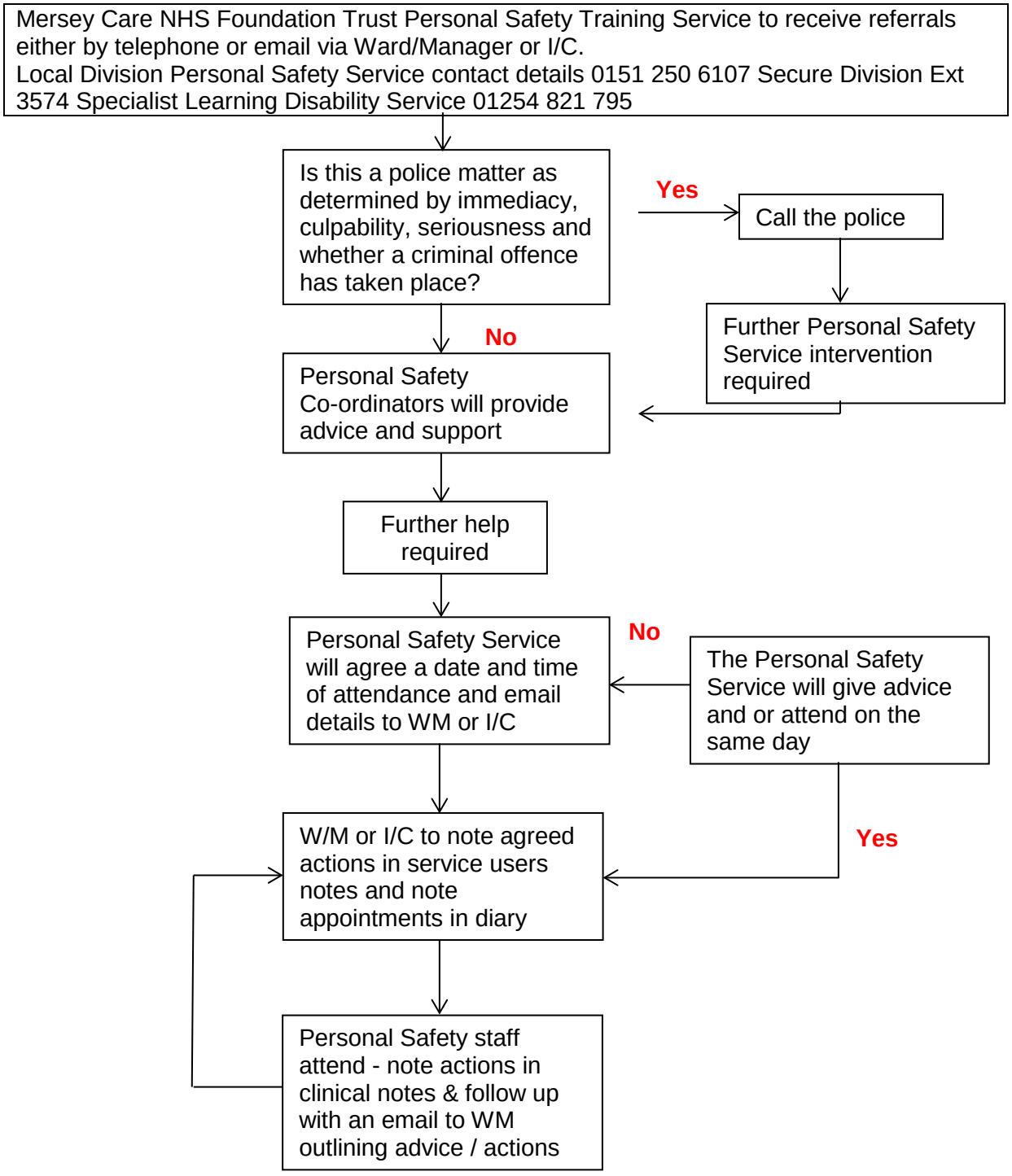
If consent and co-operation for these observations is not forthcoming from the service user to this process, then it should be clearly documented in the case notes why these checks could not be performed and what alternative actions have been taken.

(National Institute for Mental Health in England 2004*: Mental Health Policy Implementation Guide).*

(NICE Clinical Guidance 10 (2015), Violence and aggression: short-term management in mental health, health and community settings)

Appendix 2:

Personal Safety Service Referrals Flowchart



Appendix 3: Mental Health Units (Use of Force) Act 2018

An Act to make provision about the oversight and management of the appropriate use of force in relation to people in mental health units; to make provision about the use of body cameras by police officers in the course of duties in relation to people in mental health units; and for connected purposes. [1st November 2018].

Accountability

Mental health units to have a responsible person

Policy on use of force

Information about use of force

Training in appropriate use of force

Reporting

Recording of use of force

Statistics prepared by mental health units

Annual report by the Secretary of State

Investigation of deaths

Investigation of deaths or serious injuries

Delegation

Delegation of responsible person's functions

Guidance

Guidance about functions under this Act

Video recording

Police body cameras

Appendix 4: Department of Health (DH) Positive & Proactive Care

Key Themes:

• (114) Organisations that provide care and support to people who are at risk of being exposed to restrictive interventions must have clear organisational policies which reflect professional or clinical guidance, current legislation, case law and evidence of best practice.

• (115) Policies should outline the organisational approach to restrictive intervention reduction, including training strategies. Arrangements for the provision of high quality behaviour support plans for people who are likely to present behaviours that may require the use of restrictive interventions must be included. Employers and managers are responsible for ensuring that staff receive training, including updates and refresher training courses are appropriate to their role and responsibilities within the service.

• (116) All policies must be co-produced with people who use services and carers. They must include guidance to employees on the safe use of restrictive interventions as a demonstrable last resort, either as part of a behaviour support plan or as an emergency measure where behaviours cannot be predicted. There must be guidance on how the hazards associated with restrictive interventions will be minimised, for example, first aid procedures in the event of an injury or distress arising as a result of physical restraint.

• (117) Clear recording and reporting arrangements should be explicit along with the mechanism by which this data will inform the on-going review of a restrictive intervention reduction programme.

• (118) The policy should explain how people who use services, their carers, families and advocates participate in planning, monitoring and reviewing the use of restrictive interventions and in determining the effectiveness of restrictive intervention reduction programmes. This will include providing accessible updates and publishing key data within quality accounts (or equivalent report).

Appendix 5: Good Practice Guidelines for Ward Design and Organisation

A well planned physical environment is one that allows adequate space, reasonable comfort, privacy and safety. Staff must be aware of a wards design features so that they can help patients to benefit from the good aspects and minimise the effects of the bad.

1. Calming features

• All areas look clean and tidy.

• Reception areas are well planned.

• There are separate areas for patients with police escorts.

• There is natural daylight and fresh (access to outdoors, where appropriate).

• Crowding is avoided.

• There is a perception of space.

• Noise levels are controlled (e.g. television area)

• Personal effects are safe and accessible.

• There are safe activity areas inside and outside.

• Private spaces and rooms are provided.

• Privacy in toilet and bath, and in single sex areas, is ensured.

• Staff privacy areas are provided.

• Ambient temperature and ventilation are adequately controlled.

• Opportunity for physical exercise should be provided.

• Sleeping and day areas should be separate and the day room should be open for those who cannot sleep.

2. Ensuring a secure environment

• There is a safe room for severely disturbed people (strong fabrics, secure fittings, reinforced glazing, sound insulation, nearby toilet and washing facilities).

• Movable objects are of safe weight, size and construction.

• Sight lines are unimpeded.

• Exits and entrances are within sight of staff.

• Some doors should have ‘one way’ locks preventing intruders from entering but allowing those inside to leave of their own accord.

• Doors are easily accessible i.e. can facilitate prompt exit.

• Seating is arranged so that alarms can be reached and doors are not obstructed.

• Alarms are accessible and collective response to alarm calls are agreed and consistently applied.

3. Features of an effective clinical environment

• Collaboration with service users in planning clinical environments, policies and practices.

• Adequate handover between clinical teams for continuity.

• Clear management policies and leadership.

• Management/staff communications open at all levels.

• Ward size and design appropriate to patient population.

• Staff training and development with regular updating.

• Critical reviews of any incident carried out.

• Adequate staff ratios, well supervised, trained and experienced staff.

• Staff appropriate to patient population, eg gender and race.

• Multi-disciplinary consensus on clinical care.

• Structured timetable and activities.

4. Staff and management responsibilities

• Encourage and provide privacy for visits from friends and relatives.

• Ensure access to, and privacy with, keyworker.

• Ensure complaints are taken seriously.

• Ensure there is a member of staff available for users to talk to when feeling distressed.

• Ensure users reporting angry feelings are not 'threatened' or 'punished' with the use of interventions such as medication or seclusion.

• Appointments should be kept.

• Assure sensitivity to ethnic and cultural values.

• Provide easy access to, and privacy and security for, personal possessions.

• Provide activities to alleviate boredom.

• Ensure optimum self –determination and dignity.

• Ensure protection from intimidation and violence.

• Provide full information concerning legal status; diagnosis; treatment and progress; discharge and post discharge arrangements; policies and procedures.

(The Royal College of Psychiatrists 1998: Management of Imminent Violence).

Appendix 6: Violence Reduction Strategies

No Force First (2008) has been embraced by the Trust as a means of changing culture around coercive practice through adopting a culture and philosophy that is focused on the principles of least restriction and putting the service user at the centre of everything we do. The ultimate aim is to eliminate restraint, seclusion and the use excessive medication through:

• A vision committed to service user recovery and empowerment.

• Describing the use of force and coercion as a treatment failure.

• Describing relationships between service users and staff as 'risk sharing partnerships'.

• Showing compassion and understanding towards behaviours of concern.

• De-briefing, including the service user, after any use of force or coercion.

• Using positive, recovery focused, communication.

• Making No Force First principles a core element of staff training and recruitment requirements.

• Establishing peer support on in-patient units.

Appendix 7: Characteristics of a trauma-informed care environment

Characteristics	Examples of good practice
All staff understand ACE's and their effects, and are able to recognise the signs and symptoms of trauma in service users, relatives and care staff	Basic training sessions on ACE's are provided for all (including non-clinical) staff
There is an emphasis on safety, reliability and trustworthiness	Nurses use "Hello my name is…." To introduce themselves, and try to ensure service users are seen on time. They should give an explanation and apology if this not does not happen
The clinical environment is welcoming and features clear and simple information for service users	The environment is clean and bright, with up-to-date notice boards and notices phrased in positive language (for example, "Thankyou for treating all our staff and volunteers with respect")
An explanation of trauma in policies, procedures and training, so the experience of care does not add to, or mirror the original trauma	Services users are offered a choice about their treatment, options are explained to them and their responses are listened to
Nurses are supported to discuss difficult aspects of their work and, where possible, reflective practice	Hospital nurses are given the opportunity to attend clinical supervision, where they can talk about the challenges in caring for individual services users and receive positive support

ACE = adverse childhood experience. Source: Adapted from Menschner and Maul (2016)

Appendix 8: Verbal De-escalation Techniques

The staff member who assumes control of the situation should explain to the service user what they intend to do. This will involve:

• Suggesting to the aggressor that he/she moves to another area, creating space and making sure that the service user feels that they have options.

• Managing others in the environment, for example removing other service users from the area or if more appropriate enlisting the help of colleagues to do this.

• Giving clear, brief, assertive instructions, negotiating options and avoiding threats.

• Moving towards a safe place and avoiding being trapped in a corner.

The staff member who assumes control should ask for facts about the problem and encourage reasoning. This will involve:

• Offering realistic options.

• Encouraging reasoning by use of open questions and inquiring about the reason for the service user's anger.

• Asking questions about the facts rather than the feelings to assist in de-escalation, such as 'What has caused you to feel upset/angry?'

• Showing concern and attentiveness through non-verbal and verbal responses.

• Listening carefully and showing empathy, acknowledging any grievances, concerns or frustrations. Not being patronised or minimising service user concerns.

The staff member should also ensure that their own non-verbal communication is non-threatening. This will involve:

• Considering which de-escalation techniques are appropriate for the situation.

• Paying attention to non-verbal cues, such as eye contact.

• Allowing greater body space than normal.

• Adopting a non-threatening but safe posture.

• Avoiding provocative non-verbal behaviours.

• Attempting to establish rapport and emphasising cooperation.

• Appearing calm, self controlled and confident without being dismissive or overbearing.

Appendix 9: The Restraint Reduction Network Training Standards

Commissioned by NHS, the Restraint Reduction Network Training Standards 2019 provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings.

These Standards will also be mandatory for all training with a restrictive intervention component that is delivered to NHS-commissioned services for people with mental health conditions, learning disabilities, autistic people and people living with dementia in England. Implementation will be via commissioning requirements and inspection frameworks from April 2020.

In addition to improving training and practice, the standards will:

- protect people's fundamental human rights and promote person centred, best interest and therapeutic approaches to supporting people when they are distressed
- reduce reliance on restrictive practices by promoting positive culture and practice that focuses on prevention, de-escalation and reflective practice to minimise use of restrictive practices
- increase focus on prevention, understanding of the root causes of behaviour and recognition that many behaviours are the result of distress due to failing to meet needs
- improve staff skills and confidence in how to keep people safe in crisis and to better understand how to meet people's needs in order to prevent crisis situations
- improve the quality of life and protect the fundamental human rights of people at risk of being restrained and those supporting them
- where required, focus on the safe use of restrictive interventions including physical restraint

(The Restraint Reduction Network Training Standards 2019)

Appendix 10: Personal Safety Service Courses

Training Courses Available Based On The level of Risk

Decisions, regarding which training courses are to be undertaken by staff, are governed by risk assessment processes. The process coincides with a traffic light system of need. Green equates to least risk, hence the least intensive course etc.
(Course 'A')

Clinical/Non Clinical Staff **(Course A)**
'Personal Safety Training Course'
(1 day course updated bi yearly)

This course is for all **staff who enter into patient areas / homes**, or come into contact with members of the public in their work such as porters, domestics, ward clerks, workmen etc., without a direct clinical relationship with clients.

The responsibilities of these staff are ensuring they keep/make themselves safe, not cause risk to others, and hence hand over information re any incidents to lead nurse or other head of departments.

Clinical Staff (Course 'B')

Team Work Skills
'Personal Safety & 'Team Work Skills' Course
(4 Day Initial Course Followed annually by a (2 Day updated annually)

The course is for Clinical/Non Clinical staff working with patients in areas ***where physical intervention of a service user may be necessary as a demonstrable last resort***.

The training course includes Basic Life Support Training (BLS) Ligature Knife training and concentrates on a whole systems approach to managing violence and aggression including de-escalation (theory), breakaways and team work skills.

Clinical Staff (Course 'C')

Team Work Skills
2 Day Annual Refresher Course

Refresher Courses: The physical intervention techniques must be should be refreshed annually.

The training course includes Basic Life Support Training (BLS) Ligature Knife training and concentrates on refreshing on the whole systems approach to managing challenging behaviours including de-escalation (theory).

Training records will be considered out of date where they exceed the specified mandatory update of 12 months

Clinical/Non Clinical Staff. This course is for all **staff who enter into patient areas**, or come into contact with members of the public in their work such as Lone workers, ward based therapists, porters, domestics, ward clerks, workmen etc., without a direct clinical relationship with clients.

A one day course which includes Basic Life Support training (BLS) non-physical approaches to Personal Safety. The full training day consists of Breakaway techniques to help enable staff to remove themselves from danger.

Four Day (Course 'B') 'Personal Safety & Team Work Skills' Course, followed annually by a (2 Day Refresher Course)

The course is for Clinical/Non Clinical staff working with patients in areas where restraint of a service user may be necessary as a demonstrable last resort.

The four day training course includes Basic Life Support Training (BLS) Ligature Knife training and concentrates on a whole systems approach to managing challenging behaviour including de-escalation (theory), breakaways and team work skills.

Two Day Annual Refresher Course (Course 'C') Team work Skills

The training course includes Basic Life Support Training (BLS) Ligature Knife training and concentrates on a refreshing of the whole systems approach to challenging behaviours (physical skills) including de-escalation (theory) and physical intervention strategies / approaches to meet service requirements.

(NB: The referrals flowchart does not apply to Secure Division who will make decisions regarding whether to deploy Crisis Negotiators or utilise Personal Protective Equipment (See 2.11.4) under the incident command structure.

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

Equality and Human Rights Analysis

Title: SD18 Policy for the support of service users who may Present with behaviours of concern
Area covered: Trust Wide

What are the intended outcomes of this work **This is a further review of a policy that was equality assessed in April 2014.** **Part of the process in this assessment will be to consider the previous equality and human rights analysis.** **This policy and procedure provides clear guidance for the support of people who present with challenging behaviors within Mersey Care NHS Foundation Trust.** **It allows the Trust to demonstrate that the use of restrictive practices meet and uphold the guiding principles of the Mental Health Act Code of Practice (2015) and that they remain proportionate, least restrictive, last for no longer than is necessary, and take account of patient preference wherever possible.**
Who will be affected? Staff who undertake care of service users and service users

Evidence
What evidence have you considered? **The Restraint Reduction Network Training Standards** **See full list of reference documents page 20**
Disability including learning disability **Data to be collected across the Trust/Divisions in relation to agreed metrics**
Sex **Gender issues identified and addressed** **The policy takes account of Women who are pregnant**

Race **Data to be collected across the Trust/Divisions in relation to agreed metrics**

Age **Data to be collected across the Trust/Divisions in relation to agreed metrics**
Gender reassignment (including transgender) **Data to be collected across the Trust/Divisions in relation to agreed metrics**
Sexual orientation **Data to be collected across the Trust/Divisions in relation to agreed metrics**
Religion or belief **Data to be collected across the Trust/Divisions in relation to agreed metrics**
Pregnancy and maternity **Data to be collected across the Trust/Divisions in relation to agreed metrics**
Carers **Not applicable**
Cross Cutting **Service users must always be treated with dignity and respect regardless the degree of behaviours of concern and with due regard to an individual's race, ethnicity, age, religion, gender, sexual orientation, mental, physical, learning disability or transgender status.** **Monthly review of challenging incidents should take place to identify trends, including data related to the protected characteristics of age, disability, gender, race, sexual orientation, religion/belief, and transgender. The data obtained should be used to inform training and develop preventative strategies.** **7.6.11 A gender sensitive approach must be considered by staff when managing people who may present with behaviours of concern. Staff must consider history of abuse, spiritual, religious and cultural needs, beliefs and behaviours when considering interventions. Staff will receive appropriate equality and diversity training to help them facilitate this approach.**

Human Rights	**Is there an impact?** **How this right could be protected?**

This section must not be left blank. If the Article is not engaged then this must be stated.	
Right to life (Article 2)	**Human Rights based approach supported** **The importance of care in the recovery position is highlighted** **Staff receive training to enhance this approach**
Right of freedom from inhuman **and degrading treatment (Article 3)**	**Human Rights based approach supported** **On occasions the use of mechanical restraint (handcuffs) is required for security purposes for the transfer of restricted service users in secure settings to other secure or non-secure settings. The use of mechanical restraint in these circumstances should be informed by an assessment of the risks posed by the service user, as well as their presenting physical and mental condition and the need to maximise their dignity. Escorting staff should alert medical staff to any identified risks if the restraints were to be removed; however, if requested by medical staff, they should be removed only whilst medical treatment is carried out following consultation with the duty manager / bronze command.**
Right to liberty (Article 5)	**Human Rights based approach supported**
Right to a fair trial (Article 6)	**Human Rights based approach supported**
Right to private and family life **(Article 8)**	**Human Rights based approach supported**
Right of freedom of religion or belief **(Article 9)**	**Human Rights based approach supported**
Right to freedom of expression **Note: this does not include insulting language such as racism (Article 10)**	**Human Rights based approach supported**

Right freedom from discrimination **(Article 14)**	**Human Rights based approach supported**

Engagement and involvement
The Personal Safety Service team have actively involved people who have used services and have lived experience of coercive interventions to develop the training and informed the policy.
All ward based staff will be made aware of this policy via ward managers, matrons and clinical leads.

Summary of Analysis
Eliminate discrimination, harassment and victimisation **The aim of this policy is to ensure that service users who present with behaviors of concern are cared for in a manor that is consistent with the Trust values.**
Advance equality of opportunity **Not applicable**
Promote good relations between groups **Not applicable**

What is the overall impact?
The impact is intended to be positive and to see a reduction in service user experience in terms of seclusion and being subject to restraint.

Addressing the impact on equalities
Where equality issues will be addressed within the divisions monitoring processes

Action planning for improvement
Please see below

For the record **Name of persons who carried out this assessment:** **George Sullivan** **Danny Angus**
Reviewed by **Date assessment completed: 27 06 2019**
Name of responsible Director/Lead Trust Officer **Medical Director, Mersey Care NHS Foundation Trust**
Date assessment was signed: **June 2019**

Action plan

Category	Actions	Target date	Person responsible and their Division
Monitoring Data review	**Monthly review of challenging incidents should take place to identify trends, including data related to the protected characteristics of age, disability, gender, race, sexual orientation, religion/belief, and transgender. The data obtained should be used to inform training and develop preventative strategies.** **This should into the Trust equality and inclusion action plan**		**Trust lead**
	Full list of metrics to be decided within the restrictive practice group		Trust Equality lead
	There will be a review of this policy and equality issues November 2019		