

**Policy on the Use of Physical Intervention (Restrictive Practice) –
CLP060**

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Why we need this Policy

Northamptonshire Healthcare NHS Foundation Trust (NHFT) has a statutory obligation to ensure safe systems of work for employees whilst also providing security and safety for service users. NHFT recognises and accepts its responsibility to act in accordance with the relevant legislation and best practice guidance in relation to the management of violence and aggression. NHFT advocates the use of strategies to prevent aggression and violence occurring (focussed on the early recognition, prevention and de-escalation of incidents) but acknowledges that an individual’s behaviour may escalate to a point where physical restraint becomes necessary to protect the person, staff or others from significant injury / harm. This policy has been developed to provide guidance and direction to staff that face aggression / violence whilst at work. The physical interventions employed by NHFT staff must represent a reasonable, necessary and proportionate response to the harm threatened and be implemented with due consideration of the duty of care owed to service users.

What the Policy is trying to do

It is acknowledged that there may be occasions when all non-physical interventions have been tried and failed and restrictive interventions may be needed to safely manage an aggressive / violent incident or period of disturbed behaviour. The purpose of this policy is therefore to ensure that the restrictive interventions used in the management of a violent incident are a legal, necessary and legitimate response to the harm threatened. The interventions employed must represent a proportionate and reasonable response and be utilised for the minimum possible time (NICE NG 10 2015). This policy is primarily focussed on the use of one form of restrictive intervention – physical / manual restraint.

The purposes of restrictive interventions are therefore to:

- To take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken,

and
- To end or reduce significantly the danger to the patient or others (DH 2015).

It is also acknowledged that there may be occasions where a person is not overtly violent or aggressive but whose behaviour is placing themselves or others at risk. There may also be occasions as per the legal framework detailed within either the Mental Health Act 1983 (Amended 2007) or Mental Capacity Act (2005) where care or treatment can be provided without the consent of the

individual. The use of physical interventions in these contexts may be considered as part of a range of interventions to maintain safety and the provision of a therapeutic environment for all. The purpose of this policy is to guide staff so that a balance can be struck between security / safety and the provision of treatment as the two are inextricably connected. (Newman J in R (N) v Ashworth Special Hospital Authority (2001).

Which stakeholders have been involved in the creation of this Policy

- Patient Advocacy, Experts by Experience, Staff Side, Head of Safeguarding
- The PMVA Monitoring Group
- Trust Policy Board and Clinical Executive

Any required definitions/explanations

The Mental Health Act Code of Practice 2015 (“The Code”) defined restrictive interventions as:

“deliberate acts on the part of other person(s) that restrict a person’s movement, liberty and / or freedom to act independently.”

Although restrictive interventions can also include observation, seclusion, mechanical restraint and rapid tranquillisation, this policy is concerned with the use of physical / manual restraint as defined by NICE (2015):

“a skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user.”

These interventions are therefore, qualitatively different from other forms of physical contact such as manual prompting, physical guidance or providing simple support.

The physical interventions recognised by this Trust in the management of physical violence or aggression are:

4.1 Breakaway Techniques

A set of physical skills used to disengage or break away from an aggressor in a proportionate manner. They do not involve the use of restraint (NICE 2015). The Breakaway course is attendance only and participants are not assessed for competency.

4.2 Low Level Interventions

Physical techniques aimed at managing and containing lower risk incidents or those situations where a high level response is indicated but other factors contraindicate the use of Teamwork techniques.

The interventions provide a staged response that is focussed on guiding, holding and restricting movement.

4.3 Teamwork Techniques (Higher level physical interventions)

These techniques are considered only when high levels of containment are required. Teamwork techniques provide a systematic approach in dealing with overtly violent individuals.

Low Level Interventions and Teamwork training are assessed (pass or fail) to ensure that safe practice and professional attitudes are delivered and maintained. If a member of staff fails to pass these courses, they will be supported and continue to attend such courses until deemed competent.

The choice of intervention must be guided by clinical need and the obligations owed to the service-user, other service users affected by the disturbed behaviour and to members of staff and visitors. The intervention selected must represent the least restrictive option available to meet the need, be used for the shortest time possible and represent a proportionate and reasonable response to the risk posed. It is important to note that during any incident where restrictive interventions have been applied, the level of intervention used may need to be reduced or increased to reflect the changing presentation of the service user.

Key duties

- **The Chief Executive**

The Chief Executive has ultimate responsibility for the management of violence and aggression and health and safety within the Trust.

- **The Chief Operating Officer**

The Chief Operating Officer is responsible for providing direction and leadership for the management of violence and aggression in the Trust and for ensuring that policy and procedures are embedded into clinical practice. The Director of Operations is also responsible for identifying and implementing any educational or training needs arising from new legislation and national guidance. The Director of Operations carries the responsibility for increasing the use of recovery based approaches to care and for reducing the use of restrictive interventions with the Trust (Positive and Proactive Care DH 2014) The Director of Operations is responsible for ensuring that the PMVA team has adequate resources to provide the training required.

- **Matrons, Managers and Service Leads**

It is the responsibility of Matrons, managers and service leads to disseminate this policy to their staff for implementation, release staff to attend the designated PMVA training and maintain accurate records of training attendance.

Matrons, managers and service leads are responsible for liaising with the PMVA Department in the event of changes being made to the function or remit of their area if this indicates the need to negotiate a change in the PMVA training required for their staff.

The Ward Manager / Matron is responsible for ensuring that there is an appropriate number of PMVA trained staff available on each shift and that Post Incident Reviews have been held (see section "Post incident Responses" page 11) and any concerns raised have been actioned.

- **PMVA Team**

The team will provide training in accordance with National guidance and in line with their accrediting organisation and approved practice. The PMVA manager will notify ward matrons of any concerns regarding inappropriate attitudes displayed on PMVA courses. The PMVA team will offer support and guidance to clinical areas upon request.

- **Nurse In Charge**

The nurse in charge of a ward at either Berrywood Hospital or St Mary's Hospital sites is responsible for allocating an appropriately trained staff member to respond to alarms at the commencement of each shift (see section "Responding to alarms" page 10). The NIC is responsible for ensuring that post incident reviews are held and the lessons learnt from this process are shared. The NIC is responsible for checking on the physical and psychological well-being of all staff and patients on the ward at the end of their shift and for responding / reacting appropriately to any concerns identified. The NIC is responsible for ensuring that the vital signs of all patients that have been restrained, are monitored (during and post restraint), recorded and concerns are communicated to medical staff immediately. The NIC is responsible for alerting the duty doctor when any patient has been restrained in the prone position (see section "Use of Physical Restraint" Pages 10 and 11). In the event of a life threatening medical emergency / cardiac arrest, an immediate emergency call must be made. Emergency help will be summoned by triggering the emergency alarm (where appropriate), dialling (9) 999 and giving Ambulance Control the exact incident location (see CLP002 Resuscitation & Related Medical Emergencies Policy for further guidance).

On those occasions when either the patient refuses to allow their vital signs to be monitored or the NIC considers it unsafe to attempt, the NIC is responsible for ensuring that staff continue to seek permission at regular intervals and that all possible visual observations are monitored and recorded (e.g. consciousness level, skin pallor, sweating, respiration rate and rhythm etc.).

The NIC is responsible for ensuring that the observations recommended by NICE (NG 10 2015) are adhered to if Rapid Tranquillisation has been administered as part of the management of the incident (see MMP011).

NICE (NG 10 2015) recommended that staff monitor side effects from medication and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. These observations should occur every 15 minutes if the BNF maximum dose has been exceeded or the service user:

- appears to be asleep or sedated
- has taken illicit drugs or alcohol
- has a pre-existing physical health problem
- has experienced any harm as a result of any restrictive intervention.

- **Medical Staff**

Following an alert by the nurse in charge, the Doctor will attend the ward as soon as is possible (there is an expectation that this will be within 30 minutes) in order to assess the physical health and well-being of the patient.

It is the responsibility of the RC / duty doctor to participate in post incident reviews following the use of physical restraint.

- **Employees**

Employees must ensure they adhere to the instructions within this policy and attend the PMVA training designated as required for their ward / unit. They must act in a professional, ethical and legally defensible manner at all times. It is the responsibility of all staff to understand that the safety and dignity of service users and the safety of staff are priorities when anticipating or managing violence and aggression (NICE 2015). Employees must co-operate with Occupational Health and give reasonably required health information.

- **Occupational Health Service**

Occupational Health Service has responsibility for ensuring employees are screened for safe participation on physical intervention courses, notifying the PMVA team of the results of such screening and maintaining adequate confidential records.

Policy detail

The policy will be formally approved by the PMVA Monitoring Group prior to ratification by the Board. The PMVA Monitoring Group will review the policy every 3 years unless significant changes in legislation, research and good practice demand an urgent amendment

This document is relevant to all grades and staff groups who work within areas designated as requiring physical intervention training. The need for physical intervention training was determined following an assessment of the risks to staff based upon an analysis of the incidents reported in the specific area or unit and discussion with service leads / ward matrons. The assessment of risk was undertaken in accordance with National Health Service Litigation Authority (NHSLA) guidance.

Physical intervention training in the specified areas is therefore mandatory. This policy should be read in conjunction with the NHFT HR025 Mandatory Training Policy.

- **Special Considerations**

- **Individuals that Lack Capacity**

Physical interventions are only permitted if the person using them reasonably believes they are necessary to prevent harm to the service user and the interventions used are a proportionate response to the likelihood and seriousness of the harm (MCA Code of Practice 2007). Where the risk of harm is to other service users then the common law permits a similar level of intervention. Consideration must be given as to whether the interventions are of a degree or intensity that results in a deprivation of the person's liberty or a safeguarding incident. For further guidance refer to the following Policy Documents: Mental Capacity Act Policy (CLP023), Safeguarding Children (CLP047) and Safeguarding Vulnerable Adults (CLP055).

- **Children and Young People**

Reasonable adjustments will be made with respect to age, especially the very young or elderly. Children must not be viewed as small adults. The restraining of children involves special considerations as the use of restraint should not be understood and applied from a purely adult perspective but viewed in the context of what is known about child and adolescent development.

Physical intervention to contain and or control the behaviour of children and young people should only be used to ensure safety and protection. Physical interventions should only be employed as a safety response to acute physical behaviour and their use should be restricted to the following circumstance: The child/young person, other clients, staff members or others are at imminent risk of physical harm.

Restraint techniques should not be applied to children under 5 years old, preschool children's bones, bone plates, rib cages and intercostals are not fully developed which places them at higher risk of injury during restraint.

- **Physical Restraint and Venepuncture**

The use of physical interventions in performing venepuncture techniques must be carefully considered. Practitioners must understand that there are no safe techniques available to perform this intervention in the overtly aggressive individuals and therefore, a degree of concordance will be required for any such procedure to be undertaken successfully.

- **Mechanical Restraint**

The trust does not advocate the use of mechanical restraint as a method to manage violence / aggression / disturbed behaviour unless there is a recognised need in exceptional circumstances or emergency situations. In such exceptional circumstances, a care plan must be in place for the short term application of these restraints, which will have been developed following a full assessment and multidisciplinary discussion consisting of the following members;

- Service Director / Medical Director / Director of Nursing
- Responsible Clinician
- Nursing Staff / Carers
- PMVA Team

The following staff will need to be informed of the use of mechanical restraint at the earliest opportunity

- Patient Experience Manager
 - MHA Manager / Trust Legal Advisor
 - Head of Mental Health Services South)
 - PMVA Manager
- **Violence Prevention, Risk Assessment and Care Planning**
- The Trust works on the assumption that aggression and violence happens for a reason. It is therefore the responsibility of staff to work with the individual in order to seek to understand the cause(s) of aggression and determine the appropriate preventative measures and reasonable responses to such emotions. All physical interventions training courses (Teamwork or Low Level Interventions) also include violence prevention strategies (Promoting Safer and Therapeutic Services learning outcomes and the Safewards model)

In keeping with the Human Rights Act (1998) every person is entitled to

- The right to life
- Respect for his/her private life
- The right not to be subjected to inhumane or degrading treatment
- The right to liberty and security
- The right not to be discriminated against in his/her enjoyment of these rights

The Trust recognises the need for privacy, dignity and, racial and cultural diversity as essential values which will be respected in every case. Physical interventions should always aim to achieve outcomes that reflect the rights and best interests of all concerned.

Physical interventions should be viewed as a final option in a hierarchy of therapeutic interventions. When using reasonable force it is important to note that what is reasonable in the short term might not be reasonable in the long term as other preventative and/or therapeutic strategies become effective.

Individualised risk assessments / safety plans should be established for responding to service users who are likely to present with violent or reckless behaviours. These must be subject to regular review, the frequency of which shall be determined by the clinician responsible for the service user's care. (Refer to Policy CLP021 – Working with Risk and CLP010 Care Programme Approach).

The individual assessments and management plans will identify contra-indications to physical interventions and will detail the appropriate alternative management strategies. The responsible clinician must ensure that communication with the service user regarding the use or potential use of physical interventions is delivered in a manner appropriate to the

individual. An assessment of the service users' ability to communicate and understand when physical interventions may be considered necessary should be completed and shared with appropriate staff members. The assessment must consider Learning Disability/Disabilities, cognitive impairments and or sensory impairments. Some examples of contraindications are: medication (especially its effect on the respiratory and cardiovascular system), medical / physical conditions (asthma, epilepsy, pregnancy). Restraint should be avoided in children and young people where it may result in serious emotional trauma.

- **The Management of Violent and Aggressive Incidents**

NHFT supports the view that planned physical interventions are safer for patients and staff therefore it is essential that staff working with patients with an identified risk of aggression, follow the designated care plan. Involvement of the service user in the planning of their current and possible future care is essential and this will include a plan of how to manage that individual during times of crisis e.g. a violent/disturbed incident. (NICE 2015)

- **Responding to Alarms**

Ward based staff working on specific units at Berrywood and St Mary's Hospital sites have a response system in place for the management of violent and aggressive incidents. At all times during a 24 hour period, an identified person on each designated ward will hold a pager and respond to incidents when an attack alarm is activated. The allocation of personnel to the responder role remains the responsibility of the nurse in charge of the designated wards. When allocating this role to staff it is desirable that the responder has attended the relevant PMVA Training for their role and workplace.

- **The Use of Physical Restraint**

Staff will act in accordance with the guidance contained within the Mental Health Act Code of Practice (2015) and NICE NG 10 (2015). Throughout an episode of physical intervention, the application of de-escalation/ defusion techniques will be ongoing. Staff will make every effort to utilise skills and techniques that do not use the deliberate application of pain as it has no therapeutic value and could only be justified for the immediate rescue of staff, service users and / or others.

The use of physical interventions will end as soon as possible when the individual is judged to be safe or other management strategies are available which enable the risk to the patient (or others) to be managed more appropriately. Staff must remain vigilant throughout the use of any physical intervention. They must observe the client for signs of physical distress (observing and monitoring the vital signs) and respond to any concerns by immediately taking action. This action may range from relocating to a safer position to ending the intervention and calling for medical help / emergency assistance (please refer to section "Post Incident Responses" page 11).The type of physical observations recorded during the use of restraint will be dependent upon the NIC's assessment of risk at that time but as a minimum consciousness level (AVPU) and respiration rate should be monitored.

NICE (NG10 2015) guidance recommended that a doctor trained to use resuscitation equipment should be immediately available if manual restraint *might* be used. Whilst NHFT is committed to ensuring the safety of staff and service users, the diverse services provided countywide and the non-resident on call system for the junior doctors, means that it would not be possible to guarantee that a doctor will be immediately available on every ward and at all times. Registered nurses working on wards where either Teamwork or Low Level Interventions techniques may be used, are Immediate Life Support (ILS) trained and competent. Health Care Assistants are trained in Basic Life Support skills and the in-patient wards are equipped with resuscitation equipment.

A number of factors may increase the risk of harm from the use of physical restraint. Pre-existing health conditions (in particular respiratory or cardiovascular disorders), obesity, pregnancy and the effects of alcohol or drugs have also been associated with adverse consequences in physical restraint. The physical observations taken during and post restraint are vital in ensuring that staff respond appropriately to physical health concerns. Whilst the need for physical restraint may make it difficult to obtain a full range of physical observations, staff will assess the rate and rhythm of respirations and the consciousness level of the individual throughout the restraint. If there are serious concerns regarding the physical or psychological well-being of the individual being restrained staff will disengage immediately. In addition to using their clinical and professional judgement, staff will use the National Early Warning Scores to inform their decision making regarding alerting medical staff and seeking further assistance.

The Duty Doctor will be expected to attend the scene within 30 minutes of an alert by staff in the following situations:

Following the use of prone restraint,

following a prolonged (longer than 10 minutes) restraint,

following an alert by a member of staff that has been based on the National Early Warning Score, their clinical judgement or a deterioration in consciousness levels

in line with the rapid tranquillisation policy (MMP011).

There will be an exception to the stated time (above) for medical staff attendance for the Learning Disability community based units (short breaks service) where clients are known to the service. In these situations, due to the predictability of the client groups it has been assessed by the directorate as a reasonable risk that an assessment will be made by the professional in charge of the unit regarding the medical attention required following an incident. Clients in these areas are well known to the service and have clear behaviour management plans in place which are usually successful in preventing the need for any physical restraint.

- **Post Incident Responses**

After the use of any physical restraint, staff will ensure that physical observations are completed using the National Early Warning Score (NEWS) within 15 minutes and documented accordingly. In the event that the service user refuses to allow the full range of observations to be taken, staff will record this and continue to seek cooperation on an ongoing basis. Service users will be routinely assessed for signs of physical injury and/ or psychological distress after any use of physical interventions. In the event of a service user complaining of pain following the use of physical intervention, a doctor should be alerted and advice sought.

The use of physical restraint must be reviewed and discussed during a Post Incident review to be held within 72 hours. The aims of such reviews are to learn lessons, rebuild therapeutic relationships and prevent future incidents.

All service users and their families and representatives will have ready access to an effective complaints system. NHFT will ensure that systems are in place with appropriately skilled staff to ensure that post-incident support and review are available through Communicare, psychology or the Critical Incident Support Team.

Support will be available to:

- Staff involved in the incident
- Service users
- Carers and family, where appropriate
- Other service users who witnessed the incident
- Visitors who witnessed the incident

The aim of any review will be to learn lessons and seek reconciliation of the therapeutic relationships between staff, service users and their carers. Reassessment of care plans and updating of risk assessments will be undertaken following incidents in order to prevent a reoccurrence of the incident (NICE 2015).

NHFT staff who have any concerns about the use of physical interventions on service users should refer to HR09 Guidance for Staff Raising Issues of Concern. Any allegation of abuse from a service user must be followed by an immediate referral to the Safeguarding Team.

If following a Post Incident Review, a service user wishes to raise an issue / highlight a concern that cannot be resolved on the ward, they will be encouraged / supported to access the Patient Advice and Liaison Service (PALS) or the complaints process (CRM003).

- **External Post Incident Review**

This review is in addition to the review held within 72 hours. The aim of this review is to provide additional scrutiny, monitoring and learning following the use of physical restraint, anonymised data from clinical records will be analysed at a service user experience monitoring group meeting. This meeting will be held monthly so that effective interpretation and learning can occur which can subsequently guide changes to the care environment, service philosophy, training or policies where appropriate. The group will consider if service barriers or constraints make it difficult to avoid the same course of action in the future. This

group will be led by a service user governor and include the PMVA Manager (or nominated deputy), Head of mental health services North / South (or nominated deputy) and the head of Patient experience (or nominated deputy). Feedback from this group will be disseminated via the PMVA Monitoring Group to Ward Managers / Matrons and during PMVA physical intervention training.

- **Reporting and Recording**

Incidents should be reported in line with the Trust’s Policy for the Management of Incidents CRM002. All incidents must be reported on the Trust’s integrated risk management system: DatixWeb, whether they are related to a clinical condition or not and a physical restraint form (on System1) will be completed for the use of all use of Breakaway, Low Level or Teamwork interventions. If a member of staff has been physically assaulted, the approver will have to complete further details on the Security Incident Reporting System (SIRS) which uploads information directly to NHS Protect; this includes details of police attendance so all incident and crime reference numbers must be noted.

The service user should be offered the opportunity to write an account of the incident which will be added to their health record.

- **Sites**

All frontline staff that have face to face contact with service users will attend either Conflict Resolution Training (CRT) or the Promoting Safer and Therapeutic Services (PSTS) course.

<p>Category A Sites:</p> <p>100% Compliance with</p> <ul style="list-style-type: none"> • Promoting Safer and Therapeutic Services (PSTS) • Breakaway • Low level Interventions • Teamwork Training 	<p>Ward Staff at Band 7 and below (Not including Administration staff)</p> <p>Marina PICU The Burrows Wheatfield Osprey Kingfisher Ward*</p>
<p>Category B:</p> <p>100% Compliance with</p> <ul style="list-style-type: none"> • Promoting Safer and Therapeutic Services (PSTS) • Breakaway Techniques • Low level Interventions <p>70% of Team Teamwork Training</p>	<p>Ward Staff at Band 7 and below (Not including Administration staff)</p> <p>Harbour Ward Bay Recovery Ward Cove Recovery Ward Sandpiper Recovery Ward Avocet Recovery Ward The Sett</p>

<p>Category C:</p> <p>100% Compliance with</p> <ul style="list-style-type: none"> • Promoting Safer and Therapeutic Services (PSTS) • Breakaway Techniques • Low level Interventions 	<p>Ward Staff at Band 7 and below (Not including Administration staff unless stated)</p> <p>Orchard Ward Spinney Ward The Squirrels JGS 82 Northampton Road Riverside Ward Brookview Ward Meadowbank Intensive Support Team In-patient OT departments (St Mary's and Berrywood Hospitals)</p>
<p>Category D:</p> <p>100% Compliance with</p> <ul style="list-style-type: none"> • Conflict Resolution Training (CRT) • Breakaway Techniques 	<p>Ward Staff at Band 7 and below (Not including Administration staff unless stated)</p> <p>Treatment Centre, Berrywood Chaplain Services (MH / LD) Prison Services, Forensic Team Berrywood and St Mary's Hospital Ward based Hotel Services Staff Berrywood Hospital Ward Based Administration / Clerical Staff LD Therapy SLA LD / MH Medical staff working on in-patient units Crisis Resolution Home Treatment Teams The Crisis House</p>
<p>Category E:</p> <p>100% Compliance with</p> <ul style="list-style-type: none"> • Conflict Resolution Training <p>Access to Breakaway training is available following completion of risk assessment and agreement between Service Manager and PMVA Manager</p>	<p>1 Willow (staff may attend Breakaway / Low level Interventions dependent on the manager's assessment of the risk presented by client group)</p> <p>All other front line Mental health and Learning Disability clinical staff</p>
<p>Category F:</p> <p>100 % Compliance</p> <p>Conflict Resolution Training</p>	<p>All remaining front line clinical staff not listed above</p>

***Kingfisher Ward requires 100% compliance with teamwork training despite its function being the same as Harbour Ward at Berrywood Hospital. This decision has been taken in response to the need to provide adequate numbers of trained staff at the St Mary's Hospital site as it is significantly smaller than Berrywood Hospital and the pool of staff available to respond to an incident is smaller.**

- **Police Involvement (see CLP 022 Police Responses to NHFT)**

At no time will staff put themselves at risk if the individual is armed with a weapon or if the risk to staff and service users is deemed too high for staff to safely manage the incident. The police should be summoned immediately via a 999 emergency call. All those within the area should keep a safe distance from the armed aggressor and, where possible, lock the area off.

The NIC with the senior manager on site will brief the Police on their arrival. The Police must be given the relevant information on the incident and the risk and physical health history of the aggressor. This is to ensure that the intervention adopted is a proportionate and reasonable response. Following this handover the Police will (working in conjunction with the senior staff from the hospital) assume control of the incident. The Police will make a judgement as to which intervention they will employ bearing in mind the safety and risks to all involved. Such interventions may include verbal de-escalation, physical restraint, Personal Protective Equipment (such as shields), batons, Synthetic Pepper Spray, Tasers / armed response teams. The incident must be reported and recorded in keeping with the Incident Reporting Policy and the Duty Director must be informed.

Training requirements associated with this Policy

- **Mandatory Training**

Training required to fulfil this policy will be provided in accordance with the Trust's Training Needs Analysis. Management of training will be in accordance with the Trust's Statutory and Mandatory Training Policy.

- **Non Physical Interventions**

All clinical frontline staff that do not require manual restraint training will attend Conflict Resolution Training (CRT). This will cover the recognition, prevention and defusion of aggression / violence - staff will attend a refresher course every 3 years as required by NHS Protect.

Frontline, clinical staff that are required to attend either Low Level Interventions or Teamwork courses) will receive the learning outcomes from the Promoting Safe and Therapeutic Services (PSTS) course syllabus as part of the LLI / Teamwork course. This PSTS syllabus was designed specifically for Mental Health and Learning Disability Services and was developed by NHS Security Management Service (now NHS Protect). The PSTS Learning outcomes are delivered via a modular system over a three year rolling programme

- **Physical Interventions**

Analysis of incident data has shown that staff that do not work in either mental health or learning disability in-patient services, do not routinely require physical intervention /

disengagement skills training. Attendance at Conflict Resolution Training therefore best meets the needs of these clinical services. If a specific need has been highlighted for physical intervention training then staff from these areas can access the relevant courses through the PMVA Department following discussion between the PMVA Manager and The Service Manager.

Within Mental Health and Learning Disability services, the level of physical interventions training required will be determined by the Head of Service based on risk assessment and consultation with the PMVA Manager and discussion with the service lead. See section "Sites" pages 12,13,14 for further guidance.

All Breakaway, Low Level Interventions and Teamwork courses require Occupational Health clearance prior to attendance. The responsibility for gaining Occupational Health clearance is held by the individual member of staff applying for the course using the pre-course health questionnaire. If clearance is not obtained, staff will not be permitted to participate. Staff must attend Breakaway, Low Level Interventions and Teamwork refreshers every 12 months. If a member of staff is unable to attend the course due to physical reasons/ no Occupational Health clearance then the Manager, with that member of staff, must complete a risk assessment – please refer to HSC001 – Health and Safety Policy and HSC002 Policy on the Use of Risk Registers).

The Trust recognises its statutory duties to those who are disabled and will make such adjustments as are reasonable to accommodate those who by virtue of disability are unable to fully complete necessary training or the implementation of techniques taught in training under this policy. The Trust also acknowledges there are specialist roles in clinical areas that do not require physical intervention training.

All PMVA training will be in accordance with the guidance provided by NHS Protect and the National Institute of Health and Clinical Excellence (NICE). The training will adhere to the broad principles of prevention contained within the Department of Health Positive and Safe programme (2014) and the British Institute of Learning Disabilities (BILD), the Mental Health Act 2007 Code of Practice 2015, the Human Rights Act 1998 and The Mental Capacity Act 2005 and its Code of Practice.

- **Specific Training not covered by Mandatory Training**

If a specific situation arises or an additional training need has been identified, the PMVA team will provide ad hoc training sessions based on either the individual or team's training needs.

How this Policy will be monitored for compliance and effectiveness

Audits and Monitoring

It is the responsibility of ward/unit managers to maintain a record of staff training in relation to physical interventions and achieve compliance with targets/policy.

The PMVA Department will also keep contemporaneous records of course dates, staff attendance and also course outcomes.

In keeping with the Mandatory/Statutory Training Policy a record of training delivered, attendees/non-attendees will be maintained on the Learning and Development data-base. Managers

will be alerted of staff non-attendance and it will be the responsibility of the manager to follow-up. The Learning and Development Department will produce quarterly reports for the Finance and Performance group and the Mandatory Training group on statutory/mandatory training attendance and the number of staff currently up to date in all training required. Ward Managers and Service Managers are responsible for monitoring the use of physical interventions through the performance reports provided by the SMART system.

Reports that include all patient safety incidents are produced weekly by the Risk Management Department and these should be scrutinised alongside the physical interventions data with a view to identifying trends and implementing plans to manage these. The PMVA Monitoring Group is responsible for the monitoring and review of the data collected regarding the use of physical interventions in the clinical areas through the SMART system. The PMVA Group is responsible for analysing the data provided by the SMART system and raising / highlighting areas of concern or good practice. Such data and analysis will be provided to the Trust Governance Group every quarter and subsequently the Trust Board. The data collected from SMART regarding the use of physical interventions will be used to inform practice and training delivery. The responsibility to further cascade this information lies with the representatives of Trust departments that attend the PMVA meetings.

Aspect of compliance or effectiveness being monitored	Method of monitoring	Individual responsible for the monitoring	Monitoring frequency	Group or committee who receive the findings or report	Group or committee or individual responsible for completing any actions
Duties	To be addressed by the monitoring activities below.				
<i>The number of physical interventions used on each ward in the trust</i>	<i>Performance Reports generated from Physical Restraint Form within the clinical record</i>	<i>Mental Health Act Manager / Head of mental health services (South)/ PMVA Manager</i>	<i>Bi monthly</i>	<i>PMVA Monitoring Group Governance Committee</i>	<i>PMVA Monitoring Group</i>
<i>The demographics of those patients where physical interventions have been used specifically including Ethnicity Diagnosis Age</i>	<i>Performance Reports generated from Physical Restraint Form within the clinical record</i>	<i>Mental Health Act Manager / Head of mental health services (South)/ PMVA Manager</i>	<i>Bi monthly</i>	<i>PMVA Monitoring Group Governance Committee</i>	<i>PMVA Monitoring Group</i>
<i>The type of physical intervention used</i>	<i>Performance Reports generated from Physical Restraint Form within the clinical record</i>	<i>Mental Health Act Manager / Head of mental health services (South)/ PMVA</i>	<i>Bi monthly</i>	<i>PMVA Monitoring Group Governance Committee</i>	<i>PMVA Monitoring Group</i>

		<i>Manager</i>			
<i>Response of Medical staff to an alert by staff</i>	<i>Reports generated from Physical Restraint Form within the clinical record</i>	<i>Mental Health Act Manager / Head of mental health services (South)/ PMVA Manager</i>	<i>Bi monthly</i>	<i>PMVA Monitoring Group Governance Committee</i>	<i>PMVA Monitoring Group</i>
<i>Post incident Review (Internal / External)</i>	<i>Reports generated from Physical Restraint Form within the clinical record</i>	<i>Mental Health Act Manager / Head of mental health services (South)/ Service user Governor PMVA Manager</i>	<i>Monthly</i>	<i>PMVA Monitoring Group Governance Committee</i>	<i>PMVA Monitoring Group</i>
<i>PSTS, CRT, Breakaway, Low Level Interventions, Teamwork</i>	Training will be monitored in line with the Statutory and Mandatory Training Policy.				
Where a lack of compliance is found, the identified group, committee or individual will identify required actions, allocate responsible leads, target completion dates and ensure an assurance report is represented showing how any gaps have been addressed.					

For further information

Please contact the Head of mental health services South, MHA Manager, PMVA Manager, PMVA Advisor.

Equality considerations

The Trust has a duty under the Equality Act and the Public Sector Equality Duty to assess the impact of Policy changes for different groups within the community. In particular, the Trust is required to assess the impact (both positive and negative) for a number of ‘protected characteristics’ including:

- Age;
- Disability;
- Gender reassignment;
- Marriage and civil partnership;

- Race;
- Religion or belief;
- Sexual orientation;
- Pregnancy and maternity; and
- Other excluded groups and/or those with multiple and social deprivation (for example carers, transient communities, ex-offenders, asylum seekers, sex-workers and homeless people).

The author has considered the impact on these groups and incorporated the findings of these into appendix 2.

Reference Guide

BILD (2001) *Code of Practice for Trainers in the Use of Physical Interventions*. Available from BILD, Campion House, Green Street, Kidderminster, Worcs DY10 1JL

Department for Constitutional Affairs (2007) *Mental Capacity Act 2005. Code of Practice. Issued by the Lord Chancellor on 23 April 2007 in accordance with sections 42 and 43 of the Act*. London. TSO

Department of Health (2015). *Mental Health Act 1983 Code of Practice – revised 2015*.

Department of Health (2002) *Guidance for restrictive physical interventions. How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder*. London. Department of Health

Health and Safety at Work Act etc 1974. London. HSE

Human Rights Act (1998) Elizabeth II. Chapter 42 Reprinted May 2001 and September 2006. London. TSO

Management of Health and Safety at Work Regulations. 1999 (SI 1999:3242). London. HMSO

National Institute for Clinical Excellence (2002) *Principles for Best Practice in Clinical Audit*. Oxon. Radcliffe Medical Press.

National Institute for Health and Care Excellence, (2015) *Violence and Aggression: Short –term management in mental health, health and community settings. NICE Guidelines 10*. National Institute for Health and Care Excellence.

Independent Inquiry into the death of David Bennett. Cambridge. Norfolk, Suffolk and Cambridgeshire Strategic Health Authority

Restraint Advisory Board (2011) *Assessment of Minimising and managing physical restraint (MMPR) for children in the secure estate*. National Offender Management Service

Security Management Service, (2005) *Promoting Safer and Therapeutic Services. Implementing the national syllabus in mental health and learning disability services*. Gateway Reference SMS/PSTS/10/05/01. NHS Security Management Service.

Document control details

Author:	Head of mental health services South, MHA Manager, PMVA Manager, PMVA Advisor
Approved by and date:	Exec. board – 10.10.16
Responsible Committee:	Clinical Exec.
Any other linked Policies:	CLP002 - Resuscitation and Related Medical Emergencies CLP007 - Seclusion CLP010 - CPA CLPMHA CLP021 - Working with Risk CLP022 - Police Response for NHFT CLP023 - MCA (2005) Including DOLS CLP024 - Non Concordance with Care and Treatment Plans CLP040 - Policy for Service User and Carer involvement in NHFT Activities CLP042 - Privacy and Dignity Policy CLP047 - Policy for Safeguarding Children CLP055 - Policy for Safeguarding Vulnerable Adults, CLP070 - Physical Health Policy MMP011 - Rapid Tranquillisation Policy HR09 - Guidance for Staff Raising Issues of Concern HSC001 – Health and Safety Policy HSC002 - Policy on Use of Risk Registers NHFT HR025 - Mandatory Training Policy CRM002 - Incident Policy
Policy number:	CLP060
Version control:	Version 1.1

Version No.	Date Ratified/ Amended	Date of Implementation	Next Review Date	Reason for Change (eg. full rewrite, amendment to reflect new legislation, updated flowchart, minor amendments, etc.)
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1.0	10.10.16	10.10.16	10.10.19	New governance of trust policies template. Review of NICE guidance.
1.1	27.1.17			CQC recommended title amendment to include restrictive practice in brackets.

APPENDIX 1 - SystemOne

Seclusion Restraint Guidance

Restraint Page 2 of 3

Legal physical restraint 

For each physical restraint please complete the following questionnaire:

 Physical Restraint CC

Document Clinical Observations during and/or after restraint here:

 Clinical Observations

 [DATIX](#)

Datix Reference Number 

Legal physical restraint

Date ▼	Checked	...
29 Apr 2016	<input checked="" type="checkbox"/>	
29 Apr 2016	<input checked="" type="checkbox"/>	

Show recordings from other templates

Show empty recordings

Information Print Suspend Ok Cancel

Northamptonshire Healthcare  NHS Foundation Trust								
Equality Analysis Report								
Name of function:		Policy on the use of Physical Interventions						
Date:		15/6/2016						
Assessing officers:		Andres Patino						
Description of policy including the aims and objectives of proposed: (service review/resign, strategy, procedure, project, programme, budget, or work being undertaken):								
Northamptonshire Healthcare NHS Foundation Trust (NHFT) acknowledges that it has a statutory obligation to ensure safe systems of work, whilst also providing security and safety for service users, staff and members of the general public. This policy therefore includes a written procedure for employees concerning the nature, circumstances and use of approved physical interventions as endorsed by the Trust. This document is a review of the previous policy that was implemented in 2009.								
Evidence and Impact – provide details data community, service data, workforce information and data relating specific protected groups. Include details consultation and engagement with protected groups.								
Evidence base:								
<ul style="list-style-type: none"> ▪ NHFT Equality Information Report August 2012 ▪ Northampton County Council :Northamptonshire Results: 2011 Census Data Summary 								
	Corby	Daventry	East Northants	Kettering	Northampton	South Northants	Wellingborough	Northants
2001	53,400	72,100	76,600	82,200	194,200	79,400	72,500	630,400
2011	61,100	77,700	86,800	93,500	212,100	85,200	75,400	691,900
% rise	14.4%	7.8%	13.3%	13.7%	9.2%	7.3%	4.0%	9.8%
<ul style="list-style-type: none"> ▪ Ethnicity: 85.7% (White) and 14.3% (BME)- 1.75% (dual heritage); 4.01% (Asian); 2.5%(Black including British, African and Caribbean) ; 0.85 % (Chinese) ; 6.05 % (white other EEA, polish, Gypsy & Traveller) ▪ Gender: 49.6% males; 50.4% females (including 1% transgender) ▪ Disabled people: 19% (including 3.5 % < aged under 18) ▪ Faith communities: 71% Christian; 29% minority faith: (includes Hindu, Muslim, Sikh, atheists, non-belief) ▪ Sexual orientation (gay, lesbian or bisexual): 5 - 7% (Stonewall estimate) 								
Service Information: provide any relevant service data or information to inform the Equality Analysis including service user feedback, external consultation and engagements or research.								

Equality Analysis Report

Name of function: Policy on the use of Physical Interventions

Date: 15/6/2016

Protected Groups (Equality Act 2010)

STAGE 3: Consider the effect of our actions on people in terms of their protected status?

The law requires us to take active steps to consider the need to:

- Eliminate unlawful discrimination, harassment and victimisation.
- Advance equality of opportunity
- Foster good relations with people with and with protected characteristic

Identify the specific adverse impacts that may occur due to this policy, project or strategy on different groups of people. Provide an explanation for your given response.

Age

The use of physical interventions will not be applied to children under the age of 5 years of age due to impact that techniques may have on the growth plates of within the arms and intercostal areas of young children.

Disability

Service users and staff with a disability will be assessed prior to the use of physical interventions and techniques that compromise their disability will not be used. Assistance will be sought from PMVA team regarding alternative techniques for use with those individuals with a disability and addressed through training and care planning. A copy of these specific care plans will be available for monitoring.

Gender (male, female and transsexual, inclu. Pregnancy and maternity)

Within the training programme delivered to staff it is made very clear that where possible same sex restraint teams should be used wherever possible and in all cases a member of the restraint team will be the same sex as the patient.

Gender reassignment

Will not have any impact on the use of this policy

Sexual Orientation (incl. Marriage & civil partnerships)

Will not have any impact on the use of this policy

Race

Will not have any impact on the use of this policy. The ethnicity of all service users to whom physical interventions are employed will be recorded and monitored as part of the NHS Minimum data set

Religion or Belief (including non belief)

Will not have any impact on the use of this policy

Equality Analysis outcome: Having considered the potential or actual effect of your project, policy etc, what changes will take place?

The PMVA Monitoring Group will continue to analyse the incident data on a monthly basis to ensure the results are reflected in training.

Northamptonshire Healthcare  NHS Foundation Trust			
Equality Analysis Report			
Name of function:	Policy on the use of Physical Interventions		
Date:	15/6/2016		
Action Plan			
Issue to be addressed	Action	Who	Date to be completed
Ratification – a completed copy of the Equality Analysis form must be sent to Equality and Inclusion Officer to be approved.			
Approving Officers	Andres Patino		
Date of completion:	27/6/2016		

Appendix 3

Report Title: Physical Interventions Policy

Situation:

The above policy went to Policy Board and was queried regarding the NICE Guidance NG10 (2015) which recommends that a doctor trained to use resuscitation equipment should be immediately available if manual restraint might be used.

Background:

Due to operating a non-resident on call shift pattern for junior doctors we are unable to comply with NICE Guidance NG10 because doctors are not always immediately available if restraint might be used. We, instead, rely upon the staff in the Manual Restraint Team being ILS trained and/or BLS trained which means that they are trained to use a defibrillator and face mask in BLS and amubag, face mask, defibrillator and LMA (Laryngeal Mask Airway) if ILS trained. This provides the same level of standard in the NICE Guidance except it is delivered by nursing staff and not by medical staff.

Assessment :

ILS and BLS trained nurses are able and trained to use the resuscitation equipment referred to in NG10 but are not trained medical practitioners. The use of nurses in this way is a safe and appropriate substitution for the manual restraint policy.

Recommendations:

The Governance Committee approves the use of nursing staff who are ILS and BLS trained as an equivalent to medical practitioners who are ILS or BLS trained to use resuscitation equipment as being an acceptable deviation from NICE Guidance.