RESTRAINT AND VIOLENCE REDUCTION POLICY

1. AIM

1.1. This policy sets of the measures taken by Cygnet Health Care to prevent and reduce the use of force, manage the risk of aggression, violence and crisis behaviours using non-physical and physical interventions, and ensure accountability and transparency about the use of force in all our services.

1.2. The policy also promotes and encourages the use of a human rights-based approach to the use of force, working with Individuals in a trauma-informed, person-centred way, and developing therapeutic environments which aim to ensure that force is used proportionately and only ever as a last resort.

1.3. We are committed to upholding our legislative requirements under the Equality Act 2010. In particular, this policy considers our responsibilities under the public sector equality duty and consequently takes an anticipatory view to identifying and reducing inequalities in the use of force.

1.4. The use of force should be rare and exceptional, rather than a common experience for Individuals and staff. It is however acknowledged that there are circumstances where it may be difficult to avoid the use of force to ensure the safe care and treatment of the Individual and the safety of others. For example, nasogastric feeding for Individuals with eating disorders or a need to restrain an Individual who is physically assaulting another person. Even within these situations it is still essential that the relevant legal principles are applied and that the use of force is proportionate.

1.5. This policy has been written in consultation with Experts by Experience via the Cygnet Co-production Steering Group, Advocacy Services, experts in Equality and Diversity and the Police and has been signed off by Cygnet's Responsible Person and the Executive Management Board.

1.6. It is the personal responsibility of every individual referring to this policy to ensure that they are viewing the latest version; this will always be published on Cygnet's online policy library, '**myPolicy**'.

2. SCOPE

2.1. This policy applies to all Cygnet Clinical Services, Care Homes, Residential services and Supported Living Services.

2.2. This policy applies to staff who have direct contact with Individuals in our Services.

2.3. It is the agreed Policy and any deviation by staff from following this policy and supporting procedures and documents may be subject to disciplinary procedures.

2.4. Procedure document for Safety Interventions and PMVA/Restraint Reduction Pathway.

3. LEGISLATION

3.1. Criminal Law Act 1967(sec 3),
3.2. Criminal Justice (Scotland) Act 2016,
3.3. Mental Health Act 1983 (as amended 2007),
3.4. Mental Health (Care and Treatment) (Scotland) Act 2003,
3.5. Mental Capacity Act 2005,
3.6. Adults with Incapacity (Scotland) Act 2000,
3.7. Adult Support and Protection (Scotland) Act 2007,
3.8. Mental Health Units (Use of Force) Act 2018 (England),
3.9. Human Rights Act 1998,
3.10. Health and Safety at Work Act 1974
3.11. Scottish Human Rights Commission (2009)
3.12. Equality Act 2010

3.13. The Children Act 1989
3.14. The Children Act 2004
3.15. The Children and Families Act 2014
3.16. The Care Act 2014
3.17. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
3.18. Data Protection Act 2018 & UK General Data Protection Regulation (GDPR)

4. DEFINITIONS AND TERMINOLOGY

Terminology

4.1. Cygnet provides services to a wide range of people in hospital, residential or day provisions. At service level, they may be referred to as either patients, service users, residents or individuals. For the purposes of this policy, where possible the term 'Individuals' will be used to mean everyone that accesses Cygnet services.

Definitions

4.2. **Use of Force** includes physical, mechanical or chemical restraint or the isolation (including Seclusion and Long-Term Segregation) of an Individual.

4.3. **Violence** is defined by the Health and Safety Executive (HSE) as;

- Any incident in which a person is abused, threatened or assaulted in circumstances related to their work. There are a number of different types of violence e.g. physical violence, psychological violence, etc.

4.4. **Physical Assault** is defined by the NHS Security Management Service as;

- The intentional application of force against the person of another without lawful justification resulting in physical injury or personal discomfort.

4.5. **Non Physical Assault/Aggression** is defined by the NHS Security Management Services as;

- The use of words or inappropriate behaviour causing distress and/or constituting harassment.

4.6. **Behaviours of Concern and Behaviours that Challenge** are defined by Bild as behaviours that have a negative impact on a person's life and/or others around them.

4.7. **Disengagement/ Breakaways** are skills designed to assist staff to escape or remove themselves from a situation or from an individual assaulting or attempting assault.

4.8. **De-escalation** is defined by the National Institute for Health and Care Excellence (NICE) Clinical Guideline 10 as the use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression.

4.9. **Approved Agencies** refers to the approved providers of Physical Intervention Instructor training used within Cygnet Health Care.

4.10. **Physical restraint** is any method of responding to behaviours of concern which involves using a degree of direct force or physical contact where the intent is to prevent, restrict, subdue or limit another person's movement. It is also known as manual restraint or Physical Intervention. It is done to maintain safety and/or reduce the risk to self and others. Physical restraint must only be used when necessary and proportionate, as the least restrictive option where no other interventions are appropriate and for the minimum amount of time necessary to reduce or eliminate the risk (DoH 2015, RRN 2018, NHS Digital 2020).

4.11. **Negligible use of force** is a hold/restraint that involves light or gentle and proportionate pressure. In order for the force to be considered negligible, it must meet all the criteria listed below:

- a) It is the minimum necessary to carry out therapeutic or caring activities such as personal care or reassurance.
- b) It forms part of an individual's care plan.
- c) Valid consent in connection with that care and treatment has been obtained from the individual and, where appropriate, their family or carers have been consulted, particularly a person with parental responsibility if a young person is not Gillick competent. Where an individual lacks capacity to consent, a Best Interest decision needs to be made under the Mental Capacity Act.

4.12. **Mechanical restraint** is the use of a device which is intended to prevent, restrict or subdue movement of any part of the individual's body, and is for the primary purpose of behavioural control.

5. INTRODUCTION

5.1. Cygnet recognises that the organisation has a legal, professional and ethical obligation to minimise harm to Individuals, staff and others, and therefore is accountable for the use of force within the organisation. The organisation has a good understanding of why force is used within our services, develops action plans for reducing the use of force and regularly reviews performance in reducing the use of force in line with the **Positive and Safe Care Strategy** and **Positive and Safe Care: Reducing Restrictive Practice** Policy.

5.2. Cygnet is committed to reducing the use of restrictive practices in all settings through the promotion of positive cultures, relationships and approaches aimed at preventing escalation and minimising the need to use force. We aim to promote initiatives that seek to prevent and manage risk behaviours by using minimal restrictive interventions and develop a culture that promotes recovery and improved quality of life evidencing reductions according to set key performance indicators.

5.3. The organisation's 'responsible person' whose role it is to ensure that the organisation complies with all relevant statutory requirements required by the Mental Health Units (Use of Force) Act 2018 is the Group Director of Nursing.

5.4. This policy supports risk reduction systems in relation to the understanding and management of aggression, violence and behaviours that challenges within Cygnet services and gives standards and guidance on the appropriate human

rights based and trauma-informed prevention, de-escalation and physical interventions to be used when supporting Individuals in our care.

5.5. Cygnet Health Care regards the health and safety of its staff as extremely important; staff should not put themselves knowingly at risk of serious harm or injury. Sound clinical judgement and/or objective use of knowledge, skills and analysis is essential to carry out risk assessment prior to an intervention. This should be done with reference to the potential for harm occurring, the potential severity of any harm incurred, knowledge of the staff capability as well as the level of risk presented by the Individual. Staff need to be able to account for the decision they make based upon this risk assessment. The risk assessment may still need to be reviewed as an incident develops and staff need to respond to this as required.

5.6. The main emphasis at all times is on primary prevention in order to reduce the likelihood of situations escalating to the point of requiring physical interventions. The use of non-restrictive and non-physical interventions is promoted in the first instance. Cygnet however recognises that restrictive physical interventions may be necessary in order to take immediate control of a dangerous situation where there is a real possibility of harm to the individual or others if no action is taken. Where such interventions are used they will be used for no longer than necessary to prevent harm, be a proportionate response to that harm and cause minimum interference to the individual's autonomy, privacy and dignity, while being sufficient to maintain safety.

5.7. Cygnet Health Care's plan for reduction of the use of restrictive practices and interventions is set out in the **Positive and Safe Care Strategy** and the **Action Plan for the RRN RRP Self-Assessment** Action Plan. The **RRN RRP Self-Assessment Action Plan** is a live document, which is kept by Cygnet's Responsible Person, the Director of Nursing.

6. POLICY

Equality, Diversity and Inclusion, and Ethical and Human Rights Considerations

6.1. Cygnet is committed to working within the spirit and the practice of the Equality Act 2010 and upholding the stipulations of the Human Rights Act 1998. Staff are expected to protect human rights and freedoms; treat everyone as individuals, fairly and in a consistent way; avoid and challenge discrimination against people sharing particular protected characteristics should it ever arise. We will promote a culture of respect and dignity and work to proactively minimise the use of restrictive interventions and eliminate the inappropriate use of force, recognising the potentially traumatising impact it can have.

6.2. Whenever the use of restrictive interventions are considered, the diversity of the individuals we care for and their varying needs should be integral to decision-making. For example, this requires understanding the more negative implications the use of force can have on different population groups, such as children and young people, older adults, women and girls, individuals with autism or a learning disability, people from black and minority ethnic backgrounds and other people who share protected characteristics under the Equality Act 2010.

6.3. Approaches used must reflect differences to ensure that services and interventions are culturally appropriate, and respectful and responsive to the cultural differences, beliefs and practices of the service user population being served. This should include understanding of cultural identity and heritage, and the discrimination faced by many people from black and minority ethnic backgrounds, in particular by black men. Interventions should be based on proactive preventative approaches that are trauma informed and person centred.

6.4. Human rights are the fundamental freedoms and protections, which everyone is entitled to. They cannot be taken away but some rights can be restricted in specific circumstances for a legitimate reason, as long as that restriction is proportionate. Some rights, including freedom from torture, inhuman and degrading treatment are absolute and can never be restricted.

6.5. Articles 2 (right to life), 3 (freedom from torture, inhuman and degrading treatment), 8 (respect for private and family life) and 14 (protection from discrimination) of the European Convention on Human Rights (ECHR) are those which relate to the use of restrictive interventions in our services. Cygnet and all its staff are legally obliged to respect individual's rights and take reasonable steps to protect those rights.

6.6. When physical interventions become unavoidable, staff should always be mindful of related ethical and human rights principals. Interventions must reflect the differences in approach required to ensure services are culturally appropriate, and respectful and responsive to the cultural differences, beliefs and practices of the service user population being cared for. All interventions should be undertaken with the honest held belief that staff are preventing further harm or damage and always with consideration given to the Individual's rights and to the welfare of others. All interventions must be the least restrictive of an individual's basic rights and freedoms. Further guidance is available in the **Restrictive Physical Interventions Procedure**.

6.7. Cygnet will monitor and report on the use of force on people who share protected characteristics under the Equality Act 2010 on a regular basis (minimum quarterly) utilising data from all appropriate reporting systems such as the Incident Management Systems and feedback received from individuals in our care, families and carers, staff and other external stakeholders. These will be discussed at all levels of the organisation including clinical and operations governance meetings, Positive and Safe Care forums, Executive Committees and other appropriate forums. The aim will be to ensure that protected groups are not overly represented in restrictive intervention data action plan for parity as necessary.

6.8. Further guidance on consideration for individuals with protected characteristics can be found within the **Restrictive Physical Interventions Procedure**.

Reasonable Force

6.9. There is no precise legal definition of what degree of force is deemed reasonable; it will always depend upon the precise circumstances of the individual case; however the degree of force used should always be;

- Necessary i.e. the person using the force must honestly, truly and instinctively believe that they must do something to avoid harm.
- In proportion to the consequences it is intended to prevent i.e. the harm likely to be caused to the Individual as a result of the intervention should be no greater than the harm the staff member would have suffered if no intervention was made; and
- The minimum needed to prevent harm and maintain safety.

6.10. The Crown Prosecution Service view of reasonable force is;

- A person may use such force as is reasonable in the circumstances for the purposes of:
  - Self-defence.
  - Defence of another (staff or best interests of individuals in our care).
  - Defence of property.
  - Prevention of crime.
  - Lawful arrest.
  - Save or preserve life.

Necessity

6.11. The Common Law doctrine of necessity provides that mentally incapacitated adults may be restrained using reasonable force and given treatment without consent which is necessary in their best interests, without those carrying out the treatment incurring liability in battery. This Common Law doctrine is now codified in sections 5 and 6 of the Mental Capacity Act 2005 or Section 47 of the Adults with Incapacity (Scotland) Act 2000. Treatment given under the doctrine of necessity may be for physical or mental disorder however the Mental Capacity Act Code of Practice and Cygnet's **Mental Capacity Act** and **Adults with Incapacity (Scotland)** policies must be followed including capacity assessment and best interest meetings.

7. PROCEDURE

Risk Assessment and Care Planning

7.1. For guidance on Individuals' risk assessment, please refer to the **Individual Risk Assessment and Management** policy.

7.2. For guidance on care planning please refer to **Management of Individuals Care Records** Policy. Restraint care plans are required to include three elements. Primary preventative strategies that seek to prevent escalation and support the Individual to remain calm; secondary strategies such as de-escalation, distraction, diversion and sometimes disengagement techniques e used when an Individual starts to become anxious, aroused or distressed and tertiary strategies which are those used and Individual's agitation further escalates to a crisis where they place either themselves or others at significant

risk of harm. Secondary and tertiary strategies may include the use of restrictive interventions.

7.3. If routine negligible force is used on an Individual on a regular basis, then a restraint reduction plan must be completed. The plan must include the reasons why the restraint is necessary, what other less restrictive options can be considered or tried, the specific restraint types to be used in each circumstance and any discomfort they may cause to the Individual, how frequently the restraint may be used, what is the outcome for the Individual if restraint is not used, whether the Individual consented to the restraint, any special health considerations that make the Individual more vulnerable should restraint be used, for example, sensory issues, frailty, or limited communication, trauma, etc. That plan must also include any measures that are being implemented to reduce the need for restraint.

7.4. Where possible the Individual should be involved in the development and review of the care plan and be given the opportunity to exercise some choice on the types of intervention used to prevent, de-escalate and manage risky behaviours prior to physical interventions being employed. This must be done using appropriate communication to enable and enhance the Individual's understanding.

7.5. It is important to acquire an in-depth knowledge and understanding of each Individual in our care including their history of aggression, violence and behaviours that challenge. Where possible and appropriate, contact should be made with families or past carers to establish any management plans or behaviours that have been effective in past attempts at de-escalation and the safe management of any risk behaviours and information in advance statements, where available, should be considered. As much as possible, families and carers should also be included in care/support planning and monitoring.

7.6. Risk assessment should consider and identify any limiting factors with regards to the method of physical intervention proposed and should take into account the Individual's mental condition, physical condition, abilities, age, gender, ethnicity, physiological or sensory profile or any other disability. It must be noted that there are types of physical interventions that are not appropriate for Individual or particular groups of Individuals e.g. younger persons, older adults, Individuals with learning disabilities, pregnant females, etc.

7.7. The risk assessment should also take into account the cognitive ability/understanding of the Individual and the impact this may have on the situation.

7.8. Extra care must be given where there is evidence or suspicion of historical physical, sexual or psychological abuse and involvement from the Multi-Disciplinary Team and the Individual should be sought where available.

7.9. Further guidance in physical intervention care planning should be sought from the Regional Restraint and Violence Reduction Lead or local instructors where

available. The level of skill and experience is to be considered when advice is being sought to ensure that appropriate support is provided.

Personal Safety

7.10. Staff have a legal right to defend themselves and a professional duty to protect others from harm. Techniques for disengagement/ Breakaways are taught to all Cygnet staff who have face-to-face contact with Individuals.

7.11. This training emphasises the need to be aware of the physical environment, strategies to keep safe and reduce the likelihood of assault, information on how to recognise and manage escalating behaviours appropriately at the earliest opportunity, how to minimise the risk of assault and how to call for help in an emergency.

7.12. This training also provides physical skills that may be used in an emergency to escape or assist in the rescue of others.

7.13. Taught disengagement techniques cannot cover all possibilities and may not always be successful. Section 3 of the Criminal Law Act (1967) allows all citizens the right to use force that is reasonable in such a situation. The level of force used to escape from a threatening situation must, however, be within the law, necessary and proportionate to the perceived threat.

Physical Interventions

7.14. There may be instances where it may become necessary to make use of physical interventions. Such interventions should only be considered once other non-physical interventions, e.g. de-escalation techniques, have been tried and have not succeeded in calming the Individual. It is however noted that there may be emergency situations where the opportunity to use other interventions is unavailable or unsafe. Staff must ensure that they record this in incident and Individuals' records.

7.15. Physical Intervention/ restrictive physical interventions should only be used as a last resort, be used as little as possible, for the shortest time possible and only when absolutely necessary.

7.16. Seclusion, use of locked doors and Long Term Segregation (LTS) are considered environmental restrictions and dealt with in separate policies. (See **Security (Including Locked Doors)** policy and **Seclusion and LTS policy**). It is recognised that in some services such interventions may be used in combination with physical interventions.

Reasons for the use of Physical Intervention

7.17. The most common reasons for the use of physical interventions as highlighted by the Mental Health Act 1983 Code of Practice, Dept. of Health (2015):

- Physical assault.
- Extreme dangerous, threatening or destructive behaviour.
- Self-harm or risk of physical injury.
- Extreme and prolonged over-activity likely to lead to physical exhaustion.
- Attempts to abscond (where the Individual is detained under the Act).

7.18. Cygnet Health Care currently use the following Bild Association of Certification (Bild ACT) certified models for Restrictive Intervention Training. PMVA (West London Mental Health Trust) and Safety Interventions (The Crisis Prevention Institute).

7.19. Any practices deemed to be outside of this will not be supported unless the perceived risk is such that it was felt necessary to prevent significant harm and the actions taken were reasonable i.e. necessary and proportionate. Any incident involving practices or techniques that might be considered outside of the scope of techniques taught in training or a assessed as unreasonable in the circumstances will be fully investigated. All aggressive, violent or behaviours that challenge need to be treated with an appropriate, measured and reasonable response, proportionate to the level of risk presented.

7.20. Restrictive physical interventions must only be used if there is imminent risk to the Individual being physically injured, or their fellow Individuals, or members of staff/public being physically injured, or as a planned intervention where there is a foreseeable risk based on available evidence. In all instances, a clear justification for the actions taken need to be given needs to be given and recorded as noted in the Reporting and Recording section.

7.21. All forms of physical intervention requires that staff should follow a "duty of care" to the Individual and should always act in good faith. It is however recognised that the Individual may come to harm as an unintended consequence of an action taken in good faith. Appropriate investigation procedures will be undertaken to ensure that staff acted reasonably.

Physical intervention safety considerations

7.22. The use of physical interventions always comes with risk and can be a traumatic and upsetting experience for individuals when they are at their most vulnerable and in need of safe and compassionate care. It can also be upsetting for those who witness it, such as other Individuals or visitors. Staff are expected to a practice in a way that reduces the reliance on physical interventions and avoid its misuse and abuse.

7.23. It is noted that in some areas of practice there is still a greater focus on managing behaviour rather than working to prevent situations from escalating to the point at which physical interventions is seen to be the only solution. Staff are expected to shift the focus to one which respects all individuals' rights, provides skilled, trauma-informed, person-centred care, follows the principle of least restriction, and promotes recovery and/or an improved quality of life.

7.24. Where physical interventions cannot be avoided, Individuals should not be deliberately held in any way that impacts on their airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure to the neck region, rib cage and/or abdomen. Unless there are cogent reasons for doing so, there should be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor (DH 2015). Any deviations from this must be made clear in the Individual's Risk Assessment, Care/Support Plan and continuous written record outlining why this is in the Individual's best interests.

7.25. It must be noted, however, that there are various other high risk physical intervention positions that are likely to restrict breathing e.g. supine position (lying on their back facing upwards), seated forward with head held down, etc. These positions must be used for the shortest time possible to manage the situation presenting and the Individual's physical state must be monitored both during and after such interventions. Full account should be taken of the Individual's age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment, which may confer additional risks to the Individual's health, safety and wellbeing. A record of this must be made in risk assessments, care/support plans and continuous written record.

7.26. During physical interventions one team member should be responsible for communicating with the Individual in line with the Individual's care plan and take responsibility for leading the team through the physical intervention process, ensuring that the Individual's airway and breathing are not compromised, ensuring that vital signs are monitored and that the overall physical and mental wellbeing of the individual is prioritised. A trauma informed way of working is expected at all times.

7.27. The nominated lead staff member should continue to speak to the Individual on whom the physical intervention is used throughout, this should occur even if there are no verbal responses. Staff should observe the Individual for difficulties in breathing such as cyanosed lips, hands and feet, fits or seizures, vomiting or choking. If any physical difficulties become evident, staff must proceed with the appropriate emergency interventions, for example, stop, rest and recover, disengagement or immediately follow medical emergency procedures as noted in the **Resuscitation Policy**.

7.28. Additional consideration must be given to informal Individuals where planned and/or emergency physical intervention responses are being utilised. The team involved should consider whether the criteria in section 6 of the Mental Capacity Act apply (in respect of people aged 16 and over who lack capacity) and/or whether detention under the Mental Health Act is appropriate, subject to the criteria being met (DoH, 2015). This must be discussed with the Multi-Disciplinary Team and recorded in the Individual's progress notes where applicable or as soon as is practicable where the risk for restraint was unforeseen.

7.29. In line with legal and best practice guidance, Cygnet Health Care does not endorse the routine use of pain-based techniques for the purpose of obtaining compliance from Individuals. "Restrictive interventions must not be used to punish, inflict pain, suffering or humiliation, or establish dominance" (NICE 2015). This would likely represent an infringement of Individual human rights (Under Article 3). Every effort should be made to use skills and techniques that do not use the deliberate application of pain. Cygnet Health Care does acknowledge that in some situations, where there is an immediate risk to life (of life-threatening injuries), and/or of significant injury (of life changing harm), the use of techniques that cause pain, may as a last resort, be necessary for 'escape' and/or 'rescue' purposes. This is line with relevant best practice

national and statutory guidance (MHA, CoP, 2015; NICE (NG10), 2015; Restraint Reduction Network Training Standards, 2019).

7.30. It should be noted that the application of pain may lead to a worsening of an already highly charged situation and so must be avoided unless absolutely necessary.

Managing Weapons

7.31. Weapons in our services pose a serious risk to the health and safety of everyone within that service. There is an ongoing need to be aware of the rights and responsibilities in relation to weapons management within health and social care services. A proactive approach is required in relation to the deterrence and detection of weapons utilising relational security and as detailed in the **Searching Policy for Service Users, Visitors, Property and the Environment**.

7.32. In the event that staff members or other Individuals are being threatened with a weapon, the situation must be contained to minimise risks and maximize safety. Individuals and staff must remove themselves to a safer area to prevent the risk of injury to others. Communication channels with the person with the weapon should remain open at all times where it is safe to do so.

7.33. Attempts should not be made to physically disarm the Individual possessing the weapon or ask them to hand the weapon to staff. However, as long as it safe to do so, staff should maintain distance and ask the Individual to place the weapon in a neutral area and move away from it, then they can safety retrieve weapon thereafter.

7.34. De-escalation should only be attempted once the situation is contained. Where all attempts at de-escalation have failed, or it is unsafe to do so, staff should call the Police for assistance on 999.

7.35. Explicit information regarding the location of the incident, the weapon involved, a physical description of the Individual carrying the weapon and information regarding any physical conditions will assist the Police risk assessment process and allow a prompt response. All 999 calls receive a graded response and clear information is required to ensure the Police arrive in the shortest time.

Working with the Police

7.36. In exceptional circumstances, health and social care professionals may require the assistance of the Police to provide care safely. Services should work with their local Police to develop procedures for joint working according to the Memorandum of Understanding (MoU) on the Police Use of Restraint in Mental Health & Learning Disability Settings. The MoU clarifies the role of the Police in responding to incidents in our services and how Police who attend should work with staff. Agreed protocols should cover staffing in both our services and policing to enable the discharge of respective legal duties, effective communication between Police and staff in particular in relation to the assessment of risk, clear escalation procedures in both Police and our services

to problem solve at both an operational and strategic level; and provision for the joint review of individual cases that involve our service and the Police.

7.37. Where a high risk situation has arisen and de-escalation and other available strategies have failed or are considered unsafe to attempt, there is a clear rationale for calling Police assistance using 999 (emergency telephone number).

7.38. Under Section 12 of the Mental Health Units (Use of Force) Act 2018, it is now law for a Police Officer going to a mental health unit on duty that involves assisting staff who work in that unit, to wear a Body Worn Camera (BWC) and keep it operating at all times, if reasonably practicable. With this in mind, staff should consider protecting the privacy and dignity of all Individuals not involved in the incident by keeping them away from the area where the Police are operating.

7.39. Where the Police have been called to a service, all necessary actions are will be taken to ensure that there are no delays in their ability to access the building and arrive at the incident scene as quickly as possible. Where applicable, reception will be informed that the Police have been called and/or a member of staff with all the necessary building access will take responsibility for meeting the Police Officers on arrival, ensuring they know where to go and ensuring their entry into the building.

7.40. Staff must be aware that leadership of the situation with regards to decision-making about the interventions required to maintain safety is handed over to the senior Police Officer when they arrive on the unit. This however does not mean that the staff no longer have duty of care responsibility of the Individual and should act in accordance with that mandate. The staff must remain observant of the interventions used and ensure that they do not cause the individual harm. Any concerns should be immediately communicated to the senior Police Officer at the scene and reported using all appropriate recording and reporting forums.

7.41. Similarly to hostage situations, the Data Protection Act does not apply and the Police must be given a thorough handover with all necessary information to allow them to manage the situation while ensuring the Individual's safety. Information to be handed over about the Individual should include but is not limited to their mental health, physical health, cognitive functioning, risk history and trauma history. This will influence the Police's chosen management approach.

7.42. In addition to de-escalation, the Police will have four basic avenues to pursue when managing difficult situations: deployment of personal protective equipment, physical and/or mechanical restraint, use of incapacitant spray also known as 'PAVA (formerly CS gas) and deployment of a Taser. Tasers are only available to specially trained officers. It is imperative that the risks of each approach to the Individual are fully discussed with the Police on arrival to inform their choice of approach towards managing the situation. Staff should be available to assist the Police if safe and appropriate.

7.43. The usual physical health procedures both during and post incident are to be followed where an Individual has been physically or mechanically restrained. Clinical treatment of an Individual following deployment and use of either Taser or incapacitant spray must be conducted following multi-disciplinary discussion and should be care planned accordingly. Medical staff must conduct a physical examination of the Individual after either a Taser or CS gas have been used by Police and the immediate plan of care prescribed. Staff are expected to initiate a period of enhanced/supportive observations according to the **Observation and Engagement**/**Safe and Supportive Observations** policies in order to observe for any adverse reactions and be available to swiftly intervene.

7.44. Where incapacitant spray and/or Taser have been deployed, staff should also subsequently follow appropriate procedures to ensure measures to minimise negative the effects on the Individual and others. Staff must also offer support to Individuals who are not involved in the incident who may be distressed or confused by events.

7.45. All communications and Police interventions must be recorded by staff in all appropriate records. There will include incident records and continuous written records. Where appropriate, family or carers should be informed of the incident.

Post-Incident Procedures

7.46. After any incident where restrictive interventions are used, post incident support must be offered/undertaken within 24 hours so that all parties involved including staff, Individuals and those who witnessed the intervention. The aim for this is to ensure that everyone is afforded the necessary physical, emotional and psychological support.

7.47. Full instructions for carrying out post-incident procedures and all supporting recording forms and guidance can be found with the **Incident Management Reporting** Policy (4-14)

- Post Incident Review Procedures INDIVDIUALS (4-14.13.1)
- Post Incident Review Procedures STAFF (4-14.13.2)
- Post Incident Review (debrief) IMMEDIATE (4-14.13.3)
- Post incident Review (debrief) Within 72 hours INDIVIDUALS (4-14.13.4)
- Post Incident Review (debrief) within 72 hours STAFF (4-14.13.5)
- The 5 r's of an effective debrief (4-14.13.6)
- Post Incident Review (debrief) recording flowchart (4-14.13.7)
- Debrief EASYREAD (4-14.13.8)

Injuries sustained through use of Physical Interventions

7.48. Any injuries or suspected injuries should be dealt with as soon as it is safe and practically possible after an incident has occurred.

7.49. The person responsible for managing the incident must ask staff and the Individual after the incident if they have or suspect they have sustained any injuries. All injuries of Individuals and staff must be recorded and a body map completed on the IMS (Incident Management System) including as much information as possible.

7.50. Any Injuries sustained must be treated accordingly by qualified persons and where appropriate further medical assistance obtained.

Reporting and Recording

7.51. All Incidents where physical interventions are used or attempted, whether planned or in an emergency must be fully documented within the Individual's notes and reported on the IMS (Incident Management System).

7.52. Reporting must take place as soon as is practically possible and must be an accurate and honest account of the incident.

7.53. Details of the incident where physical interventions were used must include a clear record of incident times, the duration of each restraint position, staff involved and their designations/roles, details of what positions(s) Individual was held in, the positioning of staff members and the individual's characteristics including ethnicity, religion, diagnosis, etc.

7.54. Interventions where the intent is not to restrict or subdue movement and there is no resistance from the Individual, such as a guiding hand or redirection using touch support to encourage an Individual to move away from an area that might pose risk, should not be recorded as a restraint. It is identified as negligible restraint. Although these interventions may still be identified as a restrictive action as they are stopping someone from doing something that they want to do, they are however not physical restraint.

7.55. For all incidents where Physical Interventions are used, a full description of what was done must be given including the rationale/justification clearly stated. Incidents of negligible restraint are still required to be recorded both in the Individual record and on IMS. The information required about negligible restraint on IMS is limited as these incidents are not required to be included in restraint statistics.

7.56. There are however instances where what may have been intended as negligible restraint has to be recorded as a physical restraint. A restraint can never be considered as negligible in any of the following circumstances:

- The Individual verbally or physically resists the contact – special attention must paid to Individuals who communicate non-verbally.
- The Individual is upset or distressed during or after the restraint.
- The restraint involves more staff than is specified in the Individual's care plan.
- The restraint involves the use of a surface such as wall, floor, bed or any other surface.
- The restraint has been used to remove an item of clothing or a personal possession.
- There is a use of rapid tranquillisation.
- There is the use if any form of mechanical restraint.
- The restraint is effectively a seclusion where a person is kept is an area due to staff not permitting free movement.
- The restraint causes an injury to the Individual or a member of staff, however minor – this includes bruises and any marks on the skin.
- The Individual complains about the restraint either during or after its use.

- Someone else complains about the restraint - this does not have to be a formal complaint.

7.57. Individuals can be physically restrained in a number of different positions. These include but are not limited to those detailed below. If an Individual is placed in, falls into, or puts themselves into any of these positions, and the criteria for restraint as identified above is present, the incident should be recorded as a restraint in that position.

- **Standing** – any restrictive holds used while the Individual is in a standing position regardless of whether they are upright or bending forward.
- **Restricted escort** – any restrictive holds where an Individual is moved/re-located from one area of a unit to another regardless of the level of holds used.
- **Seated** – any restrictive holds where the Individual is held in a seated position.
- **Kneeling** – any restrictive holds where the Individual is held in a kneeling position.
- **Prone** – any restrictive holds where the Individual is held in a chest down position regardless of whether the Individual's face is down or to the side.
- **Supine** – any restrictive holds where an Individual is held while lying on their back.
- **Side** – any restrictive hold where an Individual is held in a side-lying position.

7.58. The intention of staff and the duration of the intervention are irrelevant in identifying if a physical restraint/intervention has occurred. A restraint should be recorded if the Individual is held in a restrictive hold in such as any of the above positions and meets the definition of restraint. It remains a restraint however brief the time that the Individual is held in that position may be. For example, where an Individual goes down in the prone position then has to be turned to supine, both prone and supine should be recorded for that incident.

7.59. Where an Individual is held in order to facilitate care or a clinical procedure (sometimes referred to as clinical holding); the incident must be recorded as a restraint, provided that all criteria of the restraint definition as identified above are present. Examples of this are: an Individual requiring resistive restrictive holds to be assisted with washing, dressing or using the toilet (where this intervention cannot be delayed for safety reasons); an Individual needing resistive restrictive holds to administer enteral feeding e.g. where they have an eating disorder or disordered eating; an Individual requiring resistive restrictive holds to take bloods. A plan for this must be agreed through a Multi-disciplinary Team (MDT) meeting or 'best interests' meeting dependent on whether the intervention is done under the Mental Health Act (MHA) or Mental Capacity Act (MCA). Where appropriate relatives/carers should be made aware.

7.60. It is irrelevant if a physical restraint is identified in a care or support plan or if it is an approved (taught) technique or not. Whenever a resistive restrictive hold that meets the definition of restraint is used, this must be recorded as a restraint. Examples of this include where Individuals are held in order to facilitate enteral feeding; provision of personal care; seclusion entry and exit;

transporting Individuals when leaving the secure perimeter of a service or ward; etc. where the restraint does not meet the definition for negligible force

7.61. Breakaway techniques i.e. those manoeuvres used in order to physically disengage from a potentially unsafe situation are not a physical restraint if used in isolation. It is however possible for a breakaway technique to result in the use of a physical restraint should the risk of harm prevail.

7.62. The IMS (Incident Management System) allows staff completing the report to choose which model of physical interventions was used, to choose which techniques/holds were applied and identify the length of time each technique/hold was used.

7.63. Following the use of restraint, staff will inform the individual's family and carers identified in the care/support plan in line with confidentiality agreements. The agreed method of communication and the frequency of this must be agreed with the family and carers and recorded in the care/support plan. Communication will be recorded on IMS and in the individual's continuous written record. The use of negligible force is exempt from the duty to inform families and carers after each use.

7.64. Further information can be found in the **Incident Reporting and Management** Policy.

8. TRAINING

8.1. Cygnet Health Care has a legal duty to provide its staff with training in the recognition, understanding, de-escalation and management of aggression, violence and behaviours that challenge.

8.2. Cygnet Health Care currently use two different models of physical interventions training across the organisation, these being;

- Restraint Reduction Pathway – also referred to as Prevention and Management of Violence and Aggression (PMVA) governed by West London NHS Trust
- Safety Interventions governed by the Crisis Prevention Institute

8.3. Cygnet Health Care employs a number of certified instructors in these models who deliver training to all staff who have contact with Individuals in our care.

8.4. All models of restrictive intervention training used by Cygnet Health Care are certified by the Bild Association of Certified Training (Bild ACT) as being complaint with the RRN (Restraint Reduction Network (RRN) Training Standards 2019.

8.5. Training delivered will be determined by Training Needs Analysis (TNA) for each service, this is to be completed by the Regional Restraint and Violence Reduction Lead and supported by the Service Manager. The Training needs analysis will determine the level of training based upon the historical intelligence, current identified risks and evidence of foreseeable risk for each service and training will be provided according to that needs.

8.6. All Restrictive Interventions Instructors/Trainers must be certified by one of the Approved Agencies and be in date with relevant qualifications set out by those agencies, work within the RRN training standards guidelines and their training organisations' instructor expectations/codes of professional practice.

8.7. All Physical Intervention Training delivered to Cygnet Health Care staff is competency based; competency is measured using various methods including formative assessment, observation, scenario based learning and completion of written assessments.

8.8. All staff trained in restrictive physical interventions must also be trained in Basic Life Support (BLS) as a minimum or Immediate Life Support (ILS) for Registered Nurses.

8.9. Further Guidance on Restrictive Interventions training can be found within the **Restrictive Physical Interventions Training procedure**.

8.10. The syllabus/curriculum for each model is also available from the Learning and Development team.

9. MECHANICAL RESTRAINT

Introduction

9.1. Cygnet Health Care recognises that the use of mechanical restraint may be considered in a very small number of cases, and, though it may appear more restrictive, it may present less risk to the Individual and be more humane than other alternative methods such as prolonged restraint, high level physical restraints, inappropriate restraints or transfer to a more restrictive setting. Mechanical restraint should only be used in exceptional cases where other forms of restriction cannot be safely employed. It should be used in line with the principle of least restrictive option and should not be an unplanned response to an emergency situation. Mechanical restraint should never be used instead of adequate staffing (MHA CoP 2015).

9.2. The use of mechanical restraint devices may be considered for use on a short or long-term basis in instances where it is necessary to limit frequent and intense self-injurious behaviour, deliberate self-harm or where there is a risk of excessively harmful violence. This will be rare and encountered with small numbers of Individuals who may have severe cognitive impairments and/or enduring disturbed mental states. Devices such as hand, leg or arm restraints, cushioned helmets, etc. may be required to safeguard an Individual from the hazardous consequences of their behaviour.

9.3. Mechanical restraints may be used on Individuals by third parties e.g. Police and secure transport services. If they are used in such instances, the practice remains the responsibility of the agencies instigating the mechanical restraints. Cygnet staff may at times be involved in the use of physical interventions on those Individuals to enable the application or removal of these mechanical devices or the enhanced observations on the Individual in mechanical restraint; however the mechanical devices will at all times remain the responsibility of the those agencies/staff applying them.

Procedure

9.4. The use of mechanical restraint should be approved following multi-disciplinary consultation (which should include an Independent Mental Health Advocate (IMHA) where the Individual has one). The Individual's continuous written record should provide details of the rationale for the decision to mechanically restrain them, the medical and psychiatric assessment, details of other less restrictive restraints considered and assessed as inappropriate for managing the risks, the Individual's condition at the beginning of mechanical restraint, the response to mechanical restraint and the outcomes of the medical reviews.

9.5. Provision for the use of mechanical restraint should be recorded as a tertiary/high risk strategy in the care/support plan/positive behaviour support plan. Tertiary/high risk strategies within care/support plan/positive behaviour support plans should aim to provide brief recurrent periods when mechanical restraints can be removed.

9.6. The care/support plan should detail the circumstances which might warrant the use of mechanical restraint, the type of device to be applied, how continued attempts should be made to de-escalate the situation and any special measures that are required to reduce the likelihood of physical or emotional trauma resulting from their use (CoP 2015). The Individual's involvement in this process, where possible, must be clearly documented within the clinical record and considered as a part of the assessment and decision making processes.

9.7. If any form of mechanical restraint is being considered, discussion must involve a group wider than just the service and/or ward MDT and include the Group Clinical Director, Group Director of Nursing, Corporate Nurse Director (Positive and Safe Care), Regional Nursing Directors, Regional Medical Directors, CQC and other key stakeholders e.g. commissioners to assess whether it is the least restrictive option, in the best interest of the Individual, and that there were no less restrictive alternatives which were appropriate and proportionate to the risk posed.

Reviews

9.8. An Individual who is mechanically restrained should remain under continuous observation throughout the intervention. An individual's continuous observation should be reviewed in line with Cygnet's **Safe and Supportive Observation** and **Support and Engagement** Policies.

9.9. The individual should be reviewed by a nurse at intervals of no more than fifteen minutes for the duration of the period of mechanical restraint (MHA CoP 2015).

9.10. The individual should have a medical review by a registered medical practitioner at least one hour after the beginning of mechanical restraint (MHA CoP 2015).

9.11. Subsequently there should be ongoing medical reviews as follows:

- At least every four hours by a registered medical practitioner.

- Reviews should be undertaken more frequently if requested by nursing staff.
- Reviews should ensure that the individual is as comfortable as possible and should include a full evaluation of their physical and mental health condition (MHA CoP 2015).

9.12. Where devices are used solely for the individual's safety, for example safety helmets, bed rails or wheelchair lap straps, these would not necessarily need a nursing or medical review and appropriate observation levels should be detailed in the individual's care plan with clear rationale for decisions made around their use. (See **Safe Use of Bed Rails** (4-11) in relation to use of bed rails)

9.13. Procedures should be in place to enable nursing staff to summon a doctor to conduct a medical review ahead of the next scheduled review if they have concerns about the individual's condition.

9.14. If, exceptionally, a belt (or similar device) is applied to an individual's body to secure their arms or wrists and the resulting degree of immobility prevents their ability to leave an area, such as where they are unable to reach or operate door handles, this will amount to either seclusion or long-term segregation. The individual should be afforded safeguards regarding associated observation and monitoring, review procedures and care plans as identified in the **Seclusion and LTS** policy in order to ensure that their privacy and dignity are preserved. Such devices should never be used as an alternative to (or in addition to) seclusion because a suitable safe environment in which to undertake seclusion is not available (MHA CoP 2015).

9.15. It may be necessary for the individual to remain on continuous observations at arm's length (MHA CoP 2015). Within arm's length observation is the most intensive and is always a consequence of a serious psychiatric or physical issue. Care/support plans will clearly evidence multidisciplinary discussions and the decision making process which will include the ways the individual will be managed. If the plan includes "within arm's length observation" the individual will be within arm's length of a staff member at all times and in all circumstances. In some situations more than one staff member may be required to observe the individual and the reasons for this must always be documented within the care plan. It may be clinically indicated for the observations to be 2:1 or in exceptional cases more than 2:1, in a specified area which should be risk assessed and recorded in the clinical record, risk assessment and care plan.

9.16. Risk assessments should be repeated at regular intervals at every medical review as a minimum if the individual's mental state is fluctuating. However, the key issue is an open and in depth dialogue between all members of the clinical team requiring: constant review, good documentation and clear communication between all team members.

9.17. The care plan/positive behaviour support plan may also allow for less frequent medical and nursing reviews provided that the whole clinical team, the individual's family, carers and advocates are in agreement (MHA CoP 2015).

Training in Mechanical Restraint

9.18. Staff applying mechanical restraint devices should have appropriate training in their application and use.

10. STANDARD FORMS, LETTERS AND REFERENCES

This Policy

10.1. Restrictive Physical Interventions Procedures (2-08.01)
10.2. 72 Hour monitoring form (2-08.03)
10.3. Restraint and Violence Assessment (2-08.04)
10.4. Positive Behaviour Support Plan Residential (2-08.05)
10.5. Positive Behaviour Support Plan Hospitals (2-08.06)
10.6. RRN Training Standards 2019 – **click here**
10.7. RRN RRP Action Plan – kept by the Director of Nursing

Linked Policy

10.8. Positive and Safe Care Strategy
10.9. Positive and Safe Care: Reducing Restrictive Practice (2-05)
10.10. Seclusion and Long Term Segregation (2-09)
10.11. Management of Individuals Records (2-01)
10.12. Individuals Risk Assessment and Management (4-01)
10.13. Incident Reporting and Management (4-14)
- Post Incident Review (debrief) (4-14.13)

10.14. Security (Including Locked Doors) (4-10)
10.15. Medication Management (3-01)
10.16. Safe and Supportive Observation (2-06)
10.17. Support and Engagement (2-07)
10.18. Safe Use of Bed Rails (4-11)

References, guidance and further reading

10.19. NICE Guidelines:
- **Violent and aggressive behaviours in people with mental health problems (QS154)** – Quality Standard
- **Short term management of violence and aggression (NG10)**
- **Reducing the Risk of Violent and Aggressive Behaviours – a Short Guide for Registered Managers of Mental Health Services for Young People**

10.20. Restraint Reduction Network
- **Training Standards 2019,**
- The Wales Reducing Restrictive Practice Framework

10.21. Department of Health (2014)
- **Positive and Proactive Care: reducing the need for restrictive interventions**

10.22. Human Rights in a Health Care Setting: Making it Work
10.23. Mental Health Act
- **Code of Practice**

10.24. NHS Protect
- **Meeting needs and reducing distress - Guidance on the prevention and management of clinically related challenging behaviour in NHS settings**

10.25. **Transforming Care 2012**
10.26. **Mental Health Act Code of Practice 2015**

10.27. **Mental Health Units (Use of Force) Act Guidance 2021**