Keele University Teaching Trust

NHS
North Staffordshire Combined Healthcare NHS Trust

Our Ref: NG/RM/25162
Date: 2nd June 2025

Nicola Griffiths
Deputy Director of Governance
North Staffordshire Combined Healthcare NHS Trust
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Reception: 0300 123 1535

Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 2nd May 2025**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:

Please could you send me an up to date version of your Use of Force policy or Restraint policy - the policy into which you have incorporated the requirements of the Mental Health Units (Use of Force) Act 2018.

I believe this is your policy (previously and maybe currently) entitled 'Policy on the Use and Reduction of Restrictive Practice'.

Please see Appendix 1 attached.

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Nicola Griffiths
Deputy Director of Governance

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Document level: Trust
Code: R01
Issue number: 2

Policy on the Use and Reduction of Restrictive Practice

Lead executive	Chief Nursing Officer
Authors details	Reducing Restrictive Practices Lead

Type of document	Policy
Target audience	Clinical Staff
Document purpose	Information and guidance

Approving meeting	Quality Committee	Meeting date	4th June 2024
Implementation date	18th June 2021	Review date	30th June 2027

Trust documents to be read in conjunction with	
	Rapid Tranquilisation policy
	Seclusion and Long-term segregation policy

Document change history		Version	Date
What is different?	• Change to name of training (from MAPA to Safety interventions™) • Change to meeting name (From Weekly Incident review group to Learning from Patient Safety Events Group) • Change to Job role title (Director of Nursing and Quality to Chief Nurse and Medical Director to Chief medical officer)	1	1/05/24
Appendices / electronic forms			
What is the impact of change?			

Training requirements	Staff to complete Safety interventions training.

Document consultation	
Directorates	Adult and urgent care, specialist directorate
Corporate services	Reducing Restrictive practices Group
External agencies	

Financial resource implications	None

External references

1. **Department of Health (2015)** Mental Health Act, 1983. Code of Practice.

2. Department of Health (2007): Mental Capacity Act 2005, Code of Practice, HMSO, LONDON

3. DFES/DoH (2002): The use of restrictive physical interventions for staff working with children and adults who display extreme behaviour in association with learning disability and/or autistic spectrum disorder, HMSO, LONDON.

4. **NICE Quality Standard (2017):** Violent and aggressive behaviours in people with mental health problems.

5. **NICE (2015).** Violence and aggression: short term management in mental health, health and community settings.

6. Stirling and West (2006). Restrictive Interventions: a professional, ethical and legal perspective for use of physical restraint in educational, social and health care settings. IN: **Paley and Brooke (Eds).** Good Practice in Physical Interventions: a guide for staff and Managers (British Institute of Learning Disabilities).

7. Ridley J & Leitch S (2019). Restraint Reduction Network (RRN) Training Standards First edition Ethical training standards to protect human rights and minimise restrictive practices.

Monitoring compliance with the processes outlined within this document	Compliance will be monitored through review of incident reporting and staff competency

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	

– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage) – **Religion and/or Belief** (includes those with religion and /or belief and those with none) – **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No No No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	N/A	
Enter details here if applicable		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There **is no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	
There **is** specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	✓

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Career Grade Doctor				

Training Grade Doctor				
Locum medical staff				
Inpatient Registered Nurse (including staff located at Crisis care centre)				
Inpatient Non-registered Nurse				
Community Registered Nurse				
Community Non Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Completed by	Robert Sillito	Date	

CONTENTS

1. Introduction

Therapeutic environments are most effective for promoting both physical and emotional wellness and restrictive interventions should only be used in a modern, compassionate health service where there is a real possibility of harm to the person or to staff, the public or others (Department of Health (DOH), 2014). The purpose of this policy is to provide a framework to provide the development of service cultures and ways of delivering services which better meet people's needs and reduce the need for restrictive physical interventions.

It is recognised that at times some individuals by their actions can endanger their own safety and/or the safety of others. In these situations, staff may need to use restrictive physical interventions in order to safeguard the individuals for whom they care. At such times, it is expected that staff will act professionally in accordance with their level of experience and training, following local policies, professional guidance, and legal doctrine. There are many types of restrictive intervention, and this policy aims to provide general guidance to staff. It aligns to the following policies which give specific guidance to issues:

- Formal detention under the Mental Health Act (MHA)
- Seclusion
- Locked Door Policy
- Weapons Policy
- Guidelines for staff regarding the police use of CS Spray
- Personal searches
- Lone worker guidelines

2. Scope of the policy

The aim of this policy is to ensure that all staff:

- Understand their responsibilities in the use of restrictive physical interventions are trained in their use.
- Understand their responsibilities for their actions or omissions (duty of care).
- Understand the process to follow following incident of using restrictive intervention e.g., incident form, completion of debrief.

The intention of this policy is to prevent undue restriction of patient's liberties, to promote good practice and to enhance the knowledge and skills of staff working within the Trust. The emphasis of care is based on restraint reduction strategies.

2.1 Diversity and inclusion

Clinical practice must take account of diversity and inclusion. All clinicians should consider the way patients are treated, to ensure that this does not inadvertently discriminate against any groups in society based on their race, disability, gender, age, sexual orientation, religion, or belief. The Trust is committed to ensuring that people are treated as individuals with privacy, dignity, respect, and modesty. Modesty comprises a set of culturally or religiously determined values that relate to the presentation of the self to others. Care must actively always promote privacy and dignity and respect modesty.

To monitor this any protected characteristics of people subject to restrictive interventions must be gathered through the trusts incident reporting systems.

3. Framework

3.1 Restrictive interventions

The National Institute for Health and Care Excellence (NICE, 2015) define restrictive interventions as:

"Interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation".

The Mental Health Act 1983 Code of Practice (DOH, 2015) stipulates that physical restraint should be used only where other strategies such as de-escalation have proved insufficient. Physical restraint should always be used in conjunction with further efforts to de-escalate the situation. It should never be used as a punishment or in a punitive manner. Action taken must be based upon a person centered risk assessment and behavioural support planning or in an emergency, the situation and level of risk.

3.2 Definitions of specific restrictive intervention methods

3.2.1 Physical intervention

Physical holding: The use of physical holds to manage, limit or restrict an individual's ability to move during the provision of safe care or in the management of a violent episode.

Disengagement: The use of physical actions to limit, stop or disengage from harmful or injurious physical contact initiated by another during the provision of safe care or in the management of a violent episode.

3.2.2 Chemical intervention

The use of chemicals or pharmaceutical agents to alleviate, treat or manage an individual's underlying psychological or psychopathological condition or reduce the risks presented by certain behaviours.

3.2.3 Mechanical intervention

The use of splints, straps, tethers, harnesses or furniture (e.g., reclining chairs, wheelchairs, bed rails) to limit or restrict an individual's autonomy.

3.2.4 Environmental intervention

The use of locked doors, baffle handles, time out rooms, low stimulus environments, fences or gates to contain or limit an individual to or from one particular room, building or location. This could be related to legal restrictions e.g., MHA 1983 (2007).

3.2.5 Social/psychological intervention

The use of verbal instructions or commands, withdrawal procedures, social restriction (e.g., time out from positive reinforcement) to limit, interrupt or stop an individual's behaviour which is viewed as potentially harmful, undesirable or socially unacceptable

3.3 Guidelines for best practice

The following guidelines set out standards for staff to safely manage actual or potential aggression ensuring that the prevention of harm is of paramount importance. The guidance within this document is of a generic nature and promotes person centred care therefore staff must interpret accordingly and apply the principles within their various work areas.

3.3.1 Management of actual or potential aggression (Safety interventions™)

NSCHT has an ongoing programme of training in the Safe and therapeutic interventions to use (Safety interventions™) This training incorporates theoretical components including legal, ethical and professional issues, proactive management strategies and physical skill components. Each of these aspects are of equal importance and are interdependent, offering a broad continuum of care options when managing actual or potential aggression.

Throughout Safety interventions™ training the emphasis is on avoidance and de-escalation, with physical interventions being taught as a "last resort" via a 'least restrictive response model'.

Safety interventions™ is a registered trademark of the Crisis Prevention Institute (CPI) and Safety interventions™ Training is certified by BILD-ACT under the Restraint Reduction Network (RRN) Training Standards. (Ridley J & Leitch S 2019).
CPI licenses the Trust on annual basis, to teach Safety interventions™ physical interventions to internal staff and through an exception clause to legitimate others, such as informal carers. The Trust is a BILD Association of Certified Training Affiliate Organisation, this means that the Safety interventions™ training delivered to trust staff, by our certified instructors is certified against the RRN Training Standards.

All staff who have undertaken an initial Safety interventions™ training program, must attend an annual update, in order to maintain their live status on the Safety interventions™ training register.

3.4 Recognition and Prevention of Disturbed or Violent Behaviour

The primary focus when managing patients who potentially present with disturbed or violent behaviour should be the establishment of a culture which focuses on early recognition, prevention and de-escalation of potential aggression thereby minimising the risk of its occurrence.

Staff should attempt to engage and gain the confidence of patients so that they can learn to recognise potential stressful events at an early point. Thereby enabling potential

risks to be managed in a pro-active and non-physical way using diffusion, de- escalation and diversion techniques.

Continuity of staffing is a key factor in both the development of skills and consistency in managing behaviours that present risk.

Patients who are identified as being at risk of disturbed or violent behaviour should, where capacity allows, be made aware of, and provided with the opportunity to discuss their views and wishes. Any such views or wishes should be recorded in the form of an Advance Statement (Chapter 9, MHA 1983 Code of Practice, (2015)). These wishes should also be recorded in the patient's individual intervention plans.

Staff should demonstrate and encourage respect for diversity and recognise the importance of privacy and dignity in relation to the safe and therapeutic management of patients.

Staff should always see the behaviour of patients in context and not categorise behaviour as disturbed without considering the circumstances in which it occurs. Whilst past behaviour is a key factor in assessing risk it should not be assumed that a previous history of violence means that the behaviour will be repeated.

Individual risk assessment or behavioural support plans should be proactive and include primary and secondary preventative strategies. Care should be taken to ensure that there are no negative or stigmatising judgements made about certain diagnosis, behaviours or personal circumstances.

Individual person centred intervention or behavioural support plans are fundamental to the appropriate management of aggressive behaviour. Challenges can be minimised by promoting the therapeutic culture of the environment and by identifying and managing potential areas or concern/risk. Positive measures may include: -

- Empowering patients by engaging, communicating, and involving them in their own care and treatment.
- Developing a therapeutic relationship between each patient and named Nurse.
- Developing a therapeutic relationship between patient and the wider Multidisciplinary team
- Seeking patient co-operation and encouraging influence in their own care and support.
- Consideration of an appropriate patient mix and good balance of skills within the staff team.
- Encouraging patients to identify their own triggers and early warning signs for aggressive behaviour and assisting to develop individual coping strategies and de-escalation plans that are personal to the patient.

- Positive environmental factors such as patients having access to their own "space", recreation rooms, single sex areas, visitor's rooms and outside areas.

- Providing appropriate activities for all patients, including exercise and encouraging participation in activities **meaningful** to each individual.

- Ensuring that the cultural, religious, and spiritual needs of the patient have been discussed, identified and responded to.

- Ensuring that complaints or issues of concern are dealt with promptly, transparently, and fairly.

3.5 Use of physical interventions

The most common reasons for the use of restrictive physical holding (Safety interventions™) are:

- Physical assault
- Dangerous, threatening, or destructive behaviour
- Self-harm or risk of physical injury by accident
- Prolonged and serious verbal abuse, threats, disruption of the living environment
- Extreme and prolonged over activity that is likely to lead to physical exhaustion.
- Attempts to abscond (where the patient is detained under the Act).
  (Mental Health Act 1983 Code of Practice, DOH, 2015)

The use of restrictive physical holding techniques / skills will always be used as a last resort. They should not be used until all other approaches have been tried and have failed or the risk is so imminent that there is no safer alternative. Staff should balance the risks when deciding whether to physically intervene. There may also be times where, following risk assessment and individual behaviour support planning, that the proactive application of restrictive physical interventions is indicated as part of a broader plan of care. All efforts should be made to include/reflect on advance statements.

Individual characteristics aid the decision-making process relating to the use of restrictive physical interventions. The person's intent and potential to cause harm to self or others must be considered. Factors to be considered may include the person's physical ability / disability, age, gender, physical characteristics, psychological and sensory disorders. Additional factors are the circumstances (i.e., the environment) and the persons "willingness to disengage" following an incident.

Any restrictive physical holding must be both reasonable and proportional in the circumstances. The force used to be the minimum required to effectively reduce the risks of the aggressive behaviour i.e. - the least restrictive option (minimum use of force for the minimum time). All actions taken by staff should facilitate the de-escalation of the aggressive behaviour.

The purpose of the restrictive physical holding is to firstly take control of a dangerous situation and secondly to limit a person's autonomy for no longer than is necessary to reduce the likely hood for harm to self or others.

It is unsafe practice for staff to attempt to physically manage aggression on their own. If staff are alone and faced with actual or potential aggression, they should attempt to disengage from the situation and summons assistance by the most appropriate means available e.g. use of alarm systems.

Where there is only a small number of staff present, they may also consider activating appropriate alarms if they feel more staff are required to safely manage the aggressive situation. In any event staff should summon support via alarm systems if they believe that this will decrease or minimise the risks of harm.

3.6 Guidelines for physical means of managing actual or potential aggression.

The physical management of aggression will always involve a degree of risk to all parties involved. It is therefore essential that all staff discharge their duty of care in that no reasonable act or omission on their part will knowingly or negligently cause harm to the person displaying aggression, and that any action taken will ensure as far as is reasonably, the safety and wellbeing of everyone involved.

It is neither possible nor desirable to outline specific methods of restrictive physical intervention in these guidelines. However, the training and application of physical intervention skills will NEVER involve weight being applied to a person's neck, chest, or abdomen. Furthermore, the use of pain compliance should never be used.

Only staff that have completed the full Safety interventions™ course, including restrictive physical holding skills, and whose names appear on the live Safety interventions™ Register should engage in the application of restrictive physical intervention. However, in an emergency individual's who have not been trained or who have allowed their registration to lapse, may do so. However, they must act in a manner that is safe, professional, and reasonable in the circumstances to prevent harm to themselves or others. If it is identified post event that it is likely that the individual may find themselves in a comparable situation again, then they should attend Safety interventions™ training as soon as it is reasonably practicable.

It is the responsibility of the Line Manager to ensure the safety and wellbeing of patients, staff, and visitors. This responsibility will be appropriately delegated when the manager is not available. It is important that managers are aware of the capabilities of their staff in relation to restrictive physical interventions and maintain appropriate levels of training to meet the needs of the service.

3.7 Restrictive holding of children

If it is deemed necessary to physically hold a child, those staff involved must discriminate their size and weight in relation to the child, this may affect type and position of physical hold used. Wherever staff should endeavour to avoid the prone position, if this is impossible then staff must adhere to the guidance given in 3.11.

3.8 Points of good proactive practice

Proactive practice is as much to do with attitude as it is about clinical practice. It is about a willingness to actively identify and then manage risks posed by an aggressive person should they display aggressive behaviour (verbal / physical). This will involve a willingness to engage with the individual pro-actively at different levels in order to develop a good rapport.

Activities: Programmes of occupation and / or diversion may be useful in reducing boredom and frustration, both of which are key factors in aggressive behaviour. Additional activities that focus on individual coping strategies are beneficial.

Assessment plans: To support completion of assessment plans, staff will complete clinical risk assessments linked to individual behaviour support plans which highlight the appropriate measures to be taken in the event of the use of the restrictive physical interventions in the management of aggression.

Appropriate communication: It is vital that appropriate information is shared with managers, nurses and other colleagues (multi-disciplinary) about potentially aggressive individuals (patients / relatives).

Dress: Can you move freely? Maintain dignity? Do you have anything on you that could cause injury to yourself or others e.g., scissors, pens, or a tie?

Environment: The environment should be as pleasant and comfortable as possible, offering therapeutic value. This may enhance the service users experience and consequently may minimise the likelihood of an aggressive or violent incident.

- The environment should be managed and designed with consideration as to whether it may under or over stimulate an individual potentially leading to aggressive behavior.

- Dependent on the service provision consideration should be given to the security of the environment (doors, windows), and the availability of weapons (e.g., pens, vases, sharps)

- Only those staff involved in the restrictive physical intervention and required to help minimise risk and facilitate communication should be present, and if possible, remove on-lookers so as to facilitate both de-escalation and dignity.

Factors that may increase the likelihood of aggression: People who feel dis-empowered, underrepresented, frustrated, under or over stimulated and unable to effectively communicate may be more likely to exhibit aggressive behaviour.

Medication: May be used as a proactive measure as well as in a crisis intervention. As required medication, should be given as indicated by the

Responsible Medical Officer or nominated deputy, and its effects monitored closely both in regard to the ability of the medication to treat the patient / client's physical and/or mental condition and minimise their aggressive behaviour (see Policy on Rapid Tranquillisation). *The above statement only applies to those clinical areas where the use of as required medication is a viable option, this will primarily be within inpatient/residential settings.*

Relationships: The establishment and maintenance of a professional therapeutic relationship between staff and service users is a key factor in reducing aggressive behaviour or in facilitating the de-escalation of an aggressive person. Staff should always treat service users with dignity and respect.

Training: All clinical staff are required to complete clinical risk training. Through risk assessment managers should be able to identify the further training needs of their staff and arrange appropriate training ensuring that services are appropriately covered. All staff in high-risk areas identified by risk assessments will require appropriate Safety interventions™ training.

3.9 Person centred care planning

All service users who present with a risk of violent/aggressive behaviour should have person centred intervention plans that identify the level of risk, and the primary, secondary and tertiary interventions necessary to reduce the risk to an acceptable level. The intervention plan must be written by a first level nurse and agreed with the multi-disciplinary team. Involvement of the service user in the identification of trigger factors, safety plans and advance statements should always be sought. The plans must be documented, agreed, reviewed and shared across all professions, (NICE Quality Standards, 2017).

Where there is a history of violence, consider the context of this including the stressors. e.g. (person/ environment). Ensure appropriate levels of observation and engagement for service users and consider the completion of a functional analysis.

The intervention plan must include a rationale for using restrictive holding, the levels of holding to be used and the preferred position the service user should be held in, bearing in mind any physical/medical conditions which would make certain positions a higher risk.

Re-assessment and evaluation of the intervention plan should be on- going and the restrictive physical intervention removed from the plan as soon as it is practical and safe to do so.

Any plan concerning restrictive physical intervention must not be used in isolation. Plans promoting primary and secondary prevention strategies and engagement must be in operation to minimise the need for physical holding.

All incidents of the use of restrictive physical holding techniques should be

documented via the electronic incident reporting system. This includes those which are required for the administration of planned care and treatments. Any protected characteristics should also be captured.

3.10 Weapons

When dealing with a violent or potentially violent situation it is important to make visual check for weapons.

A weapon may be defined as *"any object that is made for the purpose, adapted for the purpose, or intended for the purpose of inflicting physical injury upon a person",* (Crime & Disorder Act 1956).

If a weapon is identified then withdraw, negotiate, and if necessary, call the police. REMEMBER: no staff within NSCHT will have received training in disarmament techniques and they should therefore NEVER attempt to disarm an aggressor.

Within Safety interventions™ training, advice is given about what to do if attacked with a weapon; this is distinctly different from disarming an aggressor. In such situations the initial staff response should be to "back off" and try to put some distance between you and the attacker. If this is not possible try to utilise heavy items of furniture as a barrier between yourself and the attacker e.g., bed, dining table, large sofa or armchair. Consider if it possible to isolate the attacker in an area whilst the police are summoned via 999.

3.11 Safe Practice

It is recommended that a minimum of two staff are involved in any process of physical holding. This number may have to be increased depending on the level of risk and severity of the incident.

The safety of both staff and service user are paramount therefore a sufficient number of staff should be identified to manage the incident as safely as possible. Staff should be allocated a specific task, bearing in mind that these roles may need to change during the incident.

Clear on-going communication within the team and with the service user is important, aiding de-escalation and co-ordination of the team. Therefore, it is best if only one person at a time talks to the service user and leads the team.

Fewer well-briefed staff are likely to be more effective than a large number of staff acting in an un-coordinated manner. If more staff are in attendance than are needed they should be asked to leave the immediate vicinity to facilitate both de-escalation and the maintenance of the person's dignity and privacy.

Staff should seek to reduce the risks of the situation as swiftly as possible and then manage the person's aggressive behaviour. Staff should then consider moving

the person or others to achieve a low stimulus environment, to better facilitate the process of de-escalation. REMEMBER you should only consider moving the person when it is safe to do so and you will need their co-operation. Thus, it may be necessary to ask other service users to leave the area to maintain dignity.

In extreme circumstances it may be necessary to manage the aggressive person on the floor, although a seated position is preferable, as it promotes dignity and avoids some of the risks involved in conducting physical holding on the ground, (NICE, 2015).
Any descent to the ground should be controlled and initiated by the Service User; staff should never initiate it. During the descent and when on the ground the service user's head should be protected from harm.

Normal respiratory function should not be compromised, and weight should never be applied to a person's head, neck, chest, or abdomen. A "THIRD PERSON" should always be available for communication with and observation of the service user in order to monitor the service user's physical wellbeing, (NICE, 2015).

Staff must explain to the service user the reasons for the application of restrictive physical intervention, actively seek the co-operation of the person and restore autonomy to the person as soon as it is safe to do so.

During the restrictive physical interventions staff should remain mindful of issues relating to human rights, dignity, respect, gender, race and ethnicity.

Staff should always act without malice.

NB: During all restrictive physical interventions it is imperative that the person being physically held is constantly monitored for signs of physical distress, this is particularly important when the person is held in the prone position i.e. (face down) the restraining staff should monitor breathing, skin colour, pulse rate etc., if possible a pulse oximeter should be applied this will monitor pulse rate and blood oxygen levels, an explanation of what is being done and why should be given to the service user (nursing staff need to be aware that pulse oximetry is only used to assist in good nursing observations and care). If the individual becomes physically distressed i.e., difficulty in breathing, it is essential that staff respond promptly with appropriate first aid/CPR. Where there are concerns about the patient's physical wellbeing following a period of restrictive holding, staff, with the patient's consent should utilise a pulse oximeter to assess oxygen saturation levels.

The physical/physiological profile of the individual may offer risk indicators e.g.

- History of respiratory/cardiac problems
- Obesity
- Under the influence of alcohol/drugs
- Recently eaten a large meal
- Pregnancy

The use of physical Safety interventions™ skills should only be seen as a small part of the management strategy. Staff will bring their clinical experience, professionalism, knowledge and confidence to each situation. A confident approach is likely to aid the de-escalation process.

If the restrictive physical holding continues for more than 10 minutes, staff should consider the use of rapid tranquilisation and/or seclusion (NICE, 2015). In rare situations where physical restraint lasts beyond 30 Minutes, then the Quality Improvement Lead Nurse/ Site Manager must be informed and asked to review the situation. They can then decide as to the appropriateness of continuing the physical management of the aggression.
In those services where there is an out of hours on call system, the on call manager must be informed who will then carry out the review

The RMO/Doctor or nominated deputy (whichever is appropriate) following the commencement of restrictive physical holding, should see the service user as soon as is reasonably practicable and ensure the application of appropriate medical / psychological care.

The Organisation will always support staff whose practice is compatible with this policy. *"Any reasonable action taken by an employee in good faith during a violent incident, providing appropriate professional judgments and personal behaviour were in accordance with trust and directorate policies and the law will receive the understanding, sympathy and support of the trust".* (Violence and Aggression Policy 5.19).

3.12 Action to be taken after physical intervention.

Following an event of restrictive physical interventions procedural responsibilities continue at an individual, service, and organisational level. This responsibility falls broadly under three areas: reporting, support and learning.

3.12.1 Reporting:

- All incidents involving staff regardless of setting (centre, ward, community) should be reported.

- A full account of the incident must be recorded in the person's Electronic patient record and the relevant incident forms completed - Safeguard Incident Report Form and forwarded to the Patient & Organisational Safety Dept., Weekly Incident Monitoring Group, and notification should go to the appropriate Service Line Manager/Service Head/Line Manager/Senior Nurse/Quality Improvement Lead Nurse.

- Immediately following the incident, the appropriate manager or designated senior staff member will assess the situation to identify action(s) required to reduce or prevent a recurrence of the incident and to ensure the safety of all individuals. This may include increased observation and / or discussion of the incident with the patient / client.

- The Line/Appropriate Manager must be informed of any aggressive incident as soon as is reasonably practicable, who then in conjunction with the appropriate manager and a senior staff member will review the incident and assess the need for any additional staffing immediately and in the future.

- In the event of a staff member getting injured during the physical management of aggression, appropriate medical treatment should be sought as soon as is reasonably practicable.

- In the event of an aggressive person being injured during the management of their aggression and / or from an accident a decision must be made regarding informing the patient's family. With minor injuries (cuts, bruises) these will usually be reported to relatives as soon as practicable but may with agreement of the patient and family be reported at next visit or within agreed time limits. With more serious injuries (fractures, hospitalisation) a senior staff member must inform the relatives as soon as is reasonably practicable and to do so by the most appropriate means.

- Any individual who sustains an injury because of violence has Rights under the Criminal Injuries Act to seek compensation (all necessary reporting mechanisms should be utilised to lend support to any subsequent claims). Individuals do not need permission from anyone else to bring a claim against another person who has assaulted them. Advice and assistance is available from the Local Security Management Specialist, Patient and Organisational Safety Department.

3.12.2 **Post** Incident Support:

Following an incident the Trust recognises the need for support for the service user and for staff. Ideally support should be offered to everyone involved in or by default observed the incident. Debrief should take place as soon as is possible which may need to be followed by further support as required.

The patient should always be offered the opportunity to be involved in a post incident debrief. This should occur as soon as they have recovered their composure (NICE, 2017). Although the latest NICE Quality Standards (2017) state that a doctor should be involved in patient de-brief, the Trust position is that this will initially be facilitated by a nurse but may involve a doctor if deemed to be necessary or requested by the patient. Longer term, more intensive support may be required in some scenarios. Further advice on staff support can be obtained from the Staff Counselling Service or by consulting Trust Policy.

3.12.3 Post Incident Learning:

The Trust recognises the importance of incident analysis and its role in restraint reduction. This requires clinical teams and the wider organisation to looking objectively at an incident with those involved and where appropriate the service user, to identify what worked well and what can be learned to influence and shape individual restraint reduction plans. Risk assessments should be reviewed and / or conducted, as well as Incident Investigation Forms. The multidisciplinary team should meet to discuss the incident and discuss the future management of the individual(s) involved in the aggressive incident, involving the service user where possible.

The staff team are responsible within their available resources to take all reasonable actions necessary to reduce the chance of a re-occurrence of the incident. They should consider consulting with appropriate others for assistance in this task.

Senior Manager's and Department Heads have a responsibility if the incident is seen as actually or potentially serious to forward copies of all reports / forms to the appropriate Associate Director / Professional Head/Clinical Lead, and the Patient & Organisational Safety Department. Further information can be accessed via Trust Policy

4 The use of restrictive holding for invasive/investigative treatment purposes

The use of restrictive physical interventions within services for people with learning disabilities and mental ill health is widely accepted as a possible appropriate response to incidents of severe challenging behaviour, aggression and/or violence.

However the current national guidance presents difficulties in interpretation for clinicians developing a professional framework which supports the use of physical interventions for the purpose of invasive, investigative treatment or the delivery of personal care.

Consequently, there is a danger that some service users may not receive appropriate, safe or effective medical treatment because their behaviour presents a risk to themselves, to the medical practitioner or accompanying staff.

This section of the policy has therefore been developed to help clinicians make appropriate decisions relating to the assessment and treatment outcomes for those service users who may require some level of physical support or intervention as part of their treatment plan.

4.1 Definition

The DH and DFES Joint Guidance broadly defines physical intervention as the "*use of force to control a person's behaviour*", and the Mental Capacity Act, 2005, section 6(4) states that someone is using restraint if they "*use force - or threaten to use force - to make someone do something that they are resisting, or restrict another person's freedom of movement, whether they are resisting or not*".

4.2 Framework

A medical doctor involved in the care of an individual may request for investigative/treatment purposes an invasive procedure to be performed. For example, the use of venepuncture for the purpose of obtaining a sample of blood. Provision of essential care such as personal hygiene might also be an issue.

4.3 Where a service user explicitly consents

A service user with capacity may require physical assistance or support, or may behave in a manner that presents risk to self or others. In such circumstances, clinical holding may be appropriate to support the service user during the course of the treatment. The procedure must have been discussed with the service user prior to it taking place and the patient must have provided informed consent. In such scenarios the patient can withdraw consent at any time and any clinical holding should be immediately terminated.

4.4 Where a service user lacks capacity to consent

Where a person does not have capacity to consent, and it is the view of the treating doctor that it is in the best interests of the individual to undergo the relevant procedure, it may become necessary for staff to consider the use of some form of physical holding in order that the procedure can be undertaken. The Mental Capacity Act, 2005 (Policy MHA16) authorises staff to provide care and treatment to service users who lack capacity as long as it is in their best interests. Where restraint is considered under the Mental Capacity Act it must also be a proportionate response to the likelihood of the service user suffering harm and the seriousness of that harm. The use of holding techniques can only take place once all other efforts at gaining cooperation have been explored and exhausted and should represent the least restrictive and detrimental course of action. In all instances the decision to use an invasive procedure should be based on a "best interests" decision involving the MDT and (where possible) family/carers.

The Mental Capacity Assessment, Best Interests Decision and risk assessment around the use of an invasive procedure must be documented in the individual's clinical notes.

Where there is no one to consult (other than paid staff) as part of the process of establishing Best Interests, an Independent Mental Capacity Advocate (IMCA) must be consulted where the intervention is considered to be serious medical treatment (Chapter 10 MCA Code of Practice provides a definition of serious medical treatment as it can include relatively minor treatment) Referrals should be made to the IMCA service at Assist.

4.5

Where service users are detained under the Mental Health Act and who will not or are unable to consent to venepuncture as part of their treatment where such intervention falls within the definition of *'clinical treatment'* or treatment *'ancillary or concurrent with the core treatment that the patient is receiving'* as defined in Section 145 Mental Health Act 1983 guidance should be sought via the Mental Health Act 1983, Code of Practice, 2015.

Where service users are not subject to the Mental Health Act, but intervention falls within the Section 145 definition of Medical Treatment, the need for restraint may constitute that the patient is objecting to treatment and as such consideration should be given to whether formal detention under the Mental Health Act is required.

Where the intervention does not fall within the Section 145 definition of medical treatment, or the service user does not meet the criteria for detention under the Mental Health Act for other reasons, but the use of restraint is frequent, cumulative and ongoing, it may indicate that the service user is being deprived of their liberty and may need authorisation under the Deprivation of Liberty Safeguards (See Policy MHA 18 DOLS) An example of this may be where the intervention is for an physical disorder that is unrelated to the service users mental disorder.

4.6 Duty of Care

It is the responsibility of all clinicians to avoid acts or omissions that are likely to cause harm to another person. The use of clinical holding as part of a service user's treatment plan is subject to this responsibility, as it could be argued that a failure to provide individuals with the necessary support, care or treatment they require may constitute neglect or an omission of care.

It is the responsibility of all registered practitioners to safeguard the interests and wellbeing of all patients and clients in line with their individual professional codes of practice.

Consent must be obtained for any invasive procedure and an assessment of capacity to consent may be required and regularly reviewed with an individual

where the multidisciplinary team feel that the individual has intellectual impairment. (North Staffordshire Combined Healthcare Policy and Procedure for Advance Statements and Advance Decisions to Refuse Treatment - Policy 1.55)

Information will be shared with the individual at all times. There may be a requirement to utilise alternative methods of communication with individuals where there are communication difficulties and or limited intellectual ability.

The decision made by the multidisciplinary team, in conjunction with family members/carers and/or advocates must be written in the person's clinical and nursing notes. For each instance of clinical holding an Incident Notification Form must be completed under the incident type “Clinical Incident” and cause group “Treatment/Procedure” and cause “Use of Safety interventions™ for Clinical Intervention” with a written description of the reasons for using clinical holding, listing the names of the staff involved

The decision to use clinical holding is considered to be a ‘once only’ decision. For any subsequent instance of clinical holding a further decision must be made by the multi-disciplinary team for its use unless deemed inappropriate by that team.

4.7 Best Practice

The clinical holding intervention to support invasive or investigative procedures will be planned and based on risk assessment. There must be adequate numbers of staff available for the clinical holding intervention to be safely carried out. All staff involved in clinical holding must be Safety interventions™ trained and be live on the current register. If there is uncertainty regarding either the use of clinical holding or the appropriate technique to be used, then advice should be sought from a suitably trained Safety interventions™ trainer. This will be via the Reducing Restrictive Practices team. Out of hours, the normal on call arrangements apply, although wherever possible pro- active plans should be made within normal working hours if it is apparent that an issue may arise out of hours.

5. Monitoring of Restrictive Practice within the Trust

The Learning from Patient Safety Events Group (Previously Weekly Incident Review Group) should review all reported incidents. This multidisciplinary group, which represents all service lines, meets on a weekly basis. The purpose of this group is to identify and evaluate incidents and if deemed necessary investigate them. Additionally they may offer support and assistance to individuals affected by the incident and identify priority-training needs.

A review of all incident reports involving the use of restraint is also undertaken on a weekly basis by the Reducing Restrictive Practices team. Particular attention is focussed on the length of time of physical restraint, restraint

position (particularly around the use of prone restraint), and ensuring that staff adhere to policy, training and national guidelines.

6. Safety interventions™ Live Register

In the interests of safety and good clinical practice staff who have undertaken Safety interventions™ training will require updating, and that attending such dates is each individuals own responsibility. The recommendation is that staff should attend at least one update per year. If a member of staff goes beyond 18 months without attending an update the Safety interventions™ training team will decide on an individual basis whether the staff member requires extra training.
This may include having to re-attend a 5 day Safety interventions™ Foundation Course. Those that do not attend within the specified time will not be live on the register.

It is also the responsibility of Ward/Service Managers and Associate directors of each directorate to ensure so far as is reasonably practicable that the staff they have responsibility for are trained appropriately for the area in which they work.

Staff who have attended Safety interventions™ training and whose name appears on the live Register (Learning management system located via intranet) should be able to offer advice and guidance to those staff who have not been trained or to those whose names are no longer on the register during an incident where restrictive physical interventions are required (but only qualified / currently registered with Crisis Prevention Institute trainers will teach Safety interventions™ skills).

7. Duties and responsibilities

7.1 The Trust Chief Executive through the Chief Operating Officer, Chief Medical officer and Chief Nurse has overall responsibility to ensure that processes are in place to:

- Ensure that staff are aware of this policy and adhere to its requirements.
- Ensure that appropriate resources exist to meet the requirements of this policy.

7.2 The Associate director of each Directorate are responsible for ensuring that relevant Directorate policies and procedures are in place and their effectiveness is monitored as part of the Directorate Governance Plan. They are also responsible for ensuring that all operational managers in their areas are aware of this policy, understand its requirements and support its implementation with relevant staff.

7.3 Clinical Team Managers (Ward Managers, Community Team Managers) are responsible for implementing the policy with their immediate staff and

ensuring that they adhere to the requirements of the relevant policies and procedures.

7.4 North Staffordshire Combined Healthcare NHS Trust (NSCHT) adopts the policy that all staff regardless of grade or discipline have a responsibility for the safety and well-being of service users, visitors and each other. With this in mind it is the duty of each and every member of staff to offer all reasonable assistance where and when necessary in line with their experience and training. This does not mean that all staff must become directly involved in restrictive physical interventions, but that they may be able to offer all other reasonable assistance in meeting other needs of the situation.

8 References

Department of Health (2015) Mental Health Act, 1983. Code of Practice.

Department of Health (2007): Mental Capacity Act 2005, Code of Practice, HMSO, LONDON

DFES/DoH (2002): The use of restrictive physical interventions for staff working with children and adults who display extreme behaviour in association with learning disability and/or autistic spectrum disorder, HMSO, LONDON.

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

NICE (2015). Violence and aggression: short term management in mental health, health and community settings.

Ridley J & Leitch S (2019). Restraint Reduction Network (RRN) Training Standards First edition Ethical training standards to protect human rights and minimise restrictive practices.