THE SAFE AND THERAPEUTIC MANAGEMENT OF VIOLENCE AND AGGRESSION

1. INTRODUCTION

This policy outlines the approaches that may be used to safely manage aggressive and violent behaviour within the various services provided by PiC. Each facility will set out its local policies that reflect its own specific patient / resident group within the framework of this policy.

It should be read in conjunction with:

- PiC Operational Policy – *Managing Incidents and Untoward Occurrences*
- PiC Operational Policy – *Guidelines for the Use of Rapid Tranquilisation*
- PiC Operational Policy – *Use of Handcuffs*
- PiC Operational Policy – *Assessment and Management of Clinical Risk*
- RCN Publication "Let's talk about restraint"

This policy should be implemented within the context of the PiC Values:

- Valuing people – respecting our staff, patients, their families and communities
- Caring safely – for ourselves, our patients, our customers and communities
- Working together with everyone
- Uncompromising integrity, respect and honesty
- Taking quality to the highest level

1.1 Standards

This policy reflects standards and guidelines laid down in:

NIMHE – Developing positive practice to support the safe and therapeutic management of aggression and violence in mental health inpatient settings (2004).

UKCC (now NMC) – The recognition, prevention and therapeutic management of violence in mental health care (2002).

BILD – The Code of Practice.

NICE – The short-term management of disturbed / violent behaviour in psychiatric inpatient settings and emergency departments (2005).

DH – Delivering race equality in mental health care. (The Governments response to the independent enquiry into the death of David Bennett).

GSA – Recommendations for good practice, code of professional practice and practice guidelines for training in the recognition, prevention and therapeutic management of violence.

Mental Health Act 1983 Code of Practice.

NHS Security Management Service – Promoting Safer and Therapeutic Services. (Implementing the National Syllabus in Mental and Learning Disability Services).

2. HEALTH & SAFETY EXECUTIVE DEFINITION OF VIOLENCE (1974)

The Health and Safety Executive defines violence at work as "Any incident in which an employee is threatened or assaulted by a member of the public in circumstances arising out of the course of his or her employment".

Note: This definition includes verbal abuse as well as physical.

3. PRINCIPLES

The attitude and culture of PiC staff needs to reflect an unconditional positive regard for patients who require assessment and treatment for mental health related problems within a structured therapeutic environment. It follows that patient's dignity and respect should be maintained at all times.

All clinical staff should have an understanding of the causes of violence.

Staff should have a detailed knowledge of patients' histories and risk assessments.

When approaching patients, staff will be aware of and understand the importance of cultural, spiritual and religious differences, language problems, nature and degree of cognitive impairment, an understanding of gender and physical disabilities, verbal and non-verbal communication and risks associated with physical restraint. An awareness and understanding of other communication barriers such as hearing and visual impairment is also essential.

This understanding will form the basis of prevention of violence within PiC.

In order to promote a consistent team approach to an individual patient's needs, a suitable and sufficient risk assessment needs to take place, both prior to admission and thereafter. Identified needs will be outlined within the patient's overall treatment plans, with clearly established goals and interventions. It is the responsibility of the Responsible Clinician to ensure that all risk factors are assessed and clearly documented in the patient's current clinical record.

Where potentially violent situations arise the emphasis will be on de-escalation.

If violence occurs despite de-escalation, and physical intervention is required this will be a consistent and prescribed form which treats patients and staff's safety as paramount, and lasts for the shortest possible time compatible with staff and patients health and safety.

All staff that may be involved in the management of potentially violent and aggressive patients will be offered training and support, in order to ensure the safety of patients and staff during incidents of violence and aggression, in a consistent, professional and as far as possible, therapeutic manner.

4. CAUSES OF AGGRESSION

Causes may include:

- Frustration due to poor communication, unrealistic goals etc
- Boredom and lack of environmental stimulation
- Too much stimulation, noise and general disruption
- Overcrowding
- Antagonism, aggression or provocation on the part of others (real or imagined)
- Influence of alcohol or substance abuse
- An unsuitable mix of patients
- The rewarding of undesirable behaviour by attention
- Reaction to symptoms of mental illness e.g. paranoid delusions
- Cognitive impairments
- Specific causes identified in an individualised risk assessment

5. PREVENTION OF AGGRESSION

To reduce the probability of violence, preventative measures need to be taken which may include:

- Ensuring that each patient has a comprehensive risk assessment and management plan
- Ensuring care and treatment plans are up to date and specific interventions for dealing with a patient's aggression are communicated to staff
- Treating patients with dignity and respect at all times
- Developing understanding of patients and their mental disorder
- Awareness of current mental state
- Ensuring patients activity is purposeful and varied
- Ensuring patients complaints are dealt with sensitively and effectively
- Avoidance of repeated failure, experiences or undue criticism
- Be particularly sympathetic to a patient's communication difficulties
- Teaching patients to recognise stress and ways of avoiding or reducing this
- Keeping patients fully informed of what is happening and why
- Encouraging energetic activities for younger patients
- Consistent application and monitoring of an individual programme
- Encouraging and facilitating contact with family, friends and carers
- Promoting an atmosphere that is calm and friendly
- Giving each patient a defined personal space and a secure locker if possible for safe keeping of possessions
- Deliberate promotion of an atmosphere that is calm, relaxed and friendly

- Ensuring adequate access to open space
- Organising the ward to provide quiet rooms and recreation rooms
- Ensuring access to telephone
- All staff being fully orientated to the ward and the ward routines prior to any patient contact
- Providing staff training in dealing with face to face aggression to include de-escalation and de-stimulation
- A consistent approach to patients threatening / aggressive behaviour
- Monitoring the mix of patients
- Developing nurse / patient allocation systems

6. MANAGEMENT OF VIOLENT INCIDENTS

Patients should be given the earliest opportunity to have their needs and wishes recorded in the form of an advance directive / communication. This should fit within the context of their overall care and should clearly state what intervention(s) they would and would not wish to receive. This document should be subject to periodic review and discussed with the patient. Families and/or carers views may then be taken into account within this process.

At the handover of each shift all staff should be made aware of ward dynamics and particular risks posed at that time.

If a patient becomes disturbed or agitated staff should make an immediate risk assessment and, if possible, calm the patient by the use of quiet areas and de-escalation techniques (as set out in the training section).

If the situation is not controlled by de-escalation the nurse in charge should co-ordinate the staff response which may include: summoning further assistance and as a last resort physical intervention.

Physical restraint should not occur until there are sufficient staff available and the nurse in charge has made a clear plan of action consistent with approved training methods.

Should physical restraint be required, the Nurse in Charge must ensure that a full nursing and medical review be carried out on the patient, including a physical examination, as soon as practicable. A record of the medical review should be made in the patient's case notes.

The use of physical restraint must always be a measure of last resort and should only be used for the shortest period necessary for the safe management of the incident.

Physical restraint is used to take immediate control over a dangerous situation and reduce the risk of injury to patients and staff.

The use of physical restraint should only be used by members of staff who have been trained in its use and must be in accordance with the approved training methods as set out in the PiC training guidelines.

Physical restraint may lead to the use of seclusion / observation lounges or enhanced observation. The relevant policies for these interventions should be followed.

It may be appropriate to consider offering the patient medication, including their regularly prescribed medicine, or PRN, as required medicine.

Extreme care should be taken when giving medication to highly aroused patients. See Rapid Tranquillisation Policy.

7. POST-INCIDENT REVIEW AND REPORTING

7.1 Patient Support

A process should be established to carry out a review with the patient / resident after each incident. The principal aims of this are:

- To find out if the patient has sustained any injuries, or if they have any complaints about the way in which they were managed and take appropriate action
- Allow the patient to vent their anxieties / fears
- Identify antecedents to the behaviour and possible causes
- To explain why the interventions that were applied were necessary
- To ensure that the patient does not see this as punishment but as a means to allow them to regain control of their behaviour
- To discuss alternative ways of communicating in a more socially acceptable manner
- To encourage the patient to approach staff when they feel agitated or aggressive

7.2 Supporting Other Patients – Dealing with Witnesses to a Violent Incident

If other patients or visitors have witnessed a violent incident they too may need the opportunity to talk about what they have observed, as they may be left feeling vulnerable, afraid, confused or even angry.

7.3 Staff Support

The nature of violent assaults means that not all can be prevented, and so all PiC units have in place procedures for responding to incidents. These include the immediate action needed to manage the consequences of an act of violence and also the support, follow-up and evaluation that help managers and staff to cope with and learn from the incident.

Procedures may include hospital treatment for physical injuries, debriefing, referral to Care First or longer-term support.

8. INCIDENT REPORTING DOCUMENTATION AND MONITORING

8.1 Clinical Records

All incidents of violence and aggression will be reported and recorded both in Clinical Records and, where used, Ward Reports.

8.2 Specific Documentation for Interventions Used

Records will be systematically maintained of the use of an observation lounge, enhanced observations, seclusion, medication and restraint. These will be regularly monitored and the findings presented to local SMTs and Senior Clinicians. All data is readily obtainable via the Clinical Audit Officer and established databases.

Certain incidents may demand a Serious Incident Report to be completed. This will be requested by the SMT.

The Nurse in Charge of the ward must complete a PiC Incident form.

8.3 Central Database

A central database of all incidents of restraint will be maintained within PiC head office. All incidents of violence and aggression must be brought to the attention of each hospital's SMT in order to facilitate discussion about current management approaches and possible changes required to further reduce such incidents and improve patient care.

9. POLICE INTERVENTION

Any nurse / employee who has been assaulted has the right to report the incident to the police. PiC will support any employee who decides to follow this course of action.

In some situations, such as where there is an ongoing long-term therapeutic relationship with the patient or where the injury is minor, it may not always be necessary to involve the police.

In other situations, such as where the assailant was not a patient, or where the injury is severe, a report should usually be made to the police. The SMT of the Hospital will support any member of staff who wishes to report the assault to the police.

Severity can be assessed by the requirement to make a report to the Health & Safety Executive under the Reporting of Injuries, Disease and Dangerous Occurrences Regulations 1995.

9.1 Financial Compensation

A victim of violence may have a right to financial compensation. It is normally advisable that a claim is made to the Criminal Injuries Compensation Authorities (CICA), which is a government-funded scheme to compensate those who are injured

in a violent assault. A claim is made by completing an application form, which is available from the Human Resources Department within each PiC Hospital. An application has to be sent so that it is received within two years from the date of the incident causing the injury.

The police do not necessarily have to be involved, but it is important that the usual hospital reporting systems, such as the completion of incident/accident forms are completed, and that the incident was reported to the Health & Safety Officer.

It is possible to take a private prosecution against an assailant, but such cases are difficult and are unlikely to result in any financial recompense. It is possible to take independent legal advice in such instances, but legal aid is not available for private prosecutions.

10. TRAINING AND EDUCATION

Training in the management of violent and aggressive behaviour should be made available to all personnel employed within PiC hospitals / units with direct patient contact. Training should include the following key components:

- Personal Safety Awareness to include theories of understanding violence and aggression, de-escalation skills and the use of force and the law;
- Breakaway skills;
- Physical intervention skills;
- How to support staff;
- Consistent and accurate reporting of incidents.

PiC Hospitals and units should collaborate with service users and families and carers to encompass best practice in the delivery of education and training programmes to staff in the safe and therapeutic management of aggression and violence. Where this may not be possible then an agreed service user and carers perspective should be included in education and training programmes being delivered.

PiC has a designated MDT Working Party for the co-ordination, review and training in the Management of Violent and Aggressive Behaviour.

11. FITNESS TO TAKE PART IN TRAINING

For all staff with direct patient contact, the successful completion of MVA or, in the case of staff who may come into contact with patients, Breakaway training is a condition of employment.

Staff are required to present themselves fit for training and are required to complete two MVA related medical questionnaires:

- MVA 1 – Pre-Employment / Pre-Training Health Screen
- MVA 2 – Anatomical Check List

11.1 MVA 1

This questionnaire is completed by a new employee twice: once as a pre-employment check and on the second occasion on the day of the training. This is to ensure that the person is fit prior to commencing work and also at the time the training is due to take place.

Existing employees will be asked to complete the form at least two weeks prior to the course and then again on the day of the course.

Upon the first completion of MVA 1, the form will be reviewed by the Company's Occupational Health provider. On the day of the course the form will be reviewed by the course tutor. If a health concern is raised, the employee will not be allowed to attend the course and be referred to their line manager.

11.2 MVA 2

This form should be completed once at the same time as MVA 1 during the pre-employment check for new employees, or at least two weeks prior to the course for existing employees.

This form will be reviewed by the Company's Occupational Health provider.

Staff who are undertaking Breakaway training are not required to complete MVA 2.

At Appendix B is MVA 4 which shows in flowchart form the process for the review of an existing staff member who is to undergo MVA training.

At Appendix C is MVA 5 which shows in flowchart form the process for the review of a new member of staff member who is to undergo MVA training.

Any questions arising from the use or interpretation of this process should be addressed to Central Human Resources.

APPENDIX A

TRAINING

1. INTRODUCTION

Training reflects the policy on MVA. Responsibilities for ensuring the implementation, consistency and standards of training in this area is covered by the PiC Management of Violence and Aggression Director, encompassing liaison with individual site Multi Disciplinary Teams and site Management of Violence and Aggression Tutors to ensure a consistent standard of best practice is achieved across the organisation.

The overriding principle is to maintain a safe environment for all people who may be involved in violent incidents, including patients, staff and visitors, whilst maintaining the therapeutic relationships built up with patients.

No distinction is made as between male and female staff, either in teaching context or in the operational use of the techniques. However, consideration is to be given to the gender of the patient and the gender mix of the MVA team i.e. female staff present when a female patient is being restrained.

Individual, two, then three member team approach techniques are learned and, where necessary, adapted to meet day to day needs in an operational setting and in the context of local management guidelines.

Mechanical restraints are not used within PiC for management of violence, except on rare occasions when handcuffs are used, at which time the use of the Handcuffs Policy will be adhered to.

2. THE PiC TRAINING MATRIX

The following Training Matrix outlines the training requirements for clinical and non-clinical staff. Where deviations from this training matrix are required to meet specific service requirements, these should be agreed with the PiC Management of Violence and Aggression Director and would include an analysis of the required competence and confidence of staff.

	Personal Safety Awareness & Breakaway Physical Skills	Management of Violence & Aggression	Tutor Training
Anticipated duration of course (in hours)	7.5	30	112.5
Staff with no patient contact e.g. admin & secretarial	Assessed using the PiC MVA TNA tool		
Staff with non-clinical contact e.g. reception, catering & housekeeping	Mandatory		

MDT	Mandatory	Assessed using the PiC MVA TNA tool	
Nursing staff (including Bank staff)	Mandatory	Mandatory	
MVA Tutors	Mandatory	Mandatory	Mandatory
Refreshers hours (minimum)	7.5	15	22.5
Refreshers	Annual	Annual	Annual

Optional = The local SMT should identify the staff who are required to attend a particular training course using the PiC MVA Training Needs Analysis Tool (see appendix D). The decision should be based on an individual needs analysis, best practice initiatives and local departmental risk assessments.

All staff who work in areas where they may be exposed to aggression and/or violence, or may need to become involved with physically restraining patients must undertake education and training in the recognition, prevention, de-escalation and management of aggression and violence. This should include physical intervention skills – *NIMHE Mental Health Policy Implementation Guidance – Benchmarking Tool.*

3. SUGGESTED FORMAT OF TRAINING

Personal Safety Awareness and breakaway physical skills training should be offered to employees at the induction stage of their employment.

Management of violence and aggression training should be offered to employees working in direct patient contact within 3 months of them commencing employment as set out above in the PiC Training Matrix.

The training should be delivered to a nationally recognised level, and a qualified GSA Tutor formally qualified to (A) grade status should lead the course.

4. DURATION OF TRAINING

All staff who undertake recognition, prevention, de-escalation and physical skills training must attend regular refresher / update education and training programmes.

- Programmes including physical skills annually
- Programmes not including physical skills every two years *(NIMHE – Mental Health Policy Implementation Guide)*

Theory based courses should describe theoretical, pathological and environmental explanations for aggression, they should identify and demonstrate aspects of non verbal de-escalation, verbal strategies and conflict resolution styles and reflect upon the effect of functional and dysfunctional coping strategies on peoples lives and behaviour.

Sessions relating to the understanding of the positive contributions that service users can make to prevention strategies should also be included as well as risk reduction strategies, an understanding of the application of risk management interventions and the requirements for the effective assessment of dangerousness with reference to prevention planning.

Courses should also include cultural, race, disability, sexuality, age awareness and gender specific issues and an awareness of risks associated with restraint. Such risks may include positional asphyxia / excited delirium and recognising conditions of physical and respiratory distress, signs of physical collapse, side effects of medication. The course should also explain how to take appropriate action and the need for and scope of post incident review procedures.

Staff within PiC must also be guided on the importance of identifying spheres of influence in relation to the individual, team and organisational change required to achieve a reduction in aggression and violence.

All physical skills courses should include legal, ethical and moral frameworks relating to the use of force.

Managing aggressive behaviour by physical means should only be used as a last resort and never as a matter of course. However, it can and should be used as an appropriate intervention for specific situations based upon current risk assessment when there seems to be a real possibility that significant harm would occur if intervention were withheld. Any initial attempt to restrain aggressive behaviour should, as far as the situation will allow, be non-physical.

Physical interventions should be used for the shortest period of time to bring the situation under control. They should rely on being technically sound whilst avoiding any undue stress on limbs or joints. They should be consistent with the best interests of the patient and should not rely on the infliction of pain.

Special provision should be made and clearly identified approaches adopted for pregnant women and patients with physical disabilities in the event that interventions for the management of disturbed / violent behaviour are needed.

Wherever possible, restraining patients / residents on the floor should be avoided. If, however, the floor is used then this should be for the shortest possible period of time and for the central reason of gaining control of the situation.

All courses should be designed through a needs analysis and with specific reference to the diverse patient population across PiC.

All staff completing a Management of Violence and Aggression Course to an acceptable level of competence as determined by the Course tutors, should be entered onto the Central Register of Trained Personnel in Aggression Management.

All staff completing the training that are not assessed as competent should be referred back to the MVA tutors for extra tuition until appropriate levels of competence are attained. If the individual does not attain the level of competence after having received additional tuition, they may be referred back to their line manager.

All staff on the Central Register of Trained Personnel in Aggression Management should be recalled for an update / refresher Course on at least an annual basis. A designated appropriately qualified tutor should facilitate the update Course with the same additional criteria as per a full Management of Violence and Aggression Course.

Registration of competence should be as per MVA training.

Failure to update after 12 months may lead to staff being suspended from the Central Register of Trained Personnel in Aggression Management.

There may be times when members of staff are unable to attend an annual update due to personal circumstances (sickness etc). On these occasions staff will have a period of up to 3 months on their return to work to attend an annual update otherwise a full course must be completed again.

Managers will, in consultation with the Training Departments, ensure that all nursing staff receive in-service training regarding the policies and procedures for areas covering (where applicable), Diversity, the Observation Lounge, Administration of Medicines, Cardio Pulmonary Resuscitation (CPR), Enhanced Observations, Searching Patients and Seclusion, especially when changes are made to these, as well as training related to legal and ethical aspects of care.

5. NON-PHYSICAL AND PHYSICAL INTERVENTIONS

5.1 De-escalation

This is a calming technique to be used when a patient has become, or is believed to be becoming, upset or agitated. This should be used to control the situation so that other more restrictive or intrusive forms of intervention are not necessary. In the event that intrusive / restrictive intervention are necessary, de-escalation should also continue to be used throughout the incident. De-escalation can be described as; *A method of re-directing aggressive thoughts and behaviour into a calmer personal space or the successful reduction of a patients' levels of aggression by employing psychological, non-verbal and verbal techniques, usually in a face-to-face interaction.* Stevenson 1991.

5.2 De-stimulation

This includes the use of a quiet area to enable the patient to calm himself / herself down, or to have some quiet time away from others.

5.3 Responses

Some or all of the following responses will be required from staff involved or witnessing the incident development:

(i) Immediate assessment of the danger to patients and staff
(ii) De-escalation should be used during all incidents
(iii) Disengagement (Breakaway)

(iv) Summon assistance
(v) Co-ordination of staff responding
(vi) Physical intervention to re-establish control

Staff should avoid attempting to restrain an aggressive patient or patients who are fighting, until sufficient staff are present to intervene.

“Restraint may take many forms. It may be both verbal and physical and may vary in degree from an instruction to seclusion. The purpose of restraint is:

- To take immediate control of a dangerous situation
- To contain or limit the patient’s freedom for no longer than is necessary and
- To end or reduce significantly, the danger to the patient or others.”

The most common reasons for restraint are:

- Physical assault
- Dangerous, threatening or destructive behaviour
- Non-compliance with treatment (as a last resort)
- Self-harm or risk of physical injury by accident
- Extreme or prolonged over-activity likely to lead to physical exhaustion

The use of physical restraint must always be a measure of ‘last resort’. It should only be used for the shortest period necessary for the safe management of the incident and may lead to the use of other interventions outlined above, e.g. seclusion, use of medication or enhanced observation. The relevant PiC operational policies must therefore be followed.

5.4 Restraint

Restraint can be defined as ‘the intentional restriction of a person’s voluntary movement or behaviour.’ In this context, ‘behaviour’ means planned or purposeful actions, rather than unconscious, accidental or reflex actions.

5.5 Physical Restraint

Physical restraint involves one or more members of staff holding the person, moving the person, or blocking their movement to stop them leaving.

5.6 Common Restraint

Any form of physical contact with a patient that in some way prevents their free movement can be described as common restraint. Staff who have not been trained in formal MVA techniques are entitled to use common restraint. This should only be used as a last resort and only when their safety, or the safety of others, is in jeopardy.

5.7 Passive Restraint

Passive restraint using friendly come alongs level 1 and level 2. Level 1 and level 2 holds may be described as two people simply holding a patient’s arms to walk them from A to B, or whilst sitting with the patient after an incident to allow them to calm

down whilst ventilating their feelings but still maintaining some control over the patient's movement.

5.8 Physical Interventions or Restrictive Physical Intervention

Restrictive physical interventions can be described as one part of a wider strategy in which varying degrees of force may be used as a last resort while working with people who are violent or aggressive. Physical Intervention techniques are used to ensure the safety of both patients and staff using a hierarchal response during a period of physical aggression and should be used only by those members of staff fully trained in its use.

5.9 Mechanical Restraint

Mechanical restraint can described as; the application and use of materials or therapeutic aids such as: belts, helmets, clothing, straps, cuffs, splints and specialised equipment designed to **significantly** restrict the free movement of an individual, with the intention of preventing injury; as a result of behaviour that poses significant and proportionate risk to the individual of serious long term harm or immediate injury.

Mechanical devices may be:

- Partial in that it significantly impairs the free movement of a limb

Or

- Total in that the person may be unable to freely walk or stand as a result of the application of the restraint.'

5.10 The Use of Mechanical Restraint within PiC

The use of mechanical restraint within PiC must be transparent and therapeutic. Its use must be clearly justified and should be considered only if deemed reasonable in those particular circumstances. Any decision to use mechanical restraint must be considered both a necessary and proportionate response to the risk of threat or likelihood of harm or injury posed.

PiC only authorises the use of mechanical restraint of a patient in extreme, exceptional or life-threatening circumstances.

The use of mechanical restraints must be based on the findings of a behavioural risk assessment, following a careful individual patient and localised site risk review process. Any PiC site that is considering the use of a mechanical restraint device must in the first instance develop a local policy. This policy must be approved by the PIC Independent Review Panel.

Following a local site risk review process all use of mechanical restraints must be approved by the PIC Independent Review Panel which comprises of:

- PiC Medical Director
- PiC Director of Policy and Regulation
- Management of Violence and Aggression Director PIC
- PiC Legal

In addition, prior to any use of mechanical restraint the following bodies need to be fully informed in writing of the proposed care plan and rationale:

- The regulatory body (CQC/HIW/HIS) – Local regulatory Inspector/representative should be informed and kept fully up to date pre and post usage and invited to meet with the patient and their clinical team to review proposal.
- It should also be considered good practice within PiC for the patients local MHA Advisor to be informed and kept up to date pre and post usage and invited to meet with the patient and their clinical team to review proposal.
- Consideration should also be given to informing the local safeguarding adults team of the proposal.

The use of mechanical restraint should never be used for informal patients. It is the expectation of PiC that if an informal patient requires any form of restraint then a review of whether there is a need for the patient to be detained under the Mental Health Act should be considered.
For further information regarding approaches, using a mechanical device for the purpose of restraint, care planning, review, advice and training please see Appendix E below

5.11 Enhanced Observation Levels

It may be appropriate dependant on the nature of the aggressive incident and it's focus, to consider nursing the patient under close supervision. Please refer to the Enhanced Observation Policy.

5.12 Observation Lounge

Please refer to Use of Ward Observation Lounge Policy. (Reference only for units which have observation lounges and policies and procedures governing these).

5.13 Seclusion

Please refer to PiC Operational Policy – *Care of Patients in Seclusion and Longer Term Segregation*.

5.14 Weapons

PiC DO NOT routinely train staff on the disarming of patients. All staff are advised as a first part to dynamically risk assess the situation and not to attempt to disarm patients who pose a threat to others through their possession of a weapon or item, which could be potentially used as a weapon. Where a potential or actual weapon is produced and staff or others are threatened, then staff should aim to retreat to a safe distance outside of the patients reach to where they believe they are safe from immediate harm and can communicate with the patient and further assess the situation. If attempts to verbally persuade the patient to relinquish their weapon are unsuccessful, then staff should try to isolate and contain the patient ensuring the safety of themselves and all others. This may be behind a locked door. The person in charge of the hospital or the SMT person on call should be contacted and will attend

the Unit to offer guidance and support and will make any decision on calling for assistance from the police. All wards / units must have an intervention plan, and a surrender plan that addresses the potential for weapons being produced. The following options may be taken based on a dynamic risk assessment of the situation and taking into account a hierarchy of response and the various legal requirements.

- Isolate and contain the aggressor
- Negotiate a disarm
- Devise an intervention plan
- Devise a surrender plan
- Consider physical intervention (only as an extreme last resort)
- Involve the police
- Action to prevent immediate threat to life

If the police are contacted and attend the person in charge of the hospital or the SMT person on call will liaise with them and agree any action to be taken. All such events will be treated as a serious incident (refer to PiC Operational Policy – *Managing Incidents and Untoward Occurrences*).

5.15 Incident Management

Clinical team members who were not included in the actual incident should agree decisions made regarding incident management of the patient e.g. seclusion / de-escalation levels / medication.

5.16 Recording

Records will be written as soon as possible after the incident and will include the time of the incident, who was involved, the action taken and by whom, what interventions (the different levels of holds) occurred and why, who was notified / involved and what the outcome of the incident was. A PiC Incident Form will be used to record the incident and any injuries. During a potential incident it may be necessary to complete internal reports as and when events occur, which will ensure valuable information is not lost during the recording process.

6. IMMEDIATE RESPONSE

In the case of all violent incidents the following procedures should apply:

- Any member of staff that has been injured in a violent incident should be assessed by a qualified first aider and any emergency treatment given as per the hospital's 'First Aid Policy'.
- If the member of staff concerned appears to have sustained a bone related or other serious injury, arrangements **must** be made for them to be taken to nearest Accident & Emergency Department. The Human Resources Manager and Line Manager must be informed immediately so that the appropriate arrangements can be made. At weekends, bank holidays and outside of normal office hours the Senior Nurse on call must be informed. If necessary, arrangements will also be made for the member of staff to be taken home.

- A PiC incident report must **always** be completed by the nurse-in-charge of the ward at the time of the incident occurring. Any first aid administered and subsequent actions must be recorded on this form.
- The Health & Safety Officer must always be informed of any incident so that details can be entered into the staff injuries book. Any details of an injury that falls within the criteria of RIDDOR (see policy on Incident / Accident reporting) must be reported to the Health & Safety Officer at the earliest opportunity who will take any necessary further action.

7. CARE OF STAFF AFTER A VIOLENT INCIDENT

Victims of violence are likely to experience a wide range of emotions immediately following an incident. They may say that they feel 'fine' and that they are able to continue work.

It is important to note that following an attack victims enter what is known as a 'crisis phase', where they may feel shocked and numb.

However, as their adrenaline level decreases so physical and mental exhaustion takes over. It is then that they are likely to feel very upset and angry about what happened. The crisis phase may last for up to about 90 minutes (it varies from person to person).

If the incident has occurred towards the end of their shift the staff member may be advised **not** to drive home.

The victim of violence should be helped to complete the relevant documentation by another member of staff, as having to recall the details of an attack can often be very upsetting or distressing.

Even if the incident is out of normal working hours the nurse or injured person will need sensitive de-briefing from a more senior staff member.

It is vital that the nurse or injured person feels supported by the Senior Staff member who has the authority to arrange for them to take time off, for example or sick or special leave if necessary.

All the staff involved in the incident should be given the opportunity to talk about the incident and the way that it was managed before they return to their own work areas (see paragraph 8 below). The most practical approach is to gather those staff that were involved to talk about what happened with a 'neutral' person who can facilitate the group.

It is not always possible to wait until the end of a shift to arrange this, as staff may wish to rush home without having had the opportunity to talk to someone.

In such instances the appropriate Senior Nurse on call should be contacted so that they can arrange for extra staff to be bought to the ward so that a 'de-briefing' session may take place, as soon as possible. It is important that each person involved is able to say what they feel about the way the incident was handled.

Each person should be encouraged to speak openly about his or her role before, during, and after the incident and relate this to how they are currently feeling. PiC also provides a 24-hour telephone counselling service to all its employees – Care First 0800 174319.

8. DEBRIEFING AND SUPPORT – THE SPECIFICS TO BE COVERED

All staff and patients involved in the incident should be considered for de-briefing. There should be discussion on:

- What happened
- Any trigger factors
- Various people's roles in the incident
- How they feel now
- How they might feel in the next few days
- What can be done about it

It is not enough to provide 'first aid' support at the time of a violent incident, without any follow up support. Staff must also receive continued support when they return to work after a violent incident. The individual's line manager must look out for any residual effects that the incident may be having such as difficulty in returning to work, avoidance of the patient concerned, a tendency for work performance to decline, outward signs of stress / depression, increased sickness.

PiC can offer a number of continued avenues to staff that feel traumatised following a violent incident, which include:

- A confidential telephone counselling service to all employees offered by Care First
- Support / advice from other disciplines in the hospital
- The individual's line manager, or the Human Resources Manager may refer them for counselling to an external and confidential counselling service
- The individual may themselves access the hospital's Occupational Health Service

Should a victim wish to pursue criminal proceedings, the final decision will be made by the police and the Crown Prosecution Service.

Patients who are perpetuators of violence may feel shaken and upset following the incident. It may be appropriate that they are given the opportunity to talk about the incident from their perspective. Whether such discussions take place with the hospital staff or the police will depend on the cause and nature of the incident and all the circumstances of the case.

In certain situations the patient's removal into custody by the police may be the most appropriate immediate response. Violence should not be excused but can often be explained.

It is important to remember that where physical restraint is used to control a patient, this may awaken painful memories for them if they have been victims of violence, physical or sexual abuse in the past. If a patient has experienced any of these traumas then they are likely to be extremely angry, afraid and hurt following the incident and they will need sensitive management with plenty of opportunity to talk about how they feel.

Physical restraint is invasive and frightening for many people although for some it can be a welcome relief when they feel unable to contain their emotions any longer. The person who is restrained may feel disappointed and resentful towards those restraining them. Afterwards, this needs to be handled sensitively by acknowledging the patient's feelings and allowing them to talk things through, preferably with the person who has the most effective relationship with them (usually their named nurse).

The individual may also feel that their rights have been infringed. If they feel aggrieved then they must be given the opportunity and support to make a formal complaint via the hospital's complaints system. (For further details refer to policy on Complaints).

9. LEGAL POSITION

Although often non specific, managing aggression is enveloped in many guidelines, for example, Health and Safety at Work 1974, Mental Health Act 1983 Code of Practice and Criminal Law Act 1967.

Paterson et al (1997) state that the management and treatment of individuals who present with violence requires practitioners to understand how the concept of reasonable force will apply in their particular area, and cite Gostin (1986) who states that for the application of force and/or restriction of liberty to be legitimate, two principle criteria must be met:

(i) A legitimate reason to use force or restrict the individual's liberty must exist; and
(ii) The force and/or restriction used must be demonstrably reasonable.

The over-riding principle here is that there must be no alternative to the use of force.
Hoggett (1986) describes 5 principle categories, which may have relevance to professional practice:

(i) The prevention of a crime

A person may use such force as is reasonable in the circumstances in the prevention of a crime or in effecting or assisting in the lawful arrest of offenders or of person unlawfully at large. English Criminal Law Act 1967.

(ii) The prevention of a breach of the peace

Lyon (1994) defined a breach of the peace as a situation where harm is done or is likely to be done to a person or in his/her presence, to his/her property; or harm is feared through an affray, riot, assault or other disturbances.

(iii) Self defence

The law imposes a duty on a potential victim to retreat and escape and it is only where no opportunity to disengage is available that self-defence is likely to be considered legitimate (Martin, 1990).

(iv) The restraint of those covered under the terms of mental disorder, used in the Mental Health Act 1983 and the Code of Practice

Under common law, power exists to detain the insane where their behaviour places their own or others' safety at risk (Lyon, 1994; Hogger, 1990).

(v) Exercise of statutory powers / duties

In certain contexts the authority to use force may be derived from specific legislation such as the Mental Health Act 1983.

Specific guidance in relation to the use of restraint is also provided by Judge Ritchie, in the case of crime of a case relating to the introduction of formal full physical interventions training for staff within special hospitals, which applies to our own clinical practice here at PiC's hospitals / units.

Specific guidance is provided for staff within mental health services on the management of patients presenting particular problems (Mental Health Act 1983 Code of Practice, Chapter 15).

(vi) PiC and the use of force

PiC staff must act in accordance with the law at all times when force is to be used to either breakaway or physically intervene into a situation. A legitimate reason to use force must exist, it must be a reason considered legitimate by law.

All PiC staff members have a legal obligation and duty towards the patients they care for and for the staff members that they work alongside, as failure to act appropriately when required may pose moral, legal and ethical accountability.

The consequences of inaction i.e. failure to intervene may lead to failure in moral, ethical and legal duty of care, a civil offence – Negligence or Criminal offence, Omission amounting to negligence.

The decision on whether or not to use force is down to the professional judgement of the staff member concerned and should always depend on the individual circumstances.

It is unlawful to use force as a punishment. Any force used must be deemed reasonable in those particular circumstances.

Reasonable Force can be determined by two main factors, these being *"Necessity"* this is related to the term "*honestly held belief*", the person (s) applying the use of force firmly believes that failure to do so will result in a greater degree of damage to self or others and *"Proportionality"*"this being what is reasonably proportionate to the amount of harm likely to be suffered if no forcible intervention was made. English Criminal Law Act 1967, Section 3.1.

PiC staff are provided with training in the management of violence and aggression to include theoretical and physical application skills. Any member of staff identified as

working outside of this guidance, not utilising the appropriate physical skills as taught in training or using unreasonable force will be investigated.

The possible consequence of being found to have used practises outside of the training syllabus or unreasonable force could be disciplinary action, a professional misconduct hearing or dismissal.

The legal consequences of being found to have used inappropriate practice or unreasonable force could lead to being convicted of a criminal offence – e.g. assault, a breach of the Mental Health Act, a breach of the Human Rights Act or a civil offence – e.g. assault, wrongful detention, and negligence.

10. EDUCATION AND TRAINING – TRAINERS

PiC staff that wish to become tutors must have extensive knowledge and understanding of the challenges and implications within their individual client based clinical practice. They must also be able to demonstrate a high level of competence relating to therapeutic relationships, theoretical and physical components of managing violence and aggression and have a good working based knowledge of PiC's policies and procedures, which reference any issues of the above.

All tutors must have attended a recognised General Services Association (GSA) train the trainer programme, a 3-week intensive tutors course for the Recognition, Prevention and Therapeutic Management of Violence and Aggression and been assessed as competent via an external validation process.

All tutors must attend a recognised 3-day annual GSA update, which incorporates a reassessment of the tutor's competencies to practice.

All tutors must have extensive knowledge and understanding of the challenges and implications for clinical practice in mental health service provision. This should be demonstrated via a portfolio of evidence or a relevant professional qualification (health / social care / teaching).

All tutors must have a recognised teaching or assessment qualification e.g. BEd., Cert. Ed., PGCE, C&G 7307/7407 or equivalent PTLLS/CTLLS/DTLLS, ENB 998, or student assessor course developed and delivered by local academic institutions. Where this is not the case, then it should be achieved within two years as part of their Continuous Professional Development.

All tutors must have a recognised 3-day First Aid at Work qualification.

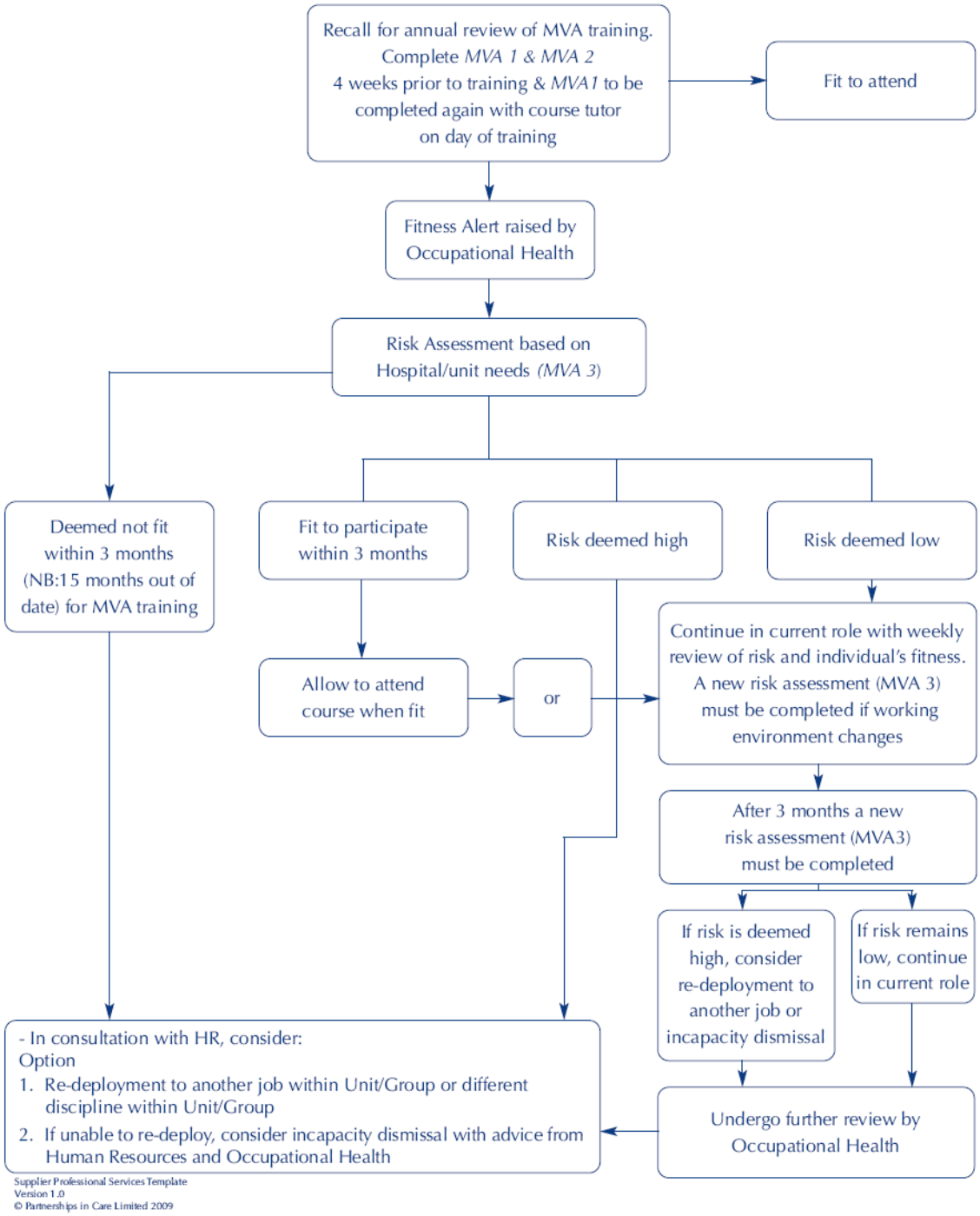
Tutors remain professionally accountable for what they teach and its influence on practice. They must promote the highest standards of professionalism to those whom they teach. Trainers need to remain clinically up-to-date and clinically credible.

All tutors must maintain a portfolio of evidence to support Continuous Professional Development and life long learning. The PiC Management of Violence and Aggression Director will review this on an annual basis for PiC.

APPENDIX B

Partnerships in care
Changing lives for the better

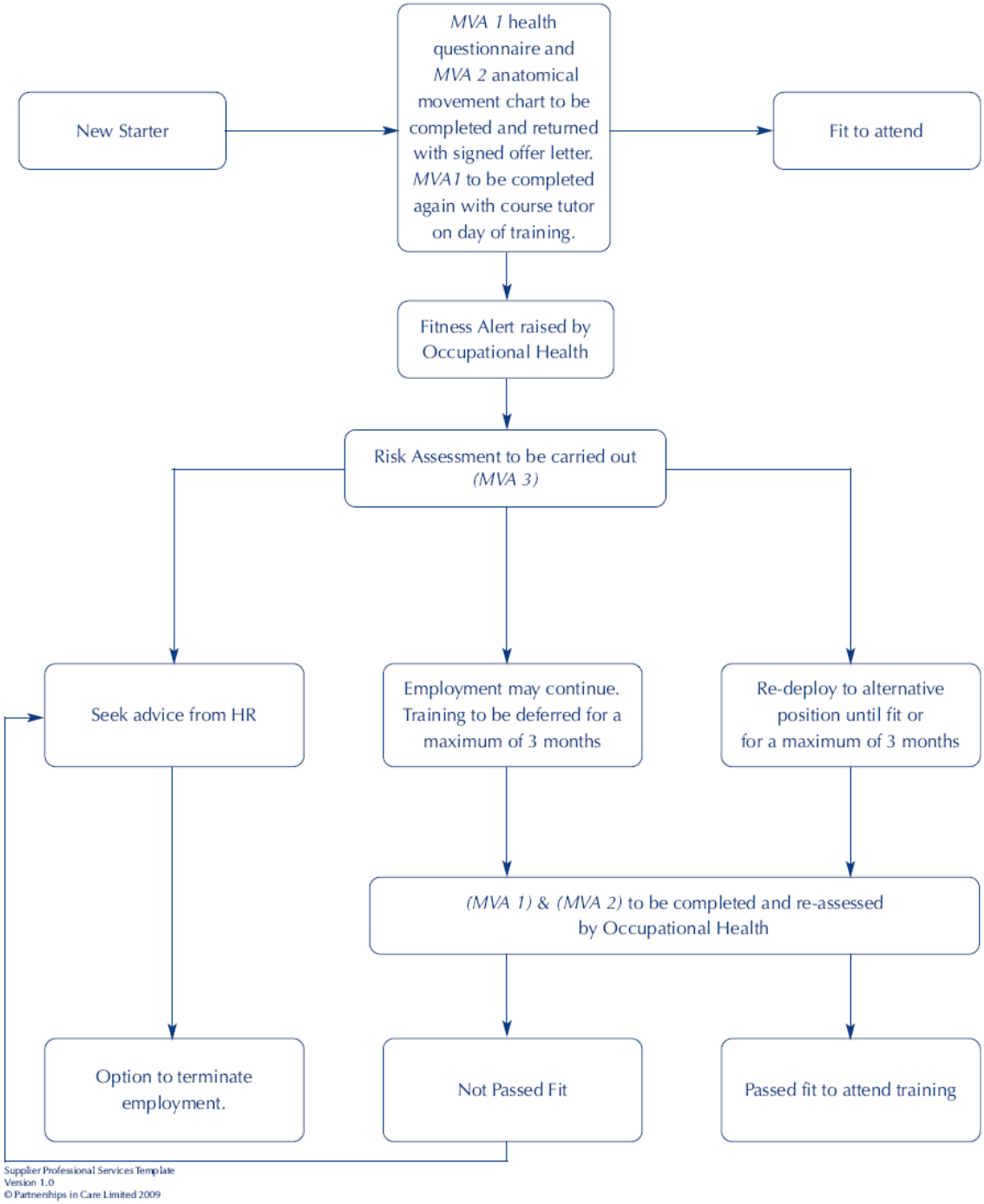
MVA 4
Management Of Violence & Aggression
EXISTING STAFF MEMBER who cares for or has regular contact with patients



APPENDIX C

Partnerships in care
Changing lives for the better

MVA 5
Management of Violence and Aggression
NEW STAFF MEMBER – who cares for or has regular contact with patients



Supplier Professional Services Template
Version 1.0

APPENDIX D

PiC MVA TRAINING NEEDS ANALYSIS

Historically within PiC there has not been a systematic approach to identifying staff in need of differing levels of MVA training.

Training profiles currently in use in our hospitals and units show a wide variation in the training profiles of different professionals, without obvious rationale or risk assessment.

The PiC MVA Director, alongside the Clinical Governance Group, agree that a comprehensive **Training Needs Analysis** should be carried out to determine the level and depth of training that the organisation should be providing to individuals, based on the risk presented within their roles. This risk assessment will help determine what level of theoretical and physical skills training is required.

NICE Clinical Guideline 25: *'The short term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments' recommends that*:

'All service providers should have a policy for training employees in relation to the short- term management of disturbed / violent behaviour. This policy should specify who will receive what level of training (based on risk assessment), how often they will be trained, and also outline the techniques in which they will be trained.

All staff whose need is determined by risk assessment should receive ongoing competency training to recognise anger, potential aggression, antecedents and risk factors of disturbed / violent behaviour, and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalation or coping with disturbed / violent behaviour. (NICE 2005)'

The Best Practice Guidance Specification for Adult Medium Secure Services states that:

'The provider should ensure that all staff are trained in the management of aggression and violence' (standard C8, DH 2007)'

This paper offers a risk assessment tool which considers four factors to assist in the prediction of the risk of aggression or violence potentially faced by staff, by considering:

- **Occupation – work role**
- **Work area – degree to which staff are directly involved with patients, in what service**
- **Exposure – degree of patient contact**
- **Expected intervention – from calling for help, breakaway through to physical restraint**

Each risk factor can be rated from 1 to 4: **1** = least likely **4** = most likely

The training matrix / traffic light system offers levels of training to be provided based on the risk assessment – represented as High, Moderate, Medium and Low.

Each Service, whether Open, Low or Medium Secure, should carry out individual occupation risk assessments.

Occupation should be rated as:
1 Lowest level of patient contact / care
2 Moderate level of patient contact / care
3 Medium level of patient contact / care
4 Highest level of patient contact / care

1 = least likely **4** = most likely

Section A – Occupation

Identify the variable by circling one score beside the category most appropriate

Admin / Secretarial / Academic / Teaching (Minimal patient contact)	**1**	**2**	**3**	**4**
Administration – Ward Clerk / Ward Secretary / Ward Based	**1**	**2**	**3**	**4**
Administration – Manager	**1**	**2**	**3**	**4**
Hotel Services ward based	**1**	**2**	**3**	**4**
Hotel Services non-ward based	**1**	**2**	**3**	**4**
Catering	**1**	**2**	**3**	**4**
Maintenance staff	**1**	**2**	**3**	**4**
Estates staff	**1**	**2**	**3**	**4**
Facilities Manager	**1**	**2**	**3**	**4**
Hairdressers or like	**1**	**2**	**3**	**4**
Locum Doctors	**1**	**2**	**3**	**4**
Psychiatrist	**1**	**2**	**3**	**4**
Associate Specialist	**1**	**2**	**3**	**4**
Occupational Therapy & Assistants	**1**	**2**	**3**	**4**
Technical Instructor	**1**	**2**	**3**	**4**
Education Assistant	**1**	**2**	**3**	**4**
Teachers	**1**	**2**	**3**	**4**
Physical Education (gym)	**1**	**2**	**3**	**4**
Physiotherapist	**1**	**2**	**3**	**4**
Physiotherapy Assistant	**1**	**2**	**3**	**4**
Registered Nurse	**1**	**2**	**3**	**4**
Registered Nurse / Other Professional – clinical managerial	**1**	**2**	**3**	**4**
Rehabilitation / Healthcare Assistant	**1**	**2**	**3**	**4**
Psychologist	**1**	**2**	**3**	**4**
Assistant Psychologist	**1**	**2**	**3**	**4**
Occupational Health Nurse	**1**	**2**	**3**	**4**
Practice Nurse / Physical Healthcare assistant	**1**	**2**	**3**	**4**
Dentist	**1**	**2**	**3**	**4**
Chiropodist	**1**	**2**	**3**	**4**
GP	**1**	**2**	**3**	**4**
Dietetics	**1**	**2**	**3**	**4**
Speech, Art and Language Therapist	**1**	**2**	**3**	**4**

Social Worker	1	2	3	4
Social Work Assistant	1	2	3	4
Student Clinician (any profession)	1	2	3	4
Registered Nurse – Bank	1	2	3	4
Healthcare Assistant – Bank	1	2	3	4
Human Resources staff	1	2	3	4
Senior Managers – limited patient contact	1	2	3	4
Pharmacy staff	1	2	3	4
Security	1	2	3	4
Advocacy or Volunteer	1	2	3	4
Chaplaincy	1	2	3	4
Finance	1	2	3	4
Health & Safety staff	1	2	3	4
Agency Staff – Clinical	1	2	3	4
Agency Staff – Non Clinical	1	2	3	4

Section B – Work Area

Office, Pharmacy, Stores, Systems	1
Reception, patients, library, ward visits – always escorted	2
Mental Health / Learning Disability ward	
- visit to carry out tasks, sessions	3
- Ward based	4

Section C – Exposure

No patient contact	1
Contact with patients, always accompanied, to carry out tasks	2
Some patient contact (less than 5 hours per week)	3
Regular prolonged, direct contact	4

Section D – Expected intervention by staff

Summon assistance	1
De-escalation	2
De-escalation and/or escape	3
De-escalation, escape, and/or physical restraint	4

Total Score

Sum of sections A, B, C and D for each category of staff ☐

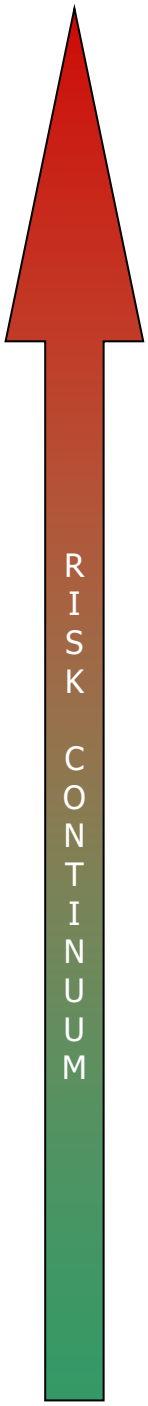
Risk Categorisation

The total score will indicate one of four categories:

Low Risk - **Score 0 – 4**
Medium Risk - **Score 5 – 8**
Moderate Risk - **Score 9 – 12**
High Risk - **Score 13 – 16**

Rationale for the Different Levels of Mandatory MVA Training

Decisions regarding levels of MVA Training to be undertaken by staff, are governed by risk assessment processes. This process coincides with a traffic light system of need. Green equates to least risk, hence the least intensive course (adapted from Delaney J 2004).



Clinical Staff – High 13-16
Staff working with clients on a clinical basis in areas where restraint has been deemed necessary, due to levels of Violence and Aggression or incidents with intensity sufficient to require restraint techniques. These staff also require breakaway techniques so that in the event of being in a room alone with a client they can ensure their own safety.

All MSU staff should be risk assessed for the highest level of training, particularly so that a representative percentage of staff from various disciplines are trained in restraint to act as part of an emergency response team.

1 day Personal Safety Course & 4 day MVA Course (3 day Annual Update)

Clinical Staff – Moderate 9-12
Staff working with clients on a clinical basis in areas where full restraint is less likely, and lower level interventions are deemed appropriate.

There may be some level of risk however, and staff should be risk assessed for the highest level of training, particularly so that a representative percentage of staff from various disciplines are trained in restraint to act as part of a rapid response team.

1 day Personal Safety Course & 4 day MVA Course (3 day Annual Update)

Clinical / Non Clinical Staff – Medium 5-8
Staff who spend time in ward areas, who may occasionally have unsupervised patient contact, in areas where the level of aggression has been a identified as a risk. (Domestic/Housekeeping staff, some therapists).

1 day Personal Safety Course (1 day Annual Update)

Non Clinical Staff – Low 0-4
People who enter into client areas, for work reasons, such as porters, domestics, ward clerks, workmen etc without a direct clinical relationship with clients.

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

1 day Personal Safety Course (1 day Annual Update)

APPENDIX E

The Use of Mechanical Restraint within PiC

Approaches

It is proposed that the use of a mechanical device as part of a proactive and preventative behavioural approach is applied within the following approaches:

Level 1

- **Advanced planning as part of a behavioural support strategy**

The development of an individual management plan based on the results of a functional assessment, which has been:

a. Risk assessed and contains short term and long term goals in behaviour reduction/prevention
b. Support
c. De-escalation
d. Reactive management.

The aim of the individual management plan will be to reduce and ultimately eliminate the use of any mechanical device via a functional analysis, the development of an individualised management of aggression positive support/care plan.

Level 2

- **To reduce risk to the individual from their environment as a result of their behaviour which is judged to be of risk to themselves in cases where the person appears to have no control over that behaviour**

This may mean the application of a mechanical device as a medium/ long term approach and in some very rare circumstances form part of a lifetime solution, when the individual's behaviour results from a biological stereotype or phenotype and cannot be managed in less restrictive ways.

Using a Mechanical Device For The Purpose Of Restraint

The following checklist should be used as a guide prior to considering the use of any mechanical restraint device:

1) Is there any alternative way of preventing the behaviours which are of concern? In comparison to other options, including the use of a restrictive physical intervention (RPI).
2) What is the social validity for the use of the restraint device? For example would the use of MVA increase the health risk to the person in the immediate or long term or would the restrictive physical intervention in itself act to reinforce the behaviour and create dependency.

3) Has a full and detailed behavioural risk assessment been conducted and is the response judged to be proportionate to the level of risk identified?
4) How will the person be supported when they are wearing the device? Are there any sensory issues which may affect the use of the equipment in relation to the individual?
5) What risks does the mechanical restraint pose to the patient? As a high risk intervention it may not be appropriate the person be left alone when wearing it?
6) Does the patient consent to the use of the mechanical restraint? Have the views of patient/and/or carer/relative (where appropriate) been sought and taken into consideration?
7) How will the device be applied and used? The practicalities of use and the ease with which it may be applied must be considered, particularly if the behaviour places staff at risk.
8) How will staff be supported and trained in the application of the device and will resources be identified to support this?
9) Is the mechanical restraint non-reinforcing in the context it is being used to restrict or prevent the behaviour?
10) Does the individual management plan identify how the individual will receive positive contacts and reinforcers at times when the restraint is not in use?
11) How will the restraint be phased out and what timescales are the team working towards?
12) Is there a robust system of recording to audit the use of the intervention? Consider any issues to protect the rights of the patient and references to advocacy and what cross references can be made to protection of vulnerable adult procedures.
13) How will the use of the device be monitored and what cross references can be made to vulnerable adult procedures to ensure the rights of the individual are protected?

Care Plan

If mechanical restraint is being considered, a draft care plan should be sent to the PiC Independent Review Panel for approval. The plan must set out why the use of mechanical restraint is necessary and proportionate to the identified risk of harm and include the following:

1. The background of the patient including the current clinical and risk issues
2. The capacity of the patient to consent to the use of the Mechanical restraint device and if the patient does not consent
3. The reasons that the mechanical restraint is necessary including incidents that have led to the use of mechanical restraints being considered and other options explored that were not viable
4. The type of mechanical restraint device that is proposed
5. The aims of the use of mechanical restraints and what goals there are for the patient
6. The timescale proposed and how the use of the mechanical restraints will be discontinued

7. The physical risks to the patient posed by the use of the particular Mechanical restraint device
8. The risk presented by the patient's particular mental disorder
9. The recommendations/steps can be taken to reduce or negate any such risks
10. The level and type observations for the patient whilst the Mechanical restraint device is in situ
11. The frequencies of physical medical reviews that are to be carried out on the patient.
12. The proposed treatment plan including how and when the patient can participate in :
    (a) Normal day-to-day activities such as hygiene, sleeping eating etc…
    (b) Activities and/or therapeutic engagement.
13. A protocol for the use of the mechanical restraint device including any specific requirements for health and safety measures required (e.g. staff to carry keys to release the patient immediately with a spare set of keys available at all times). This should also include any health and safety checks required and the frequency of those checks
14. Requirements staff training and any risk to the staff in implementing the use of the Mechanical restraint device
15. Proposal for daily monitoring of the use of the Mechanical restraint device
16. The mechanism for review including audit by the SMT

The care plan must be submitted and express approval given by PiC Independent Review Panel before the use of the mechanical restraint device can be implemented.

The patient's consent to the care plan should be sought and their views recorded. If the patient does not consent their views must be recorded and staff must ensure that the use of the mechanical restraint device does not prevent them seeking advice on the issues of the mechanical restraint device being utilised.

Where appropriate, the Nearest Relative should be consulted about the care plan, the use of the mechanical restraint device and their views recorded.

The regulatory body Inspectors or representatives should be informed of the use of the Mechanical restraint device, the care plan in place and invited to attend the unit to visit the patient.

Review

Regular reviews of the appropriateness and necessity of continued use of mechanical restraint must be conducted and the welfare of the patient kept under constant review.

A fit for purpose review of the mechanical restraint device itself must be carried out daily and recorded. This must also include cleanliness and hygiene of the mechanical restraint device in use.

The express permission of PiC Independent Review Panel is required to implement the use of a mechanical restraint device which has been agreed.

A doctor and a member of the senior nursing team are required to review the use of the mechanical restraint device daily as a minimum, inclusive of a full care plan review.

The use of the mechanical restraint device should be discontinued immediately if any review finds it to be unnecessary. The care plan must be placed in the patient records in care notes and reviewed as necessary by the SMT but, as a minimum every 7 days and this should include a full audit of the use of the mechanical restraint device.

It will be important to audit the pre and post mechanical restraint periods to ensure that the target behaviour does not increase at these times.

Advice and Training

The Council of Europe recommendations regarding the use of restraint require that staff likely to be involved in the use of any form of restraint receive appropriate training. This includes

- The safe use of any device to affect restraint protecting the dignity, human rights and fundamental freedoms of persons with mental disorder; understanding how to prevent and control violence/self-injurious behaviour to avoid the use of restraint or seclusion.

- Limited circumstances in which different methods of restraint or seclusion may be justified, taking into account the benefits and risks entailed, and the correct application of such measures.

- Guidance and training on the use of mechanical restraint devices will be offered by the Management of Violence and Aggression Director for PiC. Clinically based staff applying mechanical restraint devices must have had the appropriate training and been assessed as competent in their use.

- Mechanical restraint devices used across PiC must be of a type agreed at local level and approved by the Management of Violence and Aggression Director for PiC.

- Only qualified and currently practicing MVA tutors will be trained as mechanical restraint tutors within PiC. Tutors will be required to complete a recognised tutors course for the teaching of others in the safe procedures and application of such devices. Following this, tutors must attend a recognised refresher course. On completion of these courses, names of qualified tutors will be entered on to a central register of trained personnel.

- Identified staff members will be trained locally at each required PiC site in the safe use and application and been assessed as competent in their use. All staff trained will be required to attend an annual update. Each site will be required to maintain an up to date list of locally based trained staff.

- Where mechanical restraint is used principally as part of a response plan for severe self-injurious behaviour it is important that staff receive localised training on self-injury and causation, specifically to patients diagnostic presentation.