Therapeutic and Safe Interventions and De-escalation Procedure

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PROCEDURE SUMMARY
These procedural guidelines aim to ensure that staff are provided with the current evidence based information and guidance to prevent and manage restrictive practices.
The trust monitors the implementation of and compliance with this procedure in the following ways:
The monitoring of the use of physical interventions through Datix forms, regular Audit undertaken in conjunction with Workforce Development & Training Department and Risk Management Team and supported by the Clinical Audit Team. Also by the dissemination of information from lessons learnt from physical intervention incident analysis.

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this procedure is Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

TASID PROCEDURAL GUIDELINES

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TASID PROCEDURAL GUIDELINES

1.0 INTRODUCTION

1.1 The procedural guidance aim is to promote a consistent positive and therapeutic approach to averting behavioural disturbances, by encouraging a culture across the organisation that is committed to enhance the therapeutic environment.

The Trust has adopted the No Force First approach to facilitate the reduction of any restrictive practice. The key components of this are:

- Commitment to the concept of 'No Force First'.
- Re-defining the relationship between staff and services users as one of 'risk-sharing partnership' rather than 'risk management control' through a review of institutional rules that unnecessarily hinder and frustrate service users.
- Promotion and development of the use of 'recovery focused' positive and continually optimistic language about service users that seeks to avoid negative stereotyping.
- Defining the use of restraint and seclusion as a 'treatment failure' and critically reviewing incidents on that basis.
- Promotion of the concept of trauma informed care – seeing challenging behaviour in the context of previous traumatic events experienced by the service user

1.2 This procedural guidance will provide an overview of restrictive practices to all staff. It will also look at the process for managing behavioural disturbances using primary, secondary and tertiary approaches including reporting and evaluating the use of restrictive interventions/practices.

1.3 When episodes of challenging behaviour do occur these guidelines provide clear and effective strategies as recommendations for actions staff may take to deescalate, manage or intervene to bring the episode to a safe and rapid conclusion.

1.4 The Trust recognises the need to support staff at all times, and especially following an episode of challenging behaviour. The guidance, therefore, must be read in conjunction with Trust guidelines for Employee Wellbeing and Sickness Absence HR26 and associated documents which set out systems and processes to ensure that staff feels supported and that lessons are learnt and shared following incidents.

2.0	DEFINITIONS

2.1 The Trust follows the Department of Health guidance and definition of Restrictive Practice set out in the Positive and Proactive Care: Reducing the Need for Restrictive Interventions, 2014 document:

'Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- End or reduce significantly the danger to the person or others; and
- Contain or limit the person's freedom for no longer than is necessary'

2.2 The Skills for Care and Skills for Health, a Positive and Practice Workforce (2014) provide a simple definition:

"Making someone do something they don't want to do or stopping someone doing something they want to do."

3.0	PRACTICE STANDARDS

3.1 Restrictive practices are not only confined to physical interventions. Any actions or inactions that contravene a person's Human rights may be seen as restrictive practice. These rights must be at the centre of decision-making. Human Rights based approach, focused on the minimisation of the use of restrictive interventions, and ensuring any use of restrictive interventions and other restrictive practices is rights-respecting.

Below are some categories of restrictive practices and how these are applied. Any restrictive practice must be lawful and have a legitimate right and reason to do so. This is not an exhaustive list.

3.2 Physical Restraint

"Any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of another person" *(Positive and Proactive Care: reducing the need for restrictive interventions. DoH April 2014).*

3.3 Environmental Restrictions

This is to limit people's ability to move as they might wish, such as locking doors or parts of the building. This includes the use of electronic keypads with numbers to open doors, complicated door locking mechanisms and door handles.

3.4 Chemical Restraint

This refers to the use of drugs to modify a person's behaviour. Medication that is prescribed to be taken as and when required (PRN) can be used as a form of restraint unless applied responsibly.

3.5 Forced Care

Actions to encourage / coerce an individual into acting against their will, for example having to be restrained in order to comply with instruction or request, or non-application of Section 5/4 following advising an individual you will use it if they attempt to leave.

3.6 Cultural Restrictions

Preventing an individual from following the behaviours and beliefs characteristic of a particular social, religious or ethnic group chosen by them.

3.7 Decision making

Making a decision on the person's behalf or not accepting or acting on a decision the person has made.

3.8 Community contact

Preventing an individual from participating in community activities, including working, education, sports and community events or from spending time in the Community such as parks, leisure centres and shopping centres.

3.9 Contact with family and friends

Preventing or limiting contact with the individual's peer groups, friends or family. For example not allowing the person to receive visitors, make phone calls or allowing them contact with specific friends or family member.

3.10 Blanket Rules / Global Restrictions

Blanket / Global restrictions refers to policy rules or customs that will restrict a patient / residents' rights and liberty that are routinely implemented to all patient / residents within a service without an individual risk assessment to justify its application. There needs to be justification for the implementation of blanket restrictions. They should be avoided unless there is specific justifications which are deemed appropriate and necessary to address the risk or risks identified for particular individuals, the impact of a blanket restriction on each patient / resident should be considered and documented in their records.

3.11 Deprivation of access to normal daytime clothing

Individuals must never be deprived of appropriate clothing with the intention of restricting their freedom of movement; neither should they be deprived of other aids necessary for their daily living (COP 26.161). However there are circumstances where it will be appropriate and necessary to use restrictive clothing in order to prevent risks to self-i.e. tear-resistant clothing. Where this is implemented, a rationale for this must be recorded, the patient must be informed of reasons, reviews must be evidence (including least restrictive alternative strategies) and the use must be for the shortest amount of time.

To ensure privacy and dignity special tear-resistant clothing must only be used when a patient is either in Seclusion or being nursed in Long Term Segregation

For guidance on the use of tear–resistant clothing please refer to Appendix 3c of CLP41, the Policy for the use of Seclusion & Long–Term Segregation.

4.0   UNACCEPTABLE METHODS OF RESTRAINT/RESTRICTVE PRACTICES

4.1   The following methods of restriction are unacceptable, especially if the individual requests or is consenting to any of the following. It may be considered and applied as appropriate, this must be clearly documented. Inappropriate use of restrictions may be viewed as abuse and a safeguarding concern. The following is not an exhaustive list.

4.2   Inappropriate bed height

This is unacceptable form of restraint as it could also lead to an increased risk of falls to the patient and risks to staff.

4.3   Inappropriate use of wheelchair safety straps

Straps supplied with wheelchairs should always be used when provided for the safety of the user. Although patient / residents should only be seated in a wheelchair when this type of seating is required and not as a means of restraint or to restrict the individual's movement when there are lesser options available.

4.4   Using low chairs for seating

Low chairs should only be used when their height is appropriate - they should not be used with the intention of restraining a person; low chairs also pose a risk to staff in relation to manual handling.

Chairs by way of construction immobilise an individual e.g. Reclining chairs, bucket seats. This type of chair should be used for the comfort of the individual and not for the purpose to restrict movement.

4.5 Locked doors

Where units have locked doors for identified risks, there should be clear signage displayed informing individuals and visitors that the doors are locked and who they need to speak to gain exit from the area. If an individual wished to leave and is being prevented by the locked door that patient / resident is being restricted.

4.6 Arranging furniture to impede movement

Furniture should only be used for its intended purpose

4.7 Removal of outdoor shoes and other walking aids or the withdrawal of sensory aids e.g. glasses

As with the above they should be enabled to prevent confusion and disorientation.

4.8 Prone physical restraint

Prone restraint should not be used other than in exceptional circumstances;
- medical reasons
- potentially to exit from seclusion room
- administration of prescribed medication only if other IMI sites are felt not appropriate

Utilisation of supine, seated de-escalation or the release of the patient / resident in a controlled manner if it is deemed appropriate and safe to do so enabling them to move of their own volition to an area mutually agreed with them and staff as alternatives.

4.9 Safety pods

This equipment enables staff to restrict patients/clients movement without the need to go to the floor and may also enable staff de-escalate in them. however if a patient/clients has been placed in a safety pod and left alone but the client is unable to get them out of the safety pod this may be seen as a mechanical restraint.

5.0   ASSESSMENT AND DECISION MAKING

5.1   Risk Assessment and decision making is an integral part of providing care and treatment.

5.2   Risk Factors (**Appendix 1)** and Antecedents and Warning signs (**Appendix 2**) must be taken into consideration in the assessment and decision making process.

5.3 Risk Factors to consider when placing patients on observation are set out in **Appendix 4.** Also see Engagement & Supportive Observation Policy and Procedure, CLP8.

5.4 Risk Factors to be considered when a patient has specific needs are set out in **Appendix 5.**

5.5 Individual assessment should be carried out in partnership with the individual and considers the following.

- The individual's behaviour and underlying condition and treatment, understanding a patient / resident's behaviour, responding to their individuals identified needs and mutually agreeing a way forward. This should always be at the centre of individualised care. All individuals require a rigorous assessment to establish a positive and proactive support plan to identify appropriate management process.
- The patient / resident's mental capacity and mental health. The individual's mental capacity requires consideration as consent must be gained to use any type of restriction unless they lack capacity to make this decision and the restrictive practice is sanctioned under the Mental Health or Mental Capacity Act.
- The environment should be made to reduce the negative effects a care environment. Negative effects of a care environment include high levels of noise and disruption, inappropriate temperature control, inappropriate levels of stimulation, negative attitudes of care staff and poor communication skills.
- The risk to patient / residents and others, when using restrictive practices a balance needs to be achieved that minuses the risk of harm or injury to the individual and others within the area whilst maintaining the dignity, choice and personal freedom of the individual.
- Assessment should always place the individual at the centre of the process, involving them and those important to them as practical to do so. Evidence of personal centred care should always be documented and signed by the individual and identified staff member undertaking the assessment.

5.6 If a restriction is deemed appropriate the following must always be considered.

- The practice needs to have a legitimate goal, it must be necessary to protect the health and wellbeing of the individual or to protect the safety or human rights of others in the area. This should always be the least restricted option.
- Individuals effected by the restriction must be involved in the decision making process to the fullest extent of their capacity.
- The restrictions that are being instigated must be proportionate to the level of risk identified and the least restrictive option to achieve a safe outcome.
- The principles of dignity and respect must be observed at all times and especially at times when restrictive interventions are being implemented.

- There must be continuous review and evaluation of the practice being implemented to ensure that is used for the shortest possible time period and that it is necessary and the most effective practice at this time.

5.7 If the individual has capacity and can give valid consent and their agreement can be gained without pressure, then the restriction can be put in place as long as it does not contravene the law. The individual has the right to withdraw consent / agreement at any time and it is required that they are informed of this right at the outset.

5.8 If the individual withdraws their consent but it is felt that the restriction should continue but it is deemed that the practice should continue, this can only be achieved if the restriction is supported by the Mental Capacity Act or the Mental Health Act, Criminal Law or the Public Health Act.

5.9 **Appendix 8a** outlines the process for when considering placing of a risk of violence marker on a patient record, **Appendix 8b** provides staff with the referral form in doing so.

6.0 PRIMARY PREVENTATIVE STRATEGIES

Behavioural disturbance and the use of restrictive practice can be minimised by promoting a supportive and therapeutic culture within the care environment. Unless an individual is subject to specific justifiable restrictions (e.g. for security reasons), primary preventative strategies should typically include the following,

6.1 Positive and proactive support plans/positive behaviour support Plans

These are created to help understand and **support** children, young people and adults who display **behaviour** that others find challenging. They are designed to guide us in our responses and actions at times of distress. Patients should be involved when making decisions about their care, this is a human right.

This plan should be implemented alongside a risk management plan. The two plans will proactively and reactively manage risk and support the **reduction of restrictions**. Restrictions include any intervention (environmental, physical, relational, psychological or pharmacological) that prevent a person in your care from pursing free action.

This plan should be developed with support from a clinician with behavioural expertise following an assessment and functional analysis of the problem behaviour.

6.2 Advance Decisions

People who are identified as being at risk of presenting with behavioural disturbance which could include challenging behaviour must be given the opportunity to have their wishes and feelings recorded in an advance

statement, if they have the capacity to do so (Trust Policy Advance Decisions and Statements CG6).

6.3   Care and Treatment plan
Staff should ensure that patient / clients who are assessed as being liable to present with behavioural disturbances have a care and treatment plan which includes primary, secondary and tertiary preventative strategies. These individualised care plans, should be available and kept up to date and include the primary, secondary and tertiary interventions.

- Engaging with individuals and their families
- Care and support
- Considering the regulatory framework
- Patient / resident Community
- Patient / resident Characteristics

6.4   Risk assessments

The assessment of clinical risk in mental healthcare is challenging but provides an opportunity to engage with patients, and their careers and families in order to promote the patients' safety, recovery and wellbeing[4]. A good risk assessment will combine consideration of psychological (e.g. current mental health) and social factors (e.g. relationship problems, employment status) as part of a comprehensive review of the patient[5] to capture their care needs and assess their risk of harm to themselves or other people.

6.5   Staff primary prevention strategy

All staff must be aware that their own personal safety is paramount in any situation where they are faced with episodes of aggression or violence. This includes the right to defend themselves using the justifiable, appropriate and reasonable force to ensure they can escape to an area of safety.

6.6   All clinical staff working in inpatient environments will have access to a personal alarm. Staff who work alone or may visit clients in the community will have access to Lone Worker devices, It is the responsibility of each member of staff to familiarise themselves with the use and circumstances in which alarms should be used.

7.0   SECONDARY PREVENTATIVE STRATEGIES

7.1   De-escalation is a secondary preventative strategy. The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. P.r.n. medication can be used as part of a de-escalation strategy but p.r.n. medication used alone is not de-escalation. (NICE 10 2015)

7.2   De-escalation techniques are set out in **Appendix 3.**

7.3   It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance which could include challenging behaviour.

7.4   De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

8.0   TERTIARY INTERVENTIONS

8.1   Physical interventions / restraints are a tertiary preventative measure.

8.2   A physical intervention / restraint is defined as:

"Any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person".

Manual restraint A skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user. (NICE 10 2015).

Therapeutic and Safe Intervention (TASI previously referred to as PMVA) is set out in **Appendix 7.**

Mechanical restraint A method of physical intervention involving the use of authorised equipment, for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare (NICE 10 2015).

9.0   LEGAL CONSIDERATIONS

9.1   All staff that utilise these interventions must be aware of the legal framework that authorises their use. The main guidance is given in Chapter 1 of the Mental Health Act Code of practice 2015 and should be followed for every incident. Where departures from the guidance occur they should be rigorously recorded and justified as being in the patients best interest.

9.2   The use of Physical intervention must be as a last resort, defensible in law and within Trust Policy and Procedures.

9.3   The use of "Reasonable Force" is legally permitted. All staff must be aware that their own personal safety is paramount in any situation where they are faced with episodes of challenging behaviour. In a one on one situation removal of yourself to a safe **area is the first course of action.**

9.4   Staff need to ensure that the risk is assessed prior to carrying out any physical intervention to maintain the safety of themselves and service users.

10.0   PHARMACOLOGICAL MANAGEMENT OF ACUTELY DISTURBED BEHAVIOUR CLINICAL GUIDELINE (RAPID TRANQUILISATION COP 26.91 – 26.102)

10.1   For information regarding the use of medication in the management of acutely disturbed behaviours, staff must refer to the following Trust policies:
   - Formulary and Prescribing Guidelines, Chapter 8 - Pharmacological Management of Acutely Disturbed Behaviour Clinical Guideline (PMAD-B)
   - Safe and Secure Handling of Medicines Guidelines

11.0   SECLUSION AND LONG TERM SEGREGATION

11.1   For information regarding the use of seclusion and long-term segregation in the management of acutely disturbed behaviours, staff must refer to the Trust's Seclusion & Long Term Segregation Policy and Procedure CLP41.

11.2   Staff must also be familiar with and follow the guidance given in the Mental Health Act Code of Practice 2015.

12.0   WEAPONS AND HOSTAGE TAKING

12.1   Where a patient / resident presents with a weapon (of any description) or has taken a hostage as part of an episode of challenging behaviour the police must be called immediately. Staff must remove all persons from the area and isolate the patient / resident concerned. Safety of the staff and others takes priority in this matter.

12.2   The procedure described in **Appendix 6** should then be followed.

12.3   In all Community Services where a patient / resident presents with a weapon, the staff member will safely withdraw and dial 999 requesting emergency assistance or call a red alert on their lone worker device. (Please refer to the Trust Lone Working Policy and Procedure).

13.0   INCIDENT REPORTING AND RECORD KEEPING

13.1   All incidents and the interventions used are to be fully recorded in the patient / residents healthcare records and on Datix, see Adverse Incident Procedure and Online Incident Reporting Datix Guidance, Appendix 5.

14.0	SUPPORTING STAFF, PATIENT / RESIDENTS

14.1 Support for staff, patient is detailed in the Employee Wellbeing and Management of Sickness and Ill Health Policy HR26. Support for patients/ residents are referred to in section 15 of this procedure.

15.0	IMMEDIATE POST INCIDENT DEBRIEF AND FORMAL POST INCIDENT REVIEW

15.1 **Immediate post-incident debrief**

After using a restrictive intervention, and when the risks of harm have been contained, conduct an immediate post-incident debrief, including a nurse and a doctor, to identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses.

This is to determine the factors that contributed to an incident that led to a restrictive intervention, identify any factors that can be addressed quickly to reduce the likelihood of a further incident and amend risk and care plans accordingly.

To ensure that the service user involved has the opportunity to discuss the incident in a supportive environment with a member of staff or an advocate or carer.

To ensure that any other service users who may have seen or heard the incident are given the opportunity to discuss it so that they can understand what has happened.

(NICE 10 2015).

15.2 Post Incident for staff is detailed in HR26, Employee Wellbeing, Sickness & Ill-Health Policy

15.3 Managerial decisions will determine the level of post incident review dependant on the seriousness of the incident event. Good practice determines that where tertiary interventions are used and or where significant injury to persons or damage to property result then post incident reviews should occur.

15.4 These discussion should only take place when those involved have recovered their composure.

15.5 The aim of post incident reviews should be to seek to learn lessons, support staff and patient / resident, and encourage the therapeutic relationship between staff patient / residents and their careers.

15.6 Post incident reviews should take place as soon as possible, but in any event within 72 hours after the incident. The review should look objectively at the lead up to the incident, the dealing of the incident and the aftermath of the incident.

15.7 The post incident reviews should wherever possible be led by a person not directly involved in the incident event and address:-

- Any precursors, causative factors and trigger points;
- What happened during the incident;
- Sequence of events;
- Address individual's roles and their decision making processes;
- How a successful outcome was achieved and how the event ended;
- What went well and demonstrated good practice;
- What lessons can be learnt;
- An evaluation of the effectiveness of response times surrounding the incident;
- What strategies / interventions could be used if the incident were to reoccur;
- Issues that senior managers or the MDT need to be aware off;
- Where possible, recommendations should be made as to future management plans for the service user or the organisation.

16.0 TRAINING

Restraint Reduction Network (RRN) Training Standards 2019 provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings. These standards will ensure that training is directly related and proportional to the needs of populations and individual people. They will also ensure that training is delivered by competent and experienced training professionals who can evidence knowledge and skills that go far beyond the application of physical restraint or other restrictive interventions. The Therapeutic and Safe Interventions and De-escalation training model the Trust have adopted under pins all the principals of the Restraint Reduction Network (RRN) Training Standards.

16.1 The Trust will provide education and training surrounding physical interventions through, the Workforce Development & Training Department as guided by risk assessment of staff roles and individual service areas. (See Induction & Mandatory Training Policy / procedure appendix 1 for the training matrix).

16.2 All new nursing staff to inpatient mental health areas will undertake initial training in physical interventions.

16.3 Senior clinical staff are responsible for team based training and ensuring ongoing competency of staff in managing risks associated with lone working. Each team must ensure staff are informed about current policy requirements, through team based induction, preceptorship and supervision.

16.4   The Workforce Development and Training Department will report monthly on compliance levels for mandatory training for the Executive Team, Clinical Governance and Quality, Service Management Teams and Health Safety and Security Sub-Committee.

16.5   Managers are responsible for checking that training has been undertaken by a member of staff and is valid, so as to aid in maintaining the minimum of 3 physical intervention trained staff per shift, unless specified in local operational procedures.

16.6   Staff who are booked onto mandatory training and are, for whatever reason, unable to attend, MUST inform their line manager and ensure that their training is rebooked at the earliest opportunity.

16.7   Staff who do not attend a mandatory training course will be recorded and reported as a DNA unless prior notification was given in line with Induction and Mandatory Training policy.

16.8   A withdrawals and DNA report will be produced monthly as part of the mandatory reporting system.

16.9   Managers must determine if additional training is required in any element of restrictive practice.

17.0   MONITORING AND REVIEW

17.1   The monitoring of the use of physical interventions is an essential part of managing a ward, area, unit or department, therefore all incidents involving physical interventions will be recorded as per Adverse Incidents including Serious Untoward Incidents Policy and monitored by the Ward Manager/Nursing Home Manager Team Leader and Clinical Manager.

17.2   Audit is undertaken in conjunction with Workforce Development & Training Department and Risk Management Team and supported by the Clinical Audit Team with results presented to the Clinical Governance and Quality Sub-Committee and Health, Safety & Security Sub-Committee. This will include as a minimum:

- Duties
- Requirement to undertake appropriate risk assessments
- Arrangements for ensuring the safety of lone workers (see Lone Working Policy)

17.3   Analysis of physical intervention incidents will be undertaken by the Restrictive Practice Group to identify trends and patterns of activity in the use of physical interventions.

17.4   Any lessons learnt from physical intervention incidents that are recognised through the reporting process and the Restrictive Practice Group will be fed into the Clinical Governance Committee for sharing across the organisation.

17.5 Monitoring of training compliance will be undertaken by Workforce Development and Training.

17.6 Datix forms involving physical interventions will be reviewed by trainers, using the Datix communication processes. All clinical inpatient areas have 2 nominated full time instructors who can be contacted they will also monitor the Datixes for their clinical areas. The nominated instructor will provide support and guidance to clinical areas. Any issues/concerns identified will be discussed with the clinical teams and management. The nominated instructor will also provide feedback to the TASI team which then will be feedback to the workforce team and the restrictive practice group.

18.0 POLICY REFERENCES/ASSOCIATED DOCUMENTS

1. Restrictive Practice Framework EPUT 2019

    1. CG6 - Advance Decisions and Statements Policy
    2. CP3 - Adverse Incident Policy
    3. CLPG28 - Clinical Risk Assessment and Safety Management Procedure
    4. CLP8 - Engagement and Supportive Observation Policy
    5. RM08 - First Aid Policy
    6. SSOP31 - Protocol for the use of Handcuffs in escorting patients
    7. HR21 - Induction, Mandatory Training and Essential Training Policy
    8. RM17 - Lone Working Policy
    9. CLP75 - Search Policy
    10. CLP41- Seclusion and Long Term Segregation Policy
    11. CG71 - Self Harm Clinical Guideline
    12. CG52 - Pharmacological Management of Acutely Disturbed behaviour
    13. CG92 - Global Restrictive Practices Clinical guideline
    14. HR26 - Employee Wellbeing and Management of Sickness and Ill Health Policy

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