Essex Partnership University
NHS Foundation Trust

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Related Trust documents (to be read in conjunction with)
CG52 - Pharmacological Management of Acutely Disturbed behaviour
CP84 - Violence & Abuse, Prevention and Reduction Policy
CG6 - Advance Decisions and Statements Clinical Guideline
CG71 - Self Harm Clinical Guideline
CG92 - Global Restrictive Practices Clinical guideline
CLP41 - Seclusion and Long Term Segregation Policy
CLP75 - Search Policy
CLP8 - Engagement and Supportive Observation Policy
CLP28 - Clinical Risk Assessment and Safety Management Policy
CP3 - Adverse Incident Policy
HR21 - Induction, Mandatory Training and Essential Training Policy
HR26 - Employee Wellbeing and Management of Sickness and Ill Health Policy
Restrictive Practice Framework EPUT 2019
RM08 - First Aid Policy
RM17 - Lone Working Policy
SSOP31 - Protocol for the use of Handcuffs in escorting patients
COP02 - CAMHS guidelines for naso-gastric (ng) tube insertion and feeding regime

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			Date

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Policy at a Glance

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1 Introduction

The Therapeutic and Safe Interventions & De-escalation (TASID) Policy at Essex Partnership University NHS Foundation Trust (EPUT) provides a comprehensive framework for preventing and managing violence and aggression in mental healthcare inpatient settings through a structured, ethical, and preventative approach. Rooted in a commitment to zero tolerance for violence & abuse, the policy aligns with national best practice standards including NICE NG10, MHA code of Practice (2015) and relevant mental health legislation. Since 2021, TASID training has been accredited in line with the Restrain Reduction Network (RRN) Standards, in association with the British Institute for Learning Disabilities (BILD).

The TASID model follows a three-tiered intervention strategy inspired by the World Health Organisation's framework for violence prevention. Primary prevention focuses on creating safe environments and fostering therapeutic relationships to pre-empt challenging behaviours and better understand them through trauma-informed approaches. Secondary prevention involves early recognition of distress and the use of verbal de-escalation and other non-restrictive strategies. Tertiary intervention is reserved for situations where there is a real and immediate risk to safety, involving physical restraint or rapid tranquilisation or seclusion only as a last resort. Any use of restrictive interventions must be lawful, proportionate, least restrictive, and constantly reassessed during the incident. The policy demands individualised risk assessments, such as Positive Behaviour Support Plans, which incorporate proactive strategies and escalation indicators tailored to each service user's needs. If restraint or seclusion is used, it must be time-limited, ethically justified, and prioritise the individual's dignity, developmental stage, and psychological and physical health.

In summary, TASID serves as a dynamic policy supporting compassionate, lawful, and person-centred approaches to managing distress and risk, placing a strong emphasis on prevention, reflection and recovery.

1.1 The trust provides services to people with diverse and complex needs who may require support when presenting with behavioural disturbance that may present a risk to self or others. Such risks may require the application of restrictive interventions. This policy and associated procedural guidelines aims to promote a consistent human rights respecting, person centred, trauma and autism informed therapeutic approach to averting behavioural disturbance.

1.2 Recovery Based Approaches are used to delivery care in accordance with the principles of a positive, safe and supportive environment.

1.3 Restrictive practices may have to be used to safely manage challenging behaviours. This may involve the physical containment of an individual. For example door locks to ensure patient / residents cannot leave a designated building or area. There may be other examples of more subtle restrictive practices which may be harder to acknowledge such as prescribed medication in the form of a chemical restraint by means of sedative medication on a short or long term basis, inappropriate use of

blanket rules. For guidance in relation to such practices a number of additional policies and clinical guidelines have been developed.

1.4 The Trust advocates, that any violence and aggression will not be tolerated. The Trust recognises that staff have a right to work, and patients / residents have a right to be cared for, in safe environments. See Trust policy Criminal Behaviour within a Mental health Environment CP22 (Zero Tolerance).

1.5 The most common reason for needing to consider the use of restrictive physical interventions are:

- Physical assault by the patient / resident
- Dangerous, threatening or destructive behaviour
- Self-harm or risk of physical injury by accident
- Ensuring and maintaining privacy and dignity where an individual's mental state prevents independent self-management
- Extreme and prolonged over activity that is likely to lead to physical exhaustion
- Attempts to escape or abscond (where the patient / resident is detained under the MHA or deprived of their liberty under MCA).

1.6 The 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.

1.7 The Trust has adopted the Safewards model aims to reduce conflict and containment in mental health wards through ten simple, evidence-based interventions. It improves communication, builds mutual understanding, and fosters therapeutic relationships between staff and patients. The model promotes safety, recovery, and a calm ward environment by addressing triggers and encouraging positive, respectful interactions.

1.8 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.

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

1.10 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.

1.11 Restrictive interventions including enhanced observation, rapid tranquilisation, seclusion, long term segregation and physical interventions are commonly used in response to patients presenting an immediate risk to self or others. Restrictive interventions have the potential to; traumatise/re-traumatise individuals, cause physical injuries, compromise the therapeutic relationship, delay discharge, and infringe on individual's human rights. The Trust has adopted the 6 Core Strategies identified by Huckshorn (2006) to reduce restraint and seclusion.

1.12 Restrictive interventions must only be used as a last resort, must represent the least restrictive option to meet the immediate need, must only be used for the shortest time possible and must have a legitimate aim. Reducing restrictive interventions should be seen as a priority and can be achieved by improving quality of life and meeting the unique needs of individuals using services. Any restrictive intervention should take into account the equality needs of patients including the protected characteristics, which are; age, race, disability, gender reassignment, marriage and civil partnership, religion and belief, sex, sexual orientation, maternity and pregnancy. Individualised care plans mindful of patient and carer preferences are central to providing considerate care at a time of increased need and vulnerability; and in order to promote dignity.

2 Principles

2.1 This policy follows the general principles issued by National Institute of Clinical Excellence (NICE Guidance NG10 2015, QS 154 (2017), the Mental Health Act Code of Practice (2015) – Chapter 26; Towards Safer Services (2022), Positive and Proactive Care; Reducing the Need for Restrictive Interventions; also, A Positive and Proactive Workforce (both Department of Health 2014); Restraint Reduction Network Training Standards (2019), Seni's Law (2018)

2.2 A universal approach to trauma will be applied, which assumes all patients have experienced traumatic events and acknowledges that the mental health system (particularly through the use of restrictive interventions) has the potential to re-traumatise through overly controlling and punitive approaches to risk management and the existence of 'power over' relationships between staff and people using services. This will form part of a wider trauma informed approach.

2.3 Restrictive interventions should only be applied within the context of a framework that respects the human rights of the individual and is consider the least restrictive option to meet the immediate need.

2.4 Individualised care and support plans will be co-produced (as far as possible) identifying primary, secondary and tertiary preventative strategies, identifying at least, potential triggers that may lead to behavioural disturbance including sensory stressors/ preferences; preferred strengths based strategies for coping should behavioural disturbance occur; de-escalation strategies; preferences expressed by the patient should a restrictive intervention be necessary (this may be within an advance statement or advance decision (see CG6 Advance Decisions and Advance Statements Clinical Guideline). The care and support plans may be referred to as safety plans, or support plans but will be referred to in this policy as 'PBS plans or equivalent'

2.5 Following the application of a restrictive intervention, a process of post incident review should commence to: identify potential trauma/re-traumatisation and seek to establish what can be done in order to support the individual in the future and prevent further use of restrictive interventions through collaborative problem solving and planning. Staff will engage in a 2 part post-incident de-brief; firstly immediate post incident support, followed by a reflective learning review where findings from patient de-brief will be fed in to support learning. Witnesses to the incident will also be offered support.

2.6 Vital signs monitoring and recording must take place during and post any physical Intervention, the frequency of which will be based on decisions by a doctor and whether or not rapid tranquilisation was administered. Whenever physical interventions are applied, this must be reported on DATIX. This includes physical interventions that take place off Trust premises including acute hospital settings

2.7 If staff experience risky physical contact from a patient, and if escape is not possible, they have the right to defend themselves using force they genuinely believe to be a necessary and proportionate response to the risk posed.

3 Scope

3.1 The purpose of this policy and associated appendices/ guidance is to support all inpatient wards in EPUT to minimise the use of all restrictive interventions and promote collaborative working arrangements to ensure people are cared for in environments are trauma-informed and rights-respecting with a focus on evidence based therapeutic person-centred interventions. This policy extends to safe application of physical interventions and post-incident care and learning.

4 Definitions / Glossary

4.1 **Restrictive Practice** - 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’

Page 9 of 113.2 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.”

4.2 **Physical restraint** - The Mental Health Act Code of Practice advices it is "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. More specific examples are available in the associated guideline.

4.3 **Positive Behaviour Support (PBS) plan -** A non-aversive framework that seeks to understand the context and meaning of behaviour in order to inform the development of supportive environments and skills that can enhance a person's quality of life, and guide staff responses at times of acute distress utilising primary, secondary and tertiary preventative strategies thereby reducing behavioural disturbance and restrictive interventions applied as a result. These may be referred to locally by different terms such as support or safety plans but all should apply the principles mentioned above.

5 Duties

5.1 **Committee responsibilities**

As per *CLP28 Clinical Risk Assessment and Safety Management Policy*; accountability and responsibility for managing clinical risk is one that is shared between the organisation, individual practitioners, patients and carers. The Restrictive Practice Steering Group will monitor the use of restrictive interventions, including reviewing data to identify causality behind local increases and reductions in restrictive interventions.

5.2 **Trust Board** is responsible for:

- Ensuring that the principles of this policy and procedure and other associated policies are implemented across the organisation;
- Ensuring necessary financial resources
- Ensuring there is an appropriate and adequate infrastructure to support the reduction and safe application of restrictive interventions and that patients are safeguarded, and their equality and human rights are not compromised.

5.3 **Executive Director of Nursing** will ensure:

- That this policy is embedded into clinical practice and monitored;
- The regular review and updating of this policy and procedure and in accordance with national guidance and promotes rights respecting, trauma informed and person centred care, safeguarding against unnecessary use of restrictive interventions;
- The identification and implementation of training to meet educational needs arising from any relevant audits, reviews, reports and lessons learnt.

5.4 **Directors / Associate Directors** will:

- Co-ordinate approaches to reduce restrictive interventions in a clinical context. This includes identifying risks and designing and implementing steps to investigate those risks.
- Report to the appropriate Committee/Quality group for decision-making.
- Have a structured, robust approach to incident investigation which looks beyond immediate actions and assumed causes and identifies the contributory factors, latent conditions and root causes which lead to an incident occurring.
- Address with relevant line managers actions to be taken at local level to reduce restrictive interventions and to respond to increases in their use.
- Support services in being aware of and implementing best clinical practice, quality improvement projects and evidence based strategies designed to reduce restrictive interventions.

5.5 **Clinical Directors** will:

- Be responsible for ensuring all medical staff are conversant with this policy

5.6 **Service Managers** will:

Have operational responsibility for clinical services compliance with this policy and procedure, and will ensure mechanisms in place within each service for identifying and deploying resources within the clinical service to safely deliver this policy and procedure. Monitoring the clinical services' compliance and consistent application of the policy and procedure through Matron's Assurance and clinical audit.

5.7 **Multidisciplinary Care Team** will:

- Have a responsibility to understand their role in proposing, carrying out and reviewing the use of restrictive interventions. They must balance the potentially distressing effect on the individual of the application of restrictive interventions, against the identified risk of behavioural disturbance, in line with Trauma Informed Principles. They should ensure that the principles of last resort and least restriction are maintained and that all restrictive interventions are used for no longer than absolutely necessary. Where possible, the reasons for applying restrictive interventions should be discussed and explained to the patient in keeping with collaborative and therapeutic working. They should support and contribute to the formulation of PBS or equivalent.
- Contribute to post incident reviews when restrictive interventions have been used.
- Ensure PBS or equivalent using primary, secondary and tertiary preventative strategies aimed at reducing the need for restrictive interventions are in place having been co-produced with the patient, as far as possible.

5.8 **Responsible Clinicians** will:

- Have a legal and professional responsibility for the care and treatment of patient.
- Ensure they are kept up to date on the patient's care.

5.9 **Matrons / Integrated Clinical Leads** will:

- Provide assurance to the service managers that their wards are compliant with the requirements of this policy and procedure through Matrons Assurance.
- Have oversight of all restrictive interventions applied on their units.
- Be responsible for regularly reviewing body worn camera footage when physical interventions have been applied.

5.10 **Ward Managers** will:

- Have overall accountability for the management of their ward and must ensure that:
- Ensure there are sufficient numbers of TASID trained staff on duty. The minimum number of TASID trained staff may be decided locally depending on acuity but must not be less than 3.
- Ensure all clinical staff who may be involved in the application of restrictive interventions have read and understood the content of this policy and procedure. They must keep records that staff have done this as part of induction to the ward.
- Ward staff understand their role in initiating and reviewing the use of restrictive interventions.
- PBS plans or equivalent are in place and meaningful to the patient.
- Ward staff are equipped with the relevant information pertaining to individual PBS plans or equivalent.
- Ensure deployment of the available resources to safely deliver this policy and procedure on their ward.
- Ensure post incident reviews are undertaken following the use of physical interventions.
- Identify and respond to any areas of non-compliance with this policy and procedure on their ward, escalating as necessary and ensuring that staff competency records are up to date and maintained. Use opportunities for reflective practice and identify staff that may require further support.

5.11 **Nurse in Charge** will:

- Be responsible for identifying staff who are best placed to apply physical interventions for any planned interventions. This selection should take account of the individual's characteristics, circumstances (including factors such as experience, ethnicity, sexual identity, age and gender) and preferences where possible. They should also take into account the individual's care plan and the rationale for the physical intervention as well as any patterns of heightened risk that have previously been identified for that individual.

- Ensure presence of a TASID trained RMN to co-ordinate during physical interventions.

- Ensure adequate TASID trained staff are available

- Ensure post incident review processes are in place following the use of physical interventions.

- Ensure all documentation is completed by assigned staff. Datix which should be completed within 48 hours of the incident of physical intervention. This is stated in the Adverse Incident Reporting Policy – CP3.

- Ensure attendance of a doctor within 1 hour of commencement of an physical intervention.

5.12 **Site Officer/Unit Coordinator** will:

- Attend incidents where physical interventions are being applied to provide support and guidance to ward staff.

5.13 **All Registered Inpatient Clinical staff** will be responsible for:

- Understanding their role in preventing and applying restrictive interventions.

- Carrying out that role in line with this policy and procedure.

- Contributing to the formulation of the PBS or equivalent with their named patient; and when appropriate/ with consent of the patient including their family or carer's in constructing this.

- Including each patient in the decision around the application of restrictive interventions

- Contributing to post incident reviews following any physical interventions.

- Ensuring individual's PBS plans are implemented.

- Completing all the required documentation.

- Fully familiarising themselves with this policy.

5.14 **All Non-Registered Inpatient Clinical staff** will be responsible for:

- Understanding their role in reducing restrictive interventions
- Ensure the safe and lawful application of restrictive interventions
- Ensuring vital signs monitoring is undertaken during and post any physical intervention
- Becoming familiar with, and implementing, the patient's PBS or equivalent.
- Completing the required documentation accurately and contemporaneously.
- Reporting any relevant information that would assist the effective review of the patient's needs.
- Escalating any concerns they may have e.g. with regards to ensuring a patient's dignity and maintaining a safe level of care with the Nurse in Charge or suitably qualified substitute.

5.15 **Static Security Personnel**

- Static security personnel directly employed by EPUT will receive TASID training and may respond to incidents.
- They should only be involved in a physical intervention if:
- They have successfully completed TASID training and their direct involvement is requested by clinical staff co-ordinating the incident, OR:
- A failure to intervene would lead to an increase in risk to patient(s) and/or staff

5.16 **TASID Training Team** will:

- Provide initial and refresher training accredited under the BILD ACT scheme against the RRN Training standards
- Be allocated clinical areas to support with advice, guidance and further localised training if a need is identified
- Monitor Datix forms from allocated areas where physical interventions have been used
- Provide subject matter expertise for the purposes of reviews and investigations where it is necessary to view CCTV and/or BWC footage.

5.17 **TASID training to reflect the RRN standards:**

- Ensure Behavioural Support Plans are available on all units to be completed with patient on admission to service or unit where appropriate.
- Promote the Trust / clinical areas to adopt the Safewards model.
- Ensure the team leads with Trauma Informed Care approach.
- Ensure Restrictive Practice strategy is communicated with all relevant staff.
- Ensure Restrictive Practice Framework is communicated with all relevant staff.

5.18 **TASID training has achieved certification against the RRN standards via BILD:**

- Ensure a Behavioural support Plan is completed/reviewed for patients where appropriate on admission to service or unit.
- Ensure staff are adopting a Safewards approach to patient care.
- Ensure staff are adopting Trauma Informed Care approach to patient care.
- Ensure staff and patients are offered the 2 Tier debriefing process.
- Ensure Restrictive Practice Strategy is implemented.
- Ensure Restrictive Practice Framework is implemented.

5.19 **Ensure TASID training is reported monthly, evaluated and peer reviewed annually:**

- Ensure staff and patients review Behavioural Support plans after each restrictive practice physical intervention, including Safewards approach and Trauma Informed care approach
- Ensure staff and patients received a minimum of immediate debrief post physical intervention and offered a post debrief via psychology team
- Ensure Restrictive Practice Strategy is completed including DATIX reporting

5.20 **Ensure TASID training/trainers**:

- Adheres to the RRN standards re; revalidation updated skills etc.
- Ensure all techniques are independently risk assessed.
- Engage with Restrictive Practice Steering Group.
- Proactive in responding to clinical needs.

6 Practice Standards

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.

6.1 **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).*

6.2 **Environmental Restrictions**

To limit a person'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. More restrictive examples include; seclusion, LTS.

6.3 **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.

6.4 **Forced Care/ Psychological restraint**

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.

6.5 **Cultural Restrictions**

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

6.6 **Decision making**

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

6.7 **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.

6.8 **Mechanical restraint**

"Using equipment to make someone do something they don't want to do or stop them from doing something they do want to do" – RRN

6.9 **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.

6.10 **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.

6.11 **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.

6.11.1 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

6.11.2 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.

7 Unacceptable Methods of Restraint / Restrictive Practices

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.

7.1 **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.

7.2 **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.

7.3 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.

7.4 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.

7.5 Arranging furniture to impede movement

Furniture should only be used for its intended purpose

7.6 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.

7.7 Prone physical restraint

Prone restraint should not be used other than in exceptional circumstances;

- medical reasons
- potentially to exit from seclusion room using a mattress
- administration of prescribed medication only if other IMI sites are felt not appropriate
- Advanced statement/ decision from the patient or best interest based on preferences – consult TASID team if planning to restrain in the prone position

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.

7.8 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.

8 Assessment & Decision Making

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

8.2 Risk Factors and Antecedents and Warning signs must be taken into consideration in the assessment and decision making process.

8.3 Risk Factors to consider when placing patients on observation are set out in Engagement & Supportive Observation Policy and Procedure, CLP8.

8.4 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.

8.5 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.

8.6 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.

8.7 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.

9 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:

9.1 Positive Behaviour Support (PBS) Plans

9.1.1 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. PBS plans can detail identified patterns of behaviours and the preferred therapeutic responses in primary, secondary and tertiary stages of an incident.

9.1.2 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.

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

9.2 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).

9.3 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

9.4 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. 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 to capture their care needs and assess their risk of harm to themselves or other people.

9.5 Staff safety

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.

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.

9.6 Protective Factors

Staff should, as far as possible, invest in engaging with patients to develop therapeutic relationships, guided by mutuality, collaboration and appropriate trust. Relational and recovery-focused interventions, prior to any escalation in behaviour has been widely researched and evidenced to be an effective primary preventative strategy, as modelled by Safewards. This help the nursing team in being aware of situations that may be triggering for patients and better respond to them.

10 Secondary Preventative Strategies

10.1 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. PRN medication can be used as part of a de-escalation strategy but PRN medication used alone is not de-escalation. (NICE 10 2015)

10.2 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. This may be behaviour that presents a risk to oneself, or to others.

10.3 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 cooperation, 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.

10.4 In addition to communicative strategies, there could also be preferences around sensory modulation and related calming strategies, which can positively reinforce self-regulation. This should be strengths-based and take into account individuality and autonomy, so far as risk assessment will allow.

11 Tertiary Interventions

11.1 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". (CQC)

11.2 **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).

11.3 **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).

Use a restrictive physical intervention only if de-escalation and other preventative strategies, including PRN medication, have failed and there is an immediate risk of harm to the individual or others if no action is taken. Attempts at de-escalation must continue throughout a physical intervention. Do not use physical interventions to punish, inflict pain, suffering or humiliation, or establish dominance.

Ensure that the techniques and methods used:

- Consider the history of previous trauma and potential for trauma/re-traumatisation
- Take into account the patient's preferences, including preferred gender of staff, sensory needs if known via PBS or advance decision/statement and it is possible to do so
- Involve a minimum of 2 trained members of staff
- Represent the **least restrictive option to meet the immediate need**
- Are used for the shortest time possible
- Have a legitimate aim
- Take into account the patient's physical health, degree of frailty and developmental age

12 Decision Making for the Use of a Physical Intervention

12.1 Where risk assessments identify that a restrictive physical intervention may be needed, their implementation should be planned in advance and recorded as tertiary strategies within the PBS (or equivalent), placing emphasis on voice and choice of the patient. Staff should ensure familiarity with any PBS plans (or equivalent).

12.2 On other occasions, behavioural disturbance may not have been predicted by risk assessments. In such cases emergency management of the situation and the use of restrictive physical intervention should be based on clinical judgement which takes into account relevant best practice guidance (such as those published by the National Institute for Health and Care Excellence (NG10)) and all available knowledge of the patient's circumstances and preferences. Essentially, this is a response to immediate risk of harm, where the judgement is that the safest option is to restraint.

12.3 Restrictive physical interventions should be used in a way that minimises any risk to the patient's health and safety and that causes the minimum interference to their autonomy, privacy and dignity, while being sufficient to protect the patient and other people. The patient's freedom should be contained or limited for no longer than is necessary.

12.4 The choice and nature of restrictive physical intervention will depend on various factors, but should be guided by:

- The patient's wishes and feelings if known, and including preferences relating to gender of staff who may be involved in the physical intervention (e.g. by an advance statement or in the tertiary section of their PBS or equivalent).
- What is necessary to meet the immediate needs of the individual based on a current assessment?
- The patient's age and any individual physical or emotional vulnerability that increases the risk of trauma arising from specific forms of restrictive physical intervention.
- Whether a particular form of restrictive intervention would be likely to cause distress, humiliation or fear.

- Obligations to others affected by the behavioural disturbance.
- Responsibilities to protect other patients, visitors and staff,
- The availability of resources in the environment of care.

12.5 Where an incident occurs, either spontaneously or as the result of a deterioration of a situation where primary and secondary preventative strategies have failed and it is necessary to apply a restrictive physical intervention, this is considered an emergency and requires the presence of the following to ensure a safe resolution of the crisis:

- Alarm systems to summon other staff to assist in the management of the incident.
- Sufficient numbers of TASID trained staff
- Grab bag must be available on all inpatient units containing Resuscitation Equipment, including Defibrillator, Bag Valve Mask, and Oxygen, suction, all of which must be contained in good working order
- Attendance of a Doctor.
- Band 5 TASID trained registered nurse (minimum) to co-ordinate the incident
- Site Officer upon arrival will be informed and updated on the situation.
- Safety pod and leg cushion (if available) to avoid a patient being restrained on the floor

12.6 For Nursing Homes where an incident occurs, either spontaneously or as the result of a deterioration of a situation where primary and secondary preventative strategies have failed and it is necessary to apply a restrictive physical intervention, this is considered an emergency and requires the presence of the following to ensure a safe resolution of the crisis:

- Alarm systems to summon other staff to assist in the management of the incident.
- Grab bag and defibrillator must be available and maintained in good working order.
- Nurse in Charge
- Contact Nursing Home Manager

12.7 Where a patient is restrained unintentionally in a prone position, staff should either release their holds or reposition into a safer alternative position as soon as possible.

12.8 In all circumstances where physical intervention is used one staff member must monitor the patient's head, airway, emotional and physical condition throughout the restraint to minimise the potential of harm or injury. Observations that include vital clinical indicators such as pulse, respiration and complexion (with special attention to pallor or discoloration) must be carried out and recorded. Staff must be trained to be competent to interpret these vital signs. If the person's physical condition and/or their expressions of distress give rise to concern, the restraint should stop immediately.

12.9 Staff must continue to monitor the patient for signs of emotional or physical distress for a significant period of time following the application of restrictive physical interventions.

12.10 Staff must only use methods of physical intervention for which they have received and passed professional training. Training records must record precisely the techniques that a member of staff has been trained to use. If in extremes and physical techniques outside of the TASID curriculum are used, this should initiate an immediate review involving TASID Lead, Matron and Ward Manager as a minimum to ensure the principles of necessity and proportionality have been adhered to and that the patient has not been exposed to unnecessary risk. CCTV and body worn camera footage can be accessed if necessary and/or available.

12.11 A member of staff (ideally with the best rapport) should take responsibility for communicating with the person throughout any period of restrictive physical intervention in order to continually attempt to de-escalate the situation.

12.12 The Restraint Reduction Network Training Standards (2021) and the Department of Health (2014) do not support the use of pain to gain compliance or the use of holds whereby movement from the individual induces pain. The only mitigating factor for the use of pain would be for immediate rescue in a life threatening situation where all other attempts at rescue have failed. Techniques involving the use of pain do not form part of the TASID training curriculum.

12.13 People must not be restrained in a way that impacts on the airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not result in pressure to the neck region, ribcage and/or abdomen.

12.14 Unless there are cogent reasons to do so, there must be no planned or intentional use of the prone position on any surface, not just the floor. Using a seclusion exit technique on seclusion mattress, or using IM in an emergency where alternative sites are opposed in clinical judgement, may be qualifying exceptions.

12.15 There may also be exceptional circumstances where a patient may request to be restrained in the prone position and these will need to be discussed as an MDT with the patient to explore the reason for this request and appropriate plan recorded and circulated to all staff.

12.16 Where any restrictive physical intervention occurs there should always be recording and debrief to ensure learning and continuous safety improvements.

12.17 Staff must not use physical intervention techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purposes of an immediate rescue in a life threatening situation.

13 Using Physical Interventions

The use of physical interventions removes autonomy from the patient and may result in feelings of powerlessness often experienced by survivors of trauma. It is important to provide as much voice, choice and control of the situation to the patient as possible and to take a collaborative approach to resolution of the crisis. Staff should avoid unnecessary use of instruction and absolutely avoid judgements and reprimand which may further escalate the crisis.

13.1 When a decision to use physical intervention has been made the Nurse in charge should where ever practical carry out the following actions:-

- Assemble a physical intervention team.
- Describe to staff involved the Situation, Background, Assessment and Recommendation (SBAR)
- State any possibility of infection and take appropriate precaution.
- Direct other staff not involved in the physical intervention with tasks such as removal of obstacles, supporting other patients etc.
- Feeding in substitute members of staff where fatigue or injuries dictate.
- Use the least restrictive option to mitigate risk during the restraint e.g. avoid descending to the floor if safe to remain standing
- Prepare Rapid tranquilisation medication when/if this decision is made.
- Prepare the seclusion room (if appropriate) if this decision is made.
- Ensure the attendance of a doctor / duty doctor.
- Ensure Emergency resuscitation equipment is present at the incident.
- Ensure presence of a safety pod and leg cushion.

13.2 The designated team if possible and time allows should determine team roles, especially the allocation of the lead for the physical intervention who will take on the responsibilities listed below. Be briefed on the situation using SBAR

13.3 One member of the physical intervention team should assume the role of 'head person' throughout the process. They are responsible for:-

- Liaison with the nurse responsible for co-ordination during the incident
- Continuing attempts to de-escalate and maintaining a supportive dialogue with the patient.
- Setting out for the patient the clear, positive instructions and expectations of behaviour that will end the use of physical intervention.
- Protecting and supporting the patient's head and neck, where required. (The protection of the head constitutes a duty of care owed to the patient).
- Ensuring their airway and breathing are not compromised.
- Ensuring vital signs are monitored.
- Leading the team through the process by giving clear instructions and relevant information.

13.4 If a physical intervention results in a restraint on the floor a head person must physically be in place or a nominated member of the team accepts that responsibility. In exceptional circumstances if this is not practicable (possibly due to environmental factors) then another member of staff must take over the roles and responsibilities of the head person as outlined above.

Other considerations for the use of physical intervention must include.

- Strict avoidance of excess weight being placed on any area, but particularly the areas of fingers, head, neck, thorax, abdomen, back or pelvic area.

- The consideration of gender mix of staff and any preferences expressed by the patient around gender of staff members involved in the intervention.
- Determining the end of physical interventions should, if possible, be a decision made collaboratively between staff and patient. They should take into account where appropriate, advice from other team members the Doctor and Nurse in Charge and consider factors such as:-
- Has the patient calmed sufficiently for physical intervention to be terminated. If so what follow up interventions are to follow? I.e. observation levels, de-brief, vital signs monitoring
- Has physical intervention been used for a prolonged period of time with no change in presentation from the patient? Consider Rapid Tranquillisation and or Seclusion as alternatives to lengthy physical intervention with attendant risks.
- Maintain attempts to engage with and assess the patient but respect requests for privacy and space if risk assessment allows.

13.5 When physical intervention has been used, staff must report the incident on Datix. Following any incident in mental health and learning disability services where restrictive interventions have been used, the priority is reconciliation. The continued development of the therapeutic relationship between staff and patient should be the priority.

13.6 In Community Health Services a post incident review would be undertaken prior to any future service provision to the patient.

13.7 Patients must not be dragged or picked up and carried during a physical intervention; this action may constitute abuse.

14 Post Incident

14.1 Account for all patients and staff ensuring their safety and wellbeing. Determine the safety of the environment and return to pre-crisis milieu

14.2 A Doctor must examine the service following any physical intervention, ideally within 1 hour of the commencement of the intervention. This examination must be recorded in the healthcare records. Any injuries or adverse symptoms of the patient, staff or others must be reported.

14.3 Nursing staff must carry out basic vital signs monitoring as soon as possible after the event. This should be repeated up to every 4 hours (more frequent if necessary) and for up to a period of 24 hours minimum and recorded on a NEWS2 chart. After this period the Doctor and Nurse should decide if monitoring should continue on a regular basis if necessary. If rapid tranquilisation has been administered refer to CG52 for guidance on vital signs monitoring.

If the patient does not consent to a full array of vital signs monitoring, staff may undertake ‘non-contact’ monitoring to include respiration, pallor and alertness. Oxevision may also be used under these circumstances but should not replace attempts to engage with the patient.

14.4 In conjunction with the Doctor, undertake an assessment of the patient to identify how best to meet needs and reduce distress and therefore the likelihood of further escalation, including observation status and staffing levels.

Anyone present at the time of the incident will be offered immediate debrief support this includes staff, patients and visitors who were involved or in the area.

14.5 If the prone position is used, a 7 day report must be completed to initiate review and identify learning.

14.6 Patients should be given the opportunity to record and have filed within their healthcare records their view and account of their experience, including that of any intervention used.

15 Legal Considerations

15.1 The use of force in NHS mental-health units is governed chiefly by the Mental Health Units (Use of Force) Act 2018 (often called "Seni's law") and its accompanying statutory guidance, which requires that physical, mechanical or chemical restraint, or isolation/seclusion, must only be used when necessary to deal with an immediate risk, must be a proportionate response to that risk, and must represent the **least restrictive option available to meet the immediate need.**

15.2 Additionally, the Mental Health Act 1983 (powers for detention and treatment), the Mental Capacity Act 2005 (and its Code of Practice – for decisions where a person lacks capacity) and the Human Rights Act 1998 (especially Articles 3 & 5 on prohibition of inhuman/degrading treatment and protection of liberty) sit alongside. Together these require that any use of force is lawful, necessary, proportionate, employed only when absolutely required and as the last restrictive option, recorded and subjected to oversight.

15.3 Where departures from this legislation occur, they should be rigorously recorded and would be governed under Common Law - Doctrine of Necessity.

16 Use of Force in Self-Defence

There are circumstances where the use of force may be justified relating to defence of oneself or others. This is a situation whereby there is an immediate risk of harm and there are not enough nursing staff to physically restrain. In this case, force may be necessary for the purpose of removing oneself from the situation.

Justification of self-defence is outlined below in extracts from both:

- Criminal Law Act 1967 Section 3 and
- Criminal Justice Act 2008 section 76
- Common Law

A person may use force as is reasonable in the circumstances for the purposes of:

- Self-defence; or
- Defence of another; or
- Defence of property; or
- Prevention of a crime;

Two principles in assessing the reasonableness of the force used, are:

1. Was the force necessary in the circumstances I.e. Was there a need for force?
2. Was the force used reasonable given the circumstances I.e. Was the force proportionate to the immediate risk of harm?

17 Pharmacological Management of Acutely Disturbed Behaviour (Rapid Tranquilisation COP 26.91-26.201)

17.1 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

18 Seclusion & Long Term Segregation

18.1 Staff must **not** attempt to disarm a user suspected of having a weapon without the assistance of the police.

18.2 If it is suspected that a user has a weapon (of any description) then the police must be informed immediately using 999, and giving the location and an explanation for the grounds for suspicion.

18.3 If possible and appropriate evacuate the area as quickly and calmly as possible, ensuring the safety of other patients / residents, staff and visitors is paramount.

18.4 If possible and appropriate close and lock any doors in the immediate vicinity to help isolate and contain the area, the aggressor and situation. In the event of hostage taking it may be more appropriate to leave doors open and/or unlocked.

18.5 Observation of the immediate area should be maintained if it is possible to do so without endangering the staff carrying out the observation.

18.6 The Senior Manager (Manager on call) responsible for the unit, the Consultant (or Consultant on call) responsible for the patient and the Associate Director (or Director on call) for the Service must be contacted

19 Weapons & Hostage Taking

19.1 Staff must **not** attempt to disarm a user suspected of having a weapon without the assistance of the police.

19.2 If it is suspected that a user has a weapon (of any description) then the police must be informed immediately using 999, and giving the location and an explanation for the grounds for suspicion.

19.3 If possible and appropriate evacuate the area as quickly and calmly as possible, ensuring the safety of other patients / residents, staff and visitors is paramount.

19.4 If possible and appropriate close and lock any doors in the immediate vicinity to help isolate and contain the area, the aggressor and situation. In the event of hostage taking it may be more appropriate to leave doors open and/or unlocked.

19.5 Observation of the immediate area should be maintained if it is possible to do so without endangering the staff carrying out the observation.

19.6 The Senior Manager (Manager on call) responsible for the unit, the Consultant (or Consultant on call) responsible for the patient and the Associate Director (or Director on call) for the Service must be contacted

20 Incident Reporting & Record Keeping

20.1 All incidents (physical, mechanical or chemical restraint / isolation event) and the interventions used are to be fully recorded in the patient / residents healthcare records and on Datix, see Adverse Incident Policy and Online Incident Reporting Datix Guidance, Appendix 4; this is a statutory requirement under the Mental Health Units (Use of Force) Act 2018.

21 Supporting Staff, Patients / Residents

21.1 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 policy

22 Immediate Post Incident Debrief & Formal Post Incident Review

22.1 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.

22.2 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.

22.3 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.

22.4 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).

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

22.6 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.

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

22.8 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 and return the ward to itself usual therapeutic milieu.

22.9 Following this, formal debriefs 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.

22.10 Formal debriefs 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.

23 Training requirements

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 underpins all the principals of the Restraint Reduction Network (RRN) Training Standards.

23.1 The Trust will provide education and training surrounding physical interventions through, the Workforce Development & Education Department as guided by risk assessment of staff (appendix 1 for the training matrix).

23.2 All new nursing staff to inpatient mental health areas will undertake initial 5 Day TASID training unless local arrangements are in place (such as with stand-alone older adult units where staff are not required to respond to emergencies on other wards), in which case an initial 3 day course may be completed. An update appropriate to work setting must be completed annually and at an interval no greater than 15 months from last training. If the interval exceeds 15 months, a full course is required.

23.3 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.

23.4 The Workforce Education and Learning 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.

23.5 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.

23.6 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.

23.7 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.

23.8 6A withdrawals and DNA report will be produced monthly as part of the mandatory reporting system.

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

24 Monitoring and audit

24.1 Outlined below is the Trust's process of monitoring compliance with, and the effectiveness of the document's main points.

24.2 A Trust wide audit will be undertaken at the minimum of every three years. The policy author will usually lead the audit, with the relevant clinical leads responsible for collecting data in their area. The clinical audit will be supported by the clinical audit department. The following will be audited:

- Clinical Practice in the use of physical interventions against NICE QS 154.
- Have we gained feedback from patients about their experience of restrictive interventions
- The findings of such audits will be reported to the relevant Director and discussed at relevant local quality/governance groups and committees.
- The outcome of the clinical audit will be used to inform any review and/or changes to this policy and procedure and the Trust's programme of training.
- The monitoring of training compliance will be undertaken by Workforce, Development and Learning as outlined in this procedure.

24.3 Service Managers will monitor compliance and consistent application of the policy and procedure through matron's assurance and clinical audit.

24.4 Ward managers and matrons will monitor the implementation of this policy via supervision with staff. Please refer to the 1:1 Support Policy HR48A.

24.5 The policy will be available via the Trust Intranet site.

24.6 Any amendments to this clinical policy will be submitted to the Restrictive Practice Group for approval.

24.7 This clinical policy and associated procedure will be reviewed at least once every three years, or sooner should there be a need to revisit the contents following any updates in national guidance, outcomes of any untoward incidents, changes roles and responsibilities or changes in practice

25 Approval and implementation

25.1 All Restrictive Practice policies will be approved by the Restrictive Practice Steering Group, which is the specialist group with the authority to approve Restrictive Practice documents. These will then be forwarded to the Policy team for submission and ratification by the Policy Oversight and Ratification Group.

25.2 It is the author's responsibility to inform the Restrictive Practice Group) of the approved documents when they are uploaded to the Trust's Intranet.

26 Preliminary equality analysis

26.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

(Refer to Appendix 7)

27 References

Acts of Parliament (UK Statutes)

Mental Capacity Act 2005 London: HMSO
Mental Health Units (Use of Force) Act 2018, London: HMS

Books

Van der Kolk, B.A. (2015) *The body keeps the score : mind, brain and body in the transformation of trauma*. UK: Penguin Books.

Journal articles

Andersena, C., Kolmosa, A., Andersenb, K.,Sippelc, V., and Stenagera, E. (2017) 'Applying sensory modulation to mental health inpatient care to reduce seclusion and restraint: a case control study', *Nordic Journal of Psychiatry*, 71, 7, 525–528. Available at: https://doi.org/10.1080/08039488.2017.1346142

Bowers, L. (2014) 'Safewards: a new model of conflict and containment on psychiatric wards', Journal of psychiatric and mental health nursing, 21(6), pp. 499–508. Available at: https://doi.org/10.1111/jpm.12129

Bowers, L. *et al.* (2015) 'Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial', *International journal of nursing studies*, 52(9), pp. 1412–1422. Available at: https://doi.org/10.1016/j.ijnurstu.2015.05.001.

Forsyth, S., Trevarrow, R. (2018) 'Sensory strategies in adult mental health: A qualitative exploration of staff perspectives following the introduction of a sensory room on a male adult acute ward', *International Journal of Mental Health Nursing,* 27, 1689–1697. Available at: https://doi: 10.1111/inm.12466

Mauritz, M., Goossens, P., Draijer, N. and van Achterberg, T. (2013), "Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness", '*European Journal of Psychotraumatology*', Vol. 4, available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC3621904/

Positive Behavioural Support (PBS) Coalition UK, (2015) 'A Competence Framework'

Price, O. & Baker, J. (2012). 'Key components of de-escalation techniques: A thematic synthesis'. *International Journal of Mental Health Nursing*, 21, 310–319. Available at: https://doi.org/10.1111/j.1447-0349.2011.00793.x

Price, O., Baker, J., Bee, P. & Lovell, K. (2018). 'The support-control continuum: An investigation of staff perspectives on factors influencing the success or failure of de-escalation techniques for the management of violence and aggression in mental health settings'. *International Journal of Nursing Studies*, 77, 197–206. Available at: https://dx.doi.org/10.1016/j.ijnurstu.2017.10.002

SAMHSA (2014), SAMHSA's Working Concept of Trauma and Framework for a Trauma-Informed Approach, National Centre for Trauma-Informed Care (NCTIC), SAMHSA, Rockville, MD

NICE Guidelines

NICE (2015) *Violence and Aggression: Short-Term Management in Mental Health, Health and Community Settings*. London: NICE (NG10)

NICE (2017) *Violent and Aggressive Behaviours in People with Mental Health Problems*. London: NICE (QS154)

Reports

Department of Health (2015) *Mental Health Act 1983: Code of Practice*. Norwich: Stationery Office. (Sections on least restrictive and use of mechanical restraints). Available at: https://bit.ly/3wPaiKb

Department of Health (2014) *Positive and Proactive Care: Reducing the Need for Restrictive Interventions.* London: Department of Health. Available at: https://bit.ly/3NBbXID

Department of Health: Skills for Health (2014): A *Positive and Proactive Workforce Available at:* A positive and proactive workforce.pdf

Restraint Reduction Network, (2022) Towards safer services: minimum standards for organisational restraint reduction plans. Birmingham

Ridley, J and Leitch, S (2019) Restraint Reduction Network (RRN) Training Standards: Ethical Standards to Protect Human Rights and Minimise Restrictive Practices. Birmingham: Restraint Reduction Network. Available at: https://restraintreductionnetwork.org/know-the- standard/

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Appendix 1: Physical Intervention to administer Naso-Gastric (NG) Tube Feeding

Information extracted and appropriated from the EPUT inpatient CAMHS guidelines for naso-gastric (ng) tube insertion and feeding regime COP02, 2025 - 7.4 Intervention

For more information see: COP02 Naso-Gastric Tube (Enteral) Feeding Policy CAMHS.pdf

- The team should use NG-tube feeding-specific TASID techniques to hold the patient using a safety pod.
- One nurse should be allocated to speak to the young person throughout the procedure, offering support, reassurance and explanation.
- In a 3 staff intervention, the person responsible for the head should be allocated to speak to the young person. This person would act as the communication link if the young person was feeling discomfort during the physical intervention asking for clarification of the point of pain and then asking the staff members in physical intervention to respond appropriately by re-examining their hold.
- The designated nurse should insert the NG tube, and ensure it is placed correctly using the pre-NG Tube insertion procedure as attached [see Appendix 1- COP02].
- Staff must have the competence and confidence to assess when the intervention is causing unnecessary distress and when the physical intervention is prolonged. In this instance staff should halt the procedure and review the plan.
- The nursing team should at all times monitor the young person's level of consciousness, pallor, breathing, whilst continuing to observe that the tube is correctly place.
- The nurse administering the feed should aspirate the stomach contents and document the result (appendix 5- COP02) to determine if feed can go ahead.
- After the feed has been administered the lead communicator should hand over the responsibility of the intervention to one of the staff utilising arm-holds. This person would then commence a seated de-escalation procedure.
- One nurse should remain with the young person offering support and reassurance. There may be a risk of vomiting which needs to be observed. This nurse should carry out observations of pulse and blood pressure regularly for as long as considered necessary, but most importantly directly after the procedure. The nurse should continue to offer help to the young person to discuss their anxieties.
- The procedure must be documented in the notes including a rationale for initiating 12 the 'NG feeding plan' using physical interventions.
- The team involved in the procedure should conduct a post incident review afterwards if necessary.

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Appendix 2: Observations

Practice should adhere to the following clinical guidance: Therapeutic Engagement and Supportive Observation Clinical Guideline (Inpatients) / CG100

Appendix 3: Assessing Special Needs

RISK ASSESSMENT FACTORS TO BE CONSIDERED WHEN A PATIENT HAS SPECIFIC NEEDS

When physical interventions are considered as part of risk management plans then further assessment and risk management needs to be considered when the patient/resident has particular needs. These include:-

(i) Children and adolescents
(ii) People with learning disabilities

Consider factors surrounding confused and impaired consciousness and communication strategies with the service user.

(iii) Pregnant women

Promote liaison with appropriate pregnancy support services identifying general good practice guidance and key concerns in the management of pregnancy and acutely disturbed behaviour. Acutely disturbed behaviour equals behaviour demonstrating a high risk of imminent harm towards the unborn baby and the mother.

(iv) The elderly

Consider factors such as frailty and physical health and confused mental states and ability to respond to instruction.

(v) People with a physical disability, including Risk of HIV or other infectious Diseases

Here consideration would need to be made in relation to how the service user can be safely restrained. This may require that the service user has a modified / tailored made restraint procedure prepared for them.

(vi) People with diverse backgrounds that may need an interpreter.

Consideration of the extra time required for effective communication is essential.

Where a service user with particular needs has been identified it may be necessary to consider the support of other specialist services. For instance

- Infection Control
- Health and Safety
- PMVA Lead
- Manual Handling Co-ordinator / Ergonomist
- Specialist Speech and Language Therapist
- Specialist Professional such as Midwife
- Pharmacy

Where additional considerations to manage the individual needs of a service user has been made then this should be recorded. The record should show the risk assessment and the specific care plan that has taken place in relation to the particular individual need.

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Appendix 4: Weapons & Hostage Taking

WEAPONS (INCLUDING KNIFES, FIREARMS) AND HOSTAGE TAKING

1.0 Trust Staff Response

1.1. Staff must **not** attempt to disarm a user suspected of having a weapon without the assistance of the police.

1.2. If it is suspected that a user has a weapon then the police must be informed immediately using 999, and giving the location and an explanation for the grounds for suspicion.

1.3. If possible and appropriate evacuate the area as quickly and calmly as possible, ensuring the safety of other patients / residents, staff and visitors is paramount.

1.4. If possible and appropriate close and lock any doors in the immediate vicinity to help isolate and contain the area, the aggressor and situation. In the event of hostage taking it may be more appropriate to leave doors open and/or unlocked.

1.5. Observation of the immediate area should be maintained if it is possible to do so without endangering the staff carrying out the observation.

1.6. The Senior Manager (Manager on call) responsible for the unit, the Consultant (or Consultant on call) responsible for the patient and the Associate Director (or Director on call) for the Service must be contacted.

1.7. In all instances where the Police and other emergency services are called to manage an incident involving weapons or hostage taking then the following must be informed.

- Chief Executive
- Medical Director
- Trust Chair
- Clinical Director for the relevant Directorate
- Communications Manager
- Violence & Abuse Prevention & Reduction Advisor (VAPR)

1.8. The Senior Manager or Associate Director will take over from the Nurse in Charge in the management of the Trust's response to the incident and also take over liaison with the police.

2.0 Police liaison and management of the situation

2.1. Once the police arrive the nurse in charge should establish with the police the appropriate course of action. In most instances it will be appropriate for the police to lead the effort to disarm the user.

2.2. The nurse in charge must provide the police with a full risk assessment on the individual concerned so that the response of the police is proportionate and appropriate.

2.3. The Police will set up a perimeter which they control in order to ensure the safety of police officers and others who may already be within the perimeter or entering it.

2.4. If the police are called to attend a serious incident involving weapons or a serious incident involving hostage taking the Trust's Major Incident Policy must be activated and a Major Incident Control Centre established. The following factors will be considered:

- Ongoing police liaison
- Movement in, around and out of unit site
- Potential risks for adjoining units
- Evacuation and relocation plans
- Contact with relatives
- Press liaison
- Communication with the Health Authority and PCTs

2.5. The police must be provided with:-

- A list of patients / residents and staff on the unit concerned (including ancillary staff)
- A secure and private area for the use of specific officers
- Access to staff with detailed knowledge of environment or individuals concerned.

2.6 The incident may last for lengthy period of time and management plans for staff arriving on and going off duty will need to be made. In addition the welfare of other patients / residents will need to be considered up to and after the incident has been resolved.

2.7 Once the user has been disarmed, his/her room and all his/her belongings must be searched in order to establish that no other weapons are hidden.

2.8 Urgent consideration should be given to placing the patient / resident in a more secure environment if the patient / resident are currently residing on an open unit. A full risk assessment on the user concerned must be carried out.

Source: NICE Clinical Guideline QS154 Violent and aggressive behaviours June 2017

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Appendix 5a: Violent Patient Marker Tool

1.0 INTRODUCTION

1.1 This protocol adopts the principles of NHS National Guidance and outlines the process in place when it is identified that a violent patient marker may be required.

1.2 The role of the Violence & Abuse Prevention & Reduction Advisor (VAPR) and Security Management Director (SMD), or delegated representative in relation to recommending or placing a violent marker on a patient record is to assist clinical staff in managing future risks of violence.

1.3 The aim of the risk of violence marker is to alert staff to individuals who pose/could pose a risk of violence, and enable staff to reduce the risk of violence.

1.4 The marker should achieve this by:

- Serving as an early warning for staff of a particular individual or situation that may present a risk to them, their colleagues or other patients
- Providing security warnings and handling advice to avoid or minimise any risk
- Where appropriate, enabling staff to seek further advice on what action should be taken
- Assisting in reducing the number of violent incidents reported

1.5 This protocol supports the Trust with meeting its obligations under the Department of Health guidelines, the Management of Health and Safety at Work Regulations 1999, Health & Safety Executive.

1.6 The Trust is committed to providing a safe working environment and safe systems of work to protect all staff, but also recognises the serious nature of placing a violent patient marker on an individual's record. This protocol aims to balance the risks and needs of both staff and patients.

1.7 **The Trust will take all reasonable steps to ensure the safety of staff whilst working on Trust premises or off site whilst on official Trust business, and also of any premises deemed to be Trust property.**

2.0 SCOPE

2.1 The protocol applies to all staff employed within the Trust either permanent or on a temporary basis.

2.2 This protocol outlines the process for all staff to follow when considering placing of a risk of violence marker on a patient record.

2.3 A risk of violence marker may be applied regardless of whether the act was intentional or not. The use of a marker will help reduce potential risks to all staff by enabling them to use the information as part of their risk assessment process.

2.4 A risk of violence marker does not just apply to circumstance where the perpetrator is a patient, but may equally apply to their carer, relative, friend or other associate that presents a risk of violence.

2.5 A risk of violence marker may also be applied to a patient/or their carer, relative, friend or other associate who is responsible for a dangerous animal.

2.6 It is important to note that any risk of violence marker placed is not a mechanism for attributing blame. It is a process for alerting staff to the possibility of violence regardless of the cause.

2.7 The risk of violence marker and associated information (warnings, handling advice etc.) must be available to all internal staff that may have face to face contact with the individual.

2.8 Information sharing with external NHS staff, including contractors delivering NHS care, is permissible where the risk justifies it.

3.0 RESPONSIBILITIES

3.1 **Chief Executive**
The Chief Executive is ultimately responsible for the implementation of this policy.

3.2 **Security Management Director (SMD)**
The SMD has Executive responsibility for this policy as part of his portfolio covering security management and protection of staff. The SMD, or delegated representative, is responsible for final approval of all violent patient markers.

3.3 **Non-Executive Security Champion**
The designated NED is the Trust Security Champion and is responsible for promoting security management work from the non-executive function at Board level: to challenge, scrutinise and ensure accountability in respect of all security management work, including this protocol.

3.4 **Executive Directors/Clinical Directors/Service Directors**
Other Directors are responsible for ensuring that there are suitable and sufficient control measures in place to protect their staff from violence, this includes the implementation of this protocol in their directorate.

3.5 **Deputy Director of Risk and Compliance**
The Deputy Director of Risk and Compliance has responsibility for ensuring that the VAPR locally delivers NHS national guidance, this includes the implementation and monitoring of a robust risk of violence marker process.

3.6 **Health & Safety & Violence & Abuse Prevention & Reduction Advisor (HSVAPR)**
The VAPR is responsible for implementation of NHS security management agenda across the Trust in order to achieve compliance with the NHS Security Management Standards.

The VAPR is responsible for supporting operational staff with the violent patient marker agenda and for recommending and advising the SMD, or delegated representative in the decision making process.

The VAPR is responsible for placing a violent patient marker on a record where there is serious or imminent risk to staff – alongside police involvement – where there is not time to present a case to the SMD, or delegated representative.

3.7 **Departmental Managers/Team Leaders and other Persons in Charge**
Managers and Leads are responsible for ensuring that all staff are aware of the risk of violence marker protocol.

Managers and Leads will ensure that where an individual presents a significant risk of violence to Trust staff or premises, a marker will be sought using this process to protect staff.

3.8 **Workforce, Development & Training**
Workforce, Development & Training are responsible for ensuring that where appropriate during PMVA training, staff are made aware of this protocol.

3.9 **The Clinical (Referring) Team**
The clinical team are responsible for making applications for a violent patient marker and managing all markers placed using this protocol.

3.10 **All staff**
All Trust staff have a responsibility for being aware of this protocol and using the request for a violent marker process appropriately as well as checking electronic systems and patient records as part of their clinical risk processes when planning to see/provide intervention with patients.

4.0 DEFINITIONS

4.1 The Health & Safety Executive defines **workplace violence** as:

'Any incident in which a person is abused, threatened or assaulted in circumstances related to their work'.

4.2 Physical assault is defined as:

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

Type of categorised physical assault: Physical assault (no physical injury suffered)* or Physical assault (physical injury sustained)

*Spitting is included in the definition of a physical assault, in circumstances where the spittle hits the individual.

4.3 Non-physical assault is defined as: ***'The use of inappropriate words or behaviour causing distress and/or constituting harassment'.***

- Type of categorised non-physical assault: Offensive or obscene language, verbal abuse and swearing*
- Brandishing weapons or objects which could be used as weapons; attempted assaults; offensive gestures, threats; intimidation; harassment or stalking; damage to buildings, equipment or vehicles which causes fear for personal safety.
- Offensive language or behaviour related to a person's race, gender, nationality, religion, disability, age or sexual orientation; inappropriate sexual language or behaviour.

*The use of swear words may warrant a marker depending on the circumstances in which they are used. For some individuals, swear words may be used in everyday speech, however a marker should be considered where swear words are used aggressively.

N.B. Some of the above examples of non-physical assault can be carried out by phone, letter or electronic means (e.g. e-mail, fax and text).

5.0 DPA 2018 / GDPR 2016 & INFORMATION SHARING

5.1 The VAPR and Clinical Team must be aware of the provisions in the Information Commissioners Office (ICO) guidance on the DPA 2018 / GDPR 2016 and the use of violent marker warnings and ensure that they comply with the guidance.

5.2 The Trust is the data controller and will retain ultimate responsibility in relation to processing, notification and disclosure of risk information and the security and confidentiality of such information.

5.3 The ICO guidance on violent patient markers makes it clear that employers (The Trust) have a duty of care to its staff under Health & Safety legislation. The processing of violent patient markers complies with these legal obligations provided it is fair and justified.

5.4 The Clinical Team will decide who the marker is shared with, but will consider all partnership agencies that may come into contact with the identified risk.

5.5 The VAPR will decide if a DPA request to the police is required requesting criminal history or address risk information (PNC check).

6.0 PROCESS FOR A MARKER

6.1 **If there is an immediate risk of violence staff should follow related policies (TASID, Zero Tolerance). This includes calling the police on 999 where there is an immediate threat to life or property.**

6.2 **Reporting**

Trust staff must complete a Datix incident form following any violent incident.

The Datix Handler will review the incident and immediately inform the VAPR if advice is required.

6.3 The Clinical Team will review the risks of violence and make a decision as to whether or not a violent marker may be required to protect other staff following:

- An incident of violence perpetrated by a patient
- Information shared by another agency regarding a significant risk of violence perpetrated by a patient
- Alert received either locally or nationally regarding a significant risk of violence perpetrated by a patient
- Clinical review where there is a history of violence and a current escalating risk of violence perpetrated by a patient
- Risk of violence related to the address being visited
- Risk of injury from animals at the address

Note that there may be other issues creating a risk of violence to Trust staff that may need a violent patient marker or other control measures to be considered.

6.4 If a violent patient marker is required, the clinical team will electronically complete the Violent Patient Marker Alert form (Appendix 8B) and send it to the Risk Management Team for the VAPR to process.

Investigation

6.5 The VAPR will review all violent incidents reported on Datix and determine whether or not further investigation is required. The investigation will provide information to support whether or not a violent patent marker is required.

6.6 The VAPR will receive all Violent Patient Marker request Forms and supporting evidence (this may include relevant information from PALS, Complaints, Legal, Safeguarding and other Trust teams and information from other partners e.g. the police to ensure as much information as possible is available to support the request) to present to the SMD, or delegated representative to assess the presenting risks and whether or not a marker can be placed.

6.7 Whilst it is desirable to have as much information as possible to inform a decision, it may be necessary for the VAPR and Associate Director of Risk and Compliance to make an immediate decision to place a marker, based on serious or imminent risks to staff.

Decision Making

6.8 The following risk factors should be considered when determining whether or not a record should be marked:

- Nature of incident (physical or non-physical)
- Degree of violence used or threatened by the individual
- Injuries sustained by the victim
- The level of risk of violence posed by the individual
- Whether an urgent response is required to alert staff
- Impact on staff and other victims that witnessed the incident
- Impact on service provision
- Likelihood of a reoccurrence
- Time delay since incident
- Next appointment date for individual and location
- Whether individual is a frequent or daily attender to services
- Whether individual is an inpatient
- Whether the incident is part of a pattern of escalating behaviour
- Mental health state and capacity of individual
- Physical health state of individual
- The opinion of the staff victims of violent incidents
- What other action can be taken to prevent incidents from occurring.

6.9 The VAPR decision to recommend a marker should be based on a specific incident or risk history and evidence gathered during the investigation.

6.10 If the police are called to an incident, the VAPR will liaise with the Investigating Officer to ascertain what action is being taken in relation to criminal investigations where an individual has committed a criminal offence and was responsible for his/her actions (had capacity at the time). The VAPR will support any such investigation to facilitate an expedient outcome. This should not delay placing a violent marker if there is a risk and does not replace any legal action.

6.11 The VAPR is responsible for making the final recommendation on the need for a marker, based on consultation with the victim, clinical manager and the investigation findings.

6.12 **All recommendations for a violent patient marker will then be referred to the SMD, or delegated representative for consideration and approval.**

Marker Agreed

6.13 Once a decision has been made to place a violent patient marker, the VAPR will:

IN MENTAL HEALTH, LEARNING DISABILITY & SPECIALIST SERVICES:

- Liaise with the Electronic Record team who will scan the VPM Form into the Electronic Record. **Note that the VPM request Form will be an Electronic Record Form as soon as possible*
- Liaise with the Information Team, who will place an alert on the patient summary on the Trust intranet.

IN COMMUNITY HEALTH SERVICES

- Liaise with the patient's GP who can add the VPM marker to the relevant record system e.g. SystmOne.

6.14 Placing a marker must not preclude existing lines of communication to alerting staff to the potential risk of violence from an individual if there is an imminent risk. Team / line Managers will manage immediate risks / risk assessments / control measures to mitigate risks to their staff.

Marker Declined

6.15 There may be circumstances where following a review of all evidence; the SMD, or delegated representative decision is that it is not appropriate to place a marker on the record. It may be due to the fact that the individual poses no further risk. If a marker is denied, the reasons must be recorded on the VPM Request form to be further considered by the clinical team.

6.16 The clinical team will need to review the risk management plan to ensure that staff are safe when delivering care to the individual.

7.0 INFORMING THE PERPETRATOR

7.1 The SMD or delegated representative will make the final decision as to whether or not the individual should be informed that a marker has been placed.

7.2 There may be exceptional circumstances where the clinical team have recommended not to inform an individual that a marker has been placed on the record:

- Informing the individual may provoke a violent response and put staff further at risk.
- Informing the individual may adversely affect their health.

7.3 If agreed by the SMD, or delegated representative, the VAPR or other nominated person will send a formal notification letter (Appendix 8C) to the individual outlining the reasons for the marker. The letter will clearly explain:

- The nature of the violent incident
- That their record will now show a violent marker
- The reason why the marker is being placed
- Who the information will be shared with and for what purpose
- When the marker will be reviewed
- The complaints procedure
- Relevant contact details
- A detailed record of this decision will be made on the violent patient marker request form, which includes evidence of the risk of violence.

7.4 If the incident was perpetrated by an associate of the individual, the letter should be sent to both the individual and the associate – if the associate's identity and address are known. **Care should be taken not to disclose any confidential medical information when informing associates**.

7.5 Note that associates will not be informed if by doing so would:

- Create a risk for the patient
- Disclose the patient's mental health information
- Require the patient's consent

8.0 INFORMING THE VICTIM

8.1 If the marker was requested as a result of an incident the VAPR will inform the staff victim of the incident of the decision reached by the Trust and the reasons why. This feedback will support the Trust pro- security culture.

9.0 COMPLAINTS

9.1 When the individual is informed of the decision to place a maker on his/her record, a Trust Complaints Procedure leaflet will be included.

9.2 All complaints will be dealt with in line with Trust Policy and Procedure.

10.0 REVIEW OF MARKERS

10.1 The Risk Team will hold a VPM Register and monitor all placed markers. When a marker is added to a record the VAPR will document on the VPM Register:

- The date of the incident
- Date marker effective from
- Review date

10.2 The VAPR will have in place a system that alerts them when a marker is due for review and then submit those markers to the clinical team.

10.3 Review dates will be agreed by the clinical team when the marker is added to a record and will not exceed 12 months from the incident date. A review will be undertaken earlier if there are other risks identified.

10.4 The review of a marker by the clinical team must consider the following:

- The severity of the original document and the impact on the staff member
- Any continuing risk that an individual may pose
- Any further incidents involving the individual
- Any indication that the incident is likely to be repeated
- Any action taken by other agencies e.g. police or the courts

10.5 Where a marker is placed against a patient because of a risk associated with an address, this must be reviewed when the Trust is made aware of a change in circumstances that changes the risk.

10.6 If the recommendation is made by the clinical team to retain the marker on the record, the VAPR will present the recommendation and relevant evidence to the SMD, or delegated representative for consideration and approval.

10.7 If approved, the individual will be informed/not informed as in 7.3 and a new review date will be set.

10.8 When a decision is made to remove and archive the marker based on risk assessment and agreement that the individual's behaviour gives no further cause for concern; the VAPR will facilitate the removal of the marker from the record and inform the individual.

10.9 The patient's electronic record will need to be opened for the relevant patient and the relevant Alerts form found. A report problem can be started and a descriptor given to remove that alert form. The alert form will then be removed from visibility but a copy will be retained in an electronic legal repository for audit purposes.

10.10 The VAPR will write to the relevant GP to remove a marker from the CHS system.

11.0 OVERSIGHT

11.1 The SMD retains oversight of the violent patient marker agenda.

12.0 NATIONAL, REGIONAL AND LOCAL ALERTS

12.1 The VAPR periodically receives national and regional alerts regarding individuals that present a risk of violence or other criminal behaviour to NHS staff.

12.2 On receipt of an alert, the VAPR will review the risk with the Risk Team in relation to any potential risk to Trust staff.

12.3 If the alert relates to a potential patient, the alert will be added to the Electronic Client Information Database (for Mental Health, Learning Disability and Specialist Services).

12.4 The alert will be cascaded, if appropriate, to Community Health Services staff via the Datix CAS system.

12.5 The VAPR will generate CAS Alerts locally where appropriate.

13.0 ASSOCIATED DOCUMENTATION & POLICIES

This Protocol links with the following Trust Policies:

- TASID (RM05)
- Criminal Behaviour Within A Health Environment (Zero Tolerance) Policy (CP22)
- Clinical Risk Assessment Policy (CLP28)
- Lone Working Policy (RM17)
- Security Policy (RM09)

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Appendix 5b: VPM Alert Form

Saved as a separate form for ease of printing; click here

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Appendix 5c: Formal Notification Letter

Saved as a separate document for ease of printing; click here

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Appendix 6: Pinpoint Operational Guide

1.0 INTRODUCTION

1.1 There are occasions when staff may need to summon immediate assistance from colleagues.

1.2 The Pinpoint Alarm system is an aide for alerting staff to these situations.

1.3 It is essential that the Clinical and Support Services maintain a safe environment for patients, staff, and visitors.

2.0 SCOPE

2.1 This procedural guideline is applicable to all staff, inclusive of nursing, medical, therapy and facilities staff that use the Pinpoint alarm system.

2.2 To assign responsibility and provide instructions for the monitoring and use of the Pinpoint alarm system.

2.3 To ensure every member of staff is aware of all the operational issues, correct and safe use of the Pinpoint alarm system.

3.0 RESPONSIBILITIES

3.1 It is the responsibility of the managers of each department to ensure that these procedural guidelines are adhered to and upheld at all times.

3.2 It is the direct responsibility of the person in charge of a particular shift to ensure the correct and safe use of Pinpoint alarm system.

3.3 It is the responsibility of each staff member to be aware of the correct and safe use and to follow these guidelines.

4.0 IMPLEMENTATION

4.1 The Pinpoint alarm system will alert staff and initiate a response to a situation on the wards or in a department, where assistance is required.

4.2 As part of the local induction it is the responsibility of Senior Sister/Senior Charge Nurse or designated person in charge to ensure that every member of staff has been fully inducted and understands how to operate and respond to calls when issued a Pinpoint Personal Infrared Transmitter (PIT) PIT alarm.

4.3 In the absence of senior staff, it is the responsibility of the person in charge of the shift to ensure the member of staff issued a Pinpoint PIT alarm has signed the unit induction sheet and fully understands the operational issues for using the Pinpoint alarm system.

4.4 The nurse in charge of the shift on the wards and the person in charge of other departments will ensure that all bank/agency staff signs to agree that they fully understand the operational procedures. The Senior Sister / Senior Charge Nurse / Department Manager will hold this form on record.

4.5 On the wards a PIT alarm will be issued by the security nurse on each ward at the commencement of the shift. This will be signed in and out by both the hospitality nurse and the staff member.

4.6 It is the responsibility of the individual staff member to ensure that the PIT alarm is signed for and returned back to the designated ward / area. The staff member will be aware that if the PIT is missing, the last person to whom the PIT alarm was allocated may be held accountable for the loss.

4.7 The records will be kept safe and audited by the nurse in charge, and countersigned by the Senior Sister/Senior Charge Nurse/ Manager on a set day each week that is conducive to the Ward.

4.8 The PIT alarm is to be attached to the loop on the front of the uniform as worn by nursing staff or belt of other staff whilst on duty.

4.9 It is the responsibility of each individual staff member to check the PIT alarm issued to them using the transmitter tester box or testing station within the staff office. Additionally each time they collect their PIT alarm, staff must re-charge it using the testing station provided within the office for this purpose. If the PIT alarm has not been used to activate an alarm it should take less than five seconds to bring it to full charge.

4.10 The PIT alarm system is intended to alert staff and initiate a response to an incident. The PIT alarm has two modes of activation:

The first is by pressing the button on the base of the PIT. This causes the alarm system to generate a pulsing tone. This signals that the user is in a potentially threatening situation.

The second is by pulling the PIT alarm away from the securing pin and dropping it or placing it in a pocket. This causes the system to generate a high pitched continuous alarm which signals that the user is involved in an incident. It is not recommended that the PIT alarm is thrown as this may mislead the system to read the wrong location sensor. **The activated PIT alarm is a source of powerful light and direct contact of the beam with eyes must be avoided.**

4.11 After activating a PIT alarm, it is essential that the PIT is re-charged on the ward or non-ward location using the TTS provided for this purpose. Recharging takes only a matter of seconds.

4.12 The location of an activated alarm will be displayed on the local ward or departmental main display unit as well as repeater panels within the ward or department of activation.

4.13 In addition the system will activate pagers held by allocated members of nursing staff across the wards comprising the facility. These staff will together comprise the Rapid Response Team. No member of this team shall leave the facility without formally handing over responsibility to another member of the nursing staff.

4.14 In ward areas, staff on duty within the ward will respond immediately to any activated alarm. They will be supported by the Rapid Response Team.

4.15 For activations in non-ward areas the response will be made only by the Rapid Response Team. To assist Rapid Response Team members reaching the source of the activation quickly an over the door “Follow my Leader” light system is provided in all non-ward areas. Rapid Response Team members will also carry a master key allowing entry to all doors throughout the facility.

4.16 The audible alarm will sound until either muted at any of the repeater panels, or until the system is reset at the main panel by using the re-set key system and the pin replaced into the individual PIT alarm. Staff attending the activation will have the option to mute the system at the nearest repeater panel before re-setting at the main display unit. This may be appropriate if the activation was a false alarm or the incident was quickly resolved.

4.17 **It must be noted that the system also has a permanent mute feature. Under no circumstances shall staff permanently mute the system, for example due to repeated nuisance type incidents. However, in the event that the system is inadvertently or accidentally muted a message will flash on the panels after 30 minutes. If this occurs the mute feature must be de-activated immediately.**

4.18 The system also includes an emergency call feature linked to accessible bathrooms and WCs. When activated this will sound a different tone from PITs activated alarms and will register on panels as a patient call.

4.19 All display units and receivers must be tested on a monthly basis by the Estates Department to ensure they are functioning correctly. A silent test function is provided for this purpose. Details of the tests should be recorded by the Hospitality Nurse on the Ward Log.

4.20 Staff working in Reception Area, Corridors etc. will be issued their PIT alarm via Reception. The same procedure for testing and signing alarms in and out will apply in these areas.

4.21 For Audit purposes where required the date, time and service of all alarm activations is recorded on a database (Incipog) held centrally within the Basildon Mental Health Unit.

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5.0 RECORDING, MONITORING & REPAIR

5.1 The Security Nurse will check each PIT daily and any problems encountered will be recorded and reported to the Estates Helpdesk, and the Trust Security & Compliance Officer

5.2 If a problem is encountered with the Pinpoint alarm system it is the Site Officer's responsibility to report this to the Estates Department and the Trust Security and Compliance Officer immediately.

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Appendix 7: Equality Impact Assessment [2024]

Please Note: An EIA must be attached to papers submitted to Board, the Executive Team or any other committee within EPUT. The Equality Impact Assessment (EIA) is designed to make sure that our policies, services and functions do not discriminate in line with the Equality Act (2010). The author must gauge the impact of what they propose against marginalised and minority groups.

How to complete this EIA

The lead assessor must be a member of the team leading the implementation of the service, function or project. If this is not the case, the final assessment should be approved by the lead before submission, examples of what warrants an EIA include:

- Introducing a new way of working into the Trust, or developing new services.
- Implementing new technology or processes.
- Creating a new policy or process that will affect staff in EPUT, or patients in their care.
- Implementing significant changes to an existing service, function or process within EPUT.

1) **Review evidence:** What evidence do you have that this may affect those from minority or marginalised communities? Have you looked at similar projects to identify best practice or discussed this in your team?

2) **Consultation:** Have you discussed this with stakeholders in the Trust or sought evidence?
   - Involving staff or patients who would be impacted in the decision-making process
   - Guidance from national organisations *(CQC / NHS Employers)*
   - The Equality and Inclusion Hub *(on the staff intranet)*
   - Input from Staff Equality Networks
   - Reviewing this against good practice in other NHS Trusts

3) **Provide rationale:** Explain clearly why this project will not affect marginalised or minority groups in the section below. Discuss this with your team and ensure that you are involving as many diverse viewpoints as possible in the conversation. List your reasons clearly in the boxes overleaf.

   The Equality and Inclusion Committee can review this and develop actions to support with implementation. You should also make a note on if this might benefit one group over others (for example, if an initiative improves the experience of those with disabilities or long-term conditions). This information can be used to suggest future improvements.

Submission: Please send a copy to epunft.equality@nhs.net for approval by the Equality and Inclusion Committee. These will be reviewed and approved as part of the next committee meeting. Actions may be suggested if concerns are raised by the initial screening. Please ensure that clear actions for these concerns is part of the final EIA document.

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Date (DD/MM/YYYY)	01 08 2025	
Directorate / locality / department	Mandatory Training	
Name of new policy / service / function	RM05 Therapeutic & Safe Interventions & De-Escalation Policy	
Is this a new policy / service / function or a change / review to an existing one?	Review	
Name of person(s) completing this EIA and their role(s) within the Trust *(Inc. the lead assessor completing this assessment)*	Name: **[I/S]**	Role: Mandatory Training Manager
	Name:	Role:
	Name:	Role:
Name of relevant director of services	Gill Brice	
Contact email address of lead assessor	**[I/S]**	

Actions as a result of this EIA:
Actions developed if requested by the Equality and Inclusion Committee following completion of screening questions and project details:

	E&IC suggested action (To be completed by the EIC in response to a concern raised by the screening questions overleaf)	**How / when was this completed?** (please provide a short summary of how this was addressed and when)
1		
2		
3		

This section to be completed by the Chair, following approval by the EPUT Equality and Inclusion Committee			
Equality Impact Assessment Authorised by:			
Name:		**Role:**	
Date:			

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Screening Questions: *To be Completed by lead assessor:*

Does this work affect this group more / less favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
Race, Ethnic Origins, Nationality (including traveling communities)	No	
Sex (Based on Biological / Anatomical Sex; Male, Female or Intersex)	No	
Age	No	
Sexual Orientation Including Heterosexual, Lesbian, Gay, Bisexual or any other orientation.	No	
People who are/were Married or are/were in a Civil Partnership	No	
People who are Pregnant or are on Maternity / Paternity Leave	No	
Transgender people, including those undergoing gender reassignment or those who do not identify as the gender they were assigned at birth	No	
Religion or Belief Including an absence of belief or philosophical beliefs such as Veganism	No	
Disability / Mental, Neurological or Physical health conditions Including Learning Disabilities	No	
Other Marginalised or Minority Groups Carers, Low Income Families, people without a fixed abode or currently living in sheltered accommodation.	No	