Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Safe use of Physical Restraint Techniques

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Contents

1 Purpose

This procedure covers all staff and persons within Tees, Esk and Wear Valleys NHS Foundation Trust, and any others who are acting on behalf of the Trust.

Following this procedure will help the Trust to:-

- Provide guidance in relation to the nature, circumstances and use of approved restraint techniques currently adopted by the Trust. Its aim is to help all involved act appropriately in a safe manner, thus ensuring effective responses in potential or actual difficult situations. It sets out a framework of good practice, recognising the need to ensure that all legal, ethical and professional issues have been taken into consideration.
- Recognise that in certain situations, the application of a physical restraint technique is the only option available to staff charged with the prevention of harm to the patient or others. It is acknowledged that the application of physical restraint can present a high level of risk to the patient and to the staff participating, who may be required to justify that these risks are less than the risk of not applying restraint.

2 Related documents

This procedure must be used in conjunction with the following policies

- Clinical Risk and Assessment Management
- Positive approaches to supporting people whose behaviour is described as challenging
- Searching of patients and their property Policy
- Rapid Tranquilisation Policy
- Advance decisions to refuse treatment and statements made in advance
- Mental Capacity Act
- Seclusion and Segregation Procedure
- Consent to Treatment Policy
- Clinical Risk and Assessment and Management (CRAM) Policy
- Engagements and observation Procedure
- Procedure for Using the Early Warning Score for the Early Detection and Management of the Deteriorating Patient

3 Introduction

The Trust is committed to best practise in the use of physical restraint and the application of TEWV's Trust-wide Force Reduction Framework.

The Mental Health Code of Practice (2015) and NG10 Short term management of violence and aggression (2015) provide clear recommendations for the short term use of physical restraint techniques. This procedure aims to inform Trust-wide staff of these requirements.

4 Definitions

Term	Definition
Restraint	An intervention that prevents a person from behaving in ways that threaten to cause harm to themselves, to others, or to Trust property and/or equipment.
Physical Restraint	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. Physical restraint covers anything from guided walks, arm holds, seated/mova bag restraint to in circumstances of severe risk use of supine and prone restraint.
Prone Restraint	Prone restraint, or face-down restraint, is when a person is positioned on a surface face down on their stomach preventing them from moving out of this position
Supine Restraint	Supine restraint is when a person is placed on a surface on their back and prevented from moving out of this position.
Behaviour Support Plan	Positive Behaviour Support is an evidence-based approach with a primary goal of increasing a person's quality of life and a secondary goal of decreasing the frequency and severity of their challenging behaviours.
Verbal de-escalation	The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression.
PRN medication	The use of As-required medication (PRN) can be utilised as part of a de-escalation strategy but PRN medication used alone is not de-escalation. PRN should always be considered prior to any administration of Rapid Tranquilisation.
Rapid Tranquilisation	Rapid tranquillisation Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed. (NICE NG10 May 2015)
Advanced decision	A written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future.
Advanced statement	A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.
Tertiary Interventions	Guidance as to how people should react when a person's agitation escalates to a crisis where they place either themselves or others at significant risk of harm. This may include the use of restrictive interventions.

5 Guidelines for the use of Physical Restraint

5.1 Process of Physical Restraint

The Trusts stance is that physical restraint will only be considered when all other practical means of managing the situation, such as de-escalation, verbal persuasion or consented medication administration, have failed.

All incidents of physical restraint carried out should maintain the patient's well-being and be respectful to maintain their dignity at all times.

A member of staff up-to-date with Management of Violence and Aggression (MoVA) training should be identified as the co-ordinator of the tertiary intervention.

The identified member of staff (lead) should, where possible;

- be familiar with the patient,
- use clear, direct, uncomplicated communication throughout the control and restraint,
- have knowledge of the risks associated with physical restraint, both in general and any highlighted health risks for that individual patient.

The lead person must remain in control of the restraint process, taking responsibility for communication within the restraint.

- The lead should continually communicate with the patient throughout the restraint
- Continue to use de-escalation techniques irrespective of the stage of restraint.

If a patient is involved in multiple incidents of physical restraint, a Person Centred Plan should be developed with, where appropriate, the patient.

5.2 Physical Holds Technique

All Trust staff are expected to only use physical holds approved by the General Services Association and taught by the Positive Approaches Training Team during the Positive Approaches Training. A graded response should be used and evidenced in patient records. A referral should be made to the Positive Approaches Team if staff have any issues with physical holds or require any additional support.

5.3 Prone/ Face down restraint

Where possible, restraining patients in prone positions should be avoided. In exceptional situations where the restrained person needs to be held in prone position for the safety of themselves and/or others, this should be for the shortest time possible.

If services become aware that a patient has been restrained in prone position on more than 2 to 3 occasions, services are expected to seek the support of the Positive Approaches Training Team (PATT) for support and guidance.

5.4 Physical Observations

Patients should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure to the neck region, rib cage and/or abdomen. Unless there is a rational for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor.

A full account should be taken of the individual's age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment, which may confer additional risks to the individual's health, safety and wellbeing in the face of exposure to physical restraint.

Throughout any period of physical restraint:

- The intervention lead should identify one member of staff to monitor the individual's airway and physical condition to minimise the potential of harm or injury.
- Observations, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/discolouration), should be conducted using the Procedure for Using the Early Warning Score for the Early Detection and Management of the Deteriorating Patient throughout and following any physical restraint.
- Staff must be aware that patients will often refuse these types of interventions during these periods. We would recommend that, as a minimum standard, staff visually monitor respiration levels at these times.
- The patient's physical observations need to be recorded on their Early warning Score Chart and on their Paris records for that day. Staff should be trained so that they are competent to interpret these vital signs

Emergency resuscitation devices should be readily available in the area where restraint is taking place, and a member of staff should take the lead in caring for other patients and moving them away from the area of disturbance.

5.5 Observations

Levels of observation should be set in the least restrictive form, within the least restrictive setting to protect the safety of the patient, safety of others and to promote positive therapeutic engagement. It is necessary to balance the service user's safety, dignity and privacy with the need to maintain the safety of the service user and those around them (Supportive engagement and observations Procedure).

Any changes to a patient's observation levels must be recorded in the patient's notes specifying the reason for the change.

5.6 Post-Incident Debrief

Following the use of any physical restraint all staff involved should immediately carry out a post-incident debrief once the risk of harm has been contained. The post-incident debrief should identify and address physical harm to the patient and staff, ongoing risks and the emotional impact on the patient and staff members involved including witnesses.

The patient involved in the physical restraint is to be offered the opportunity to discuss their experiences with staff were not involved in the physical restraint.

The post-incident debrief for patients, staff or witnesses should only be carried out after each party has recovered their composure with the aim to:

- Acknowledge the emotional responses to the incident and assess whether there is a need for emotional support for any trauma experienced
- Promote relaxation and feelings of safety
- Support a return to normal patterns of activity
- Learn lessons and consider future actions if similar incidences were to occur.

Staff together with the patient, their families and advocates, where appropriate, should consider whether the patients PBS plan or other aspects of the patients care plans need to be revised/updated in response to the information from the post-incident debrief.

5.7 Trauma

Physical restraint is often a major contribution to delaying recovery, and has been linked with causing serious trauma both physical and psychological, to patients and staff.

Individual risk factors, which suggest a patient is at increased risk of physical and/ or emotional trauma, must be taken into account when applying physical restraint.

The post incident review should identify if there is a need and if so, provide counselling or support for any trauma that might have resulted. It is important to establish whether anything could be done differently to make a physical restraint less traumatic.

5.8 Positive engagement following the use of physical restraint

Patients should be empowered to actively participate in their care, rather than “having things done to them”. Patients should be encouraged to participate in activities that are therapeutic, engaging and meaningful to them. Activities should instil hope in the patient, allowing them to address their difficulties constructively. Where appropriate, patients should be encouraged to participate with ward activities with their fellow patients and staff in order to facilitate their recovery journey.

5.9 Reporting and recording

Tees, Esk and Wear Valleys NHS Foundation Trust will comply with the reporting requirements relating to the use of physical restraint required by the Care Quality Commission as expressed in the Mental Health Act Code of Practice.

Following all incidents of physical restraint, a Datix should be completed. If either the patient or staff have been injured, an additional Datix report needs to be completed for each individual.

5.10 Training

The Trust provides mandatory training that meets the organisational training needs analysis. All staff within the Trust should be trained in undertaking physical restraint and the risks involved. The Trust currently trains staff with restraint techniques supplied by the General Service Association (GSA). All Trust staff should also understand and be able to the Human Rights Act 1998, and the relevant rights in the European Convention of Human Rights.

Attendance at training is monitored via Human Resources who send attendance reports to managers to ensure mandatory training needs are met.

For training that the Trust has not classified as mandatory, managers should consider the necessary competencies for the specific work required and arrange for these needs to be met through the appraisal and personal development plan process. Access to support to meet these needs is outlined in the Learning and Development policy and in the Training portfolio section of the Intranet.

Managers of the Trust will ensure the appropriate training and education is available to implement this procedure. Managers are responsible for ensuring that all employees participate in the training and education programmes as determined by the organisational training needs analysis and identified as required by their role.

Individual competencies are monitored through Trust appraisal, supervision, Occupational Health and Human Resources systems, and recorded in staff personal files.

6 Legal context of physical restraint

Where physical restraint has been used, staff should record the decision and the reasons for it, including details about how the intervention was implemented and the patient's response. If an individual is not detained under the Act, but physical restraint of any form is necessary, consideration should be given to whether the criteria in sections 5 and 6 of the Mental Capacity Act (2005) apply (restraint to be used in respect of people aged 16 and over who

lack capacity) and/or whether detention under the Act is appropriate (subject to the criteria being met).

6.1 The Law of reasonable force

Common law allows reasonable force to be used where necessary for the purposes of:

- self-defence; or
- defence of another; or
- defence of property; or
- prevention of crime; or
- lawful arrest.

Staff may have to account for any use of force in the courts. They will need to know the legal authority for their actions and be able to explain why these were necessary, reasonable and proportionate in the circumstances.

7 Police support in the use of physical restraint

Guidance from the Policing College 2017 identified that local policing services may be able to assist and offer support to healthcare staff when a serious crime may have been committed, examples with guidance include:

- **An immediate risk to life and limb**
- **Immediate risk of serious harm**
- **Serious damage to property**
- **Offensive weapons**
- **Hostages**

Throughout any incident in which police respond and assist nursing staff to regain control the responsibility of the patient's health and safety remains that of the nursing staff. Where no significant threat of harm or commission of crime is present, the police will not attend to assist in restraining patients who are receiving treatment or assessment either as compulsory or voluntary patients.

It is unlawful for the police to restrain a patient on the basis that they might be violent if not restrained. Therefore police involvement in restraint is confined to:

- As part of structured handover under Section 136 of the Mental Health Act 1983

  Or
- Where the offending behaviour has reached such a serious level that the person needs to be arrested and dealt with under the criminal justice system

Staff need to be aware that local agreements may be in place with Local Policing services where they work, which outline standardised process for joint working, reporting and review following incidents.,

8 Audit and monitoring

The organisation regularly Team provides a report to the National reporting and learning system (NRLS) of all incidents associated with patient safety. If trends or unusual activity become apparent, the Positive & Safe Team will seek clarification and strategies to address the issues from the appropriate service manager.

8.1 Governance

Training will be reviewed on a yearly basis by the Director of Nursing and Governance and programmes will be amended accordingly.

9 References

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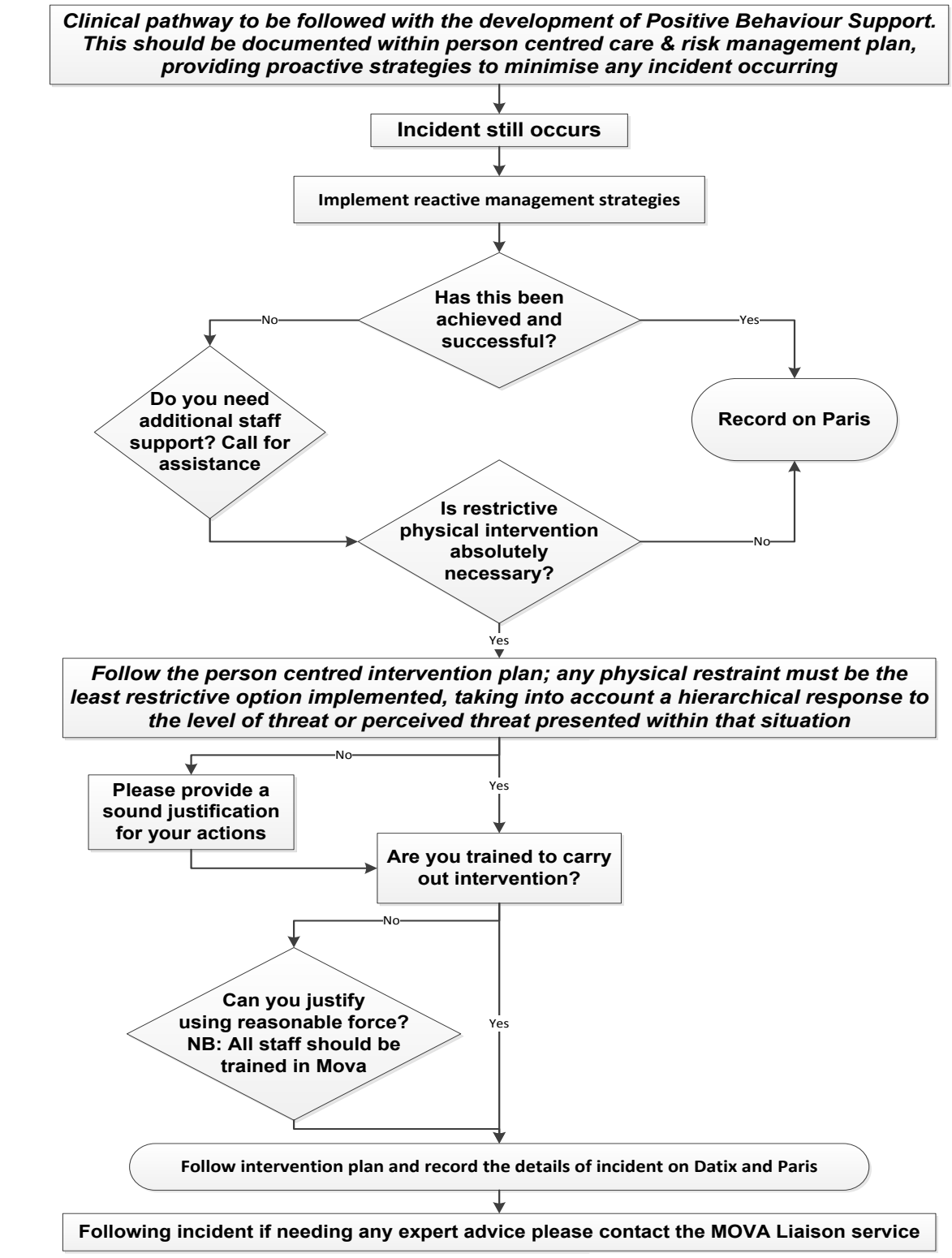
10 Appendix



NB: Prone (Face Down Restraint) should only occur in exceptional circumstances

11 Document control

Date of approval:	05 April 2017	
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This document replaces:	N/A	
Lead:	Name	Title
	Stephen Davison Judith Hurst	Force Reduction Project Lead Head of Workforce Development
Members of working party:	Name	Title
	Christine McCann Amy Smith Positive Approaches Team Force Reduction Steering Group	Associate Director of Nursing & Governance Force Reduction Project Officer
This document has been agreed and accepted by: (Director)	Name	Title
	Elizabeth Moody	Director of Nursing and Governance
This document was approved by:	Name of committee/group	Date
	Patient Safety Group	20th March 2017
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1	05 Apr 2017	New procedure	Published