Use of Force Policy

(Previously known as Physical Intervention Policy)

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Version Number	Review Date	Lead Name	Ratification Process	Notes
1	04/03/20 and 12/05/2020	K. Borrett and AMH Management team	Peer review and Senior staff review Policy Steering Group	New policy
2	29/03/2022	MHS HQP	Service User Groups MHS Governance Board Policy Steering Group Clinical Executive Group Health Watch Patient Safety Partners Team	Amended early to reflect requirements of Mental Health Units (Use of Force) Act (2018). Policy title changed to reflect new Act.

SUMMARY OF POLICY

This policy provides guidance for clinicians working in clinical settings who may use restrictive interventions. The policy incorporates all requirements of the Mental Health Units (Use of Force) Act (2018), Mental Health Act Code of Practice, (2015) and the national standards around the use of Prevention and Management of Violence and Aggression, (PMVA). The policy is part of our commitment to minimising the use of force, eliminating the inappropriate use of force and ensuring appropriate support in the event that the use of force is unavoidable.

The term 'restrictive interventions' is used to reflect current terms used by the Department of Health & Social Care and in order to encompass training systems currently employed by the Trust (PMVA). All use of restrictive interventions by employees must be lawful, necessary, reasonable in the circumstances, and undertaken in good faith. Solent NHS Trust and Isle of Wight NHS Trust are committed to protecting human rights and freedoms and reducing the disproportionate use of force and discrimination against all people, including those with protected characteristics as defined by the Equality Act (2010).

This policy also covers clinicians' personal safety, when working in a lone capacity, with breakaway techniques training and situational awareness. It also covers post restraint treatment of the individual patient and the reporting of all restraints. This incorporates the Restraint Reduction Network training standards (British Institute of Learning Disabilities, 2021. Available at: The Restraint Reduction Network Training Standards - Restraint Reduction Network).

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Use of Force Policy

Staff are expected to adhere to the processes and procedures detailed within this policy. During times of national or 'Gold Command' emergency Solent NHS Trust may seek to suspend elements of this policy in order to appropriately respond to a critical situation and enable staff to continue to work in a way that protects patient and staff safety. In such cases Quality Impact Assessments will be completed for process changes being put in place across the organisation. The QIA will require sign off by the Solent NHS Ethics Panel, which is convened at such times, and is chaired by either the Chief Nurse or Chief Medical Officer. Once approved at Ethics panel, these changes will be logged and the names/numbers of policies affected will be noted in the Trust wide risk associated with emergency situations. This sign off should include a start date for amendments and a review date or step down date when normal policy and procedures will resume.

1. INTRODUCTION & PURPOSE

1.1 This policy will outline the use of restrictive interventions, including physical intervention techniques within Solent NHS Trust and Isle of Wight NHS Trust, referred throughout this document as the Trusts. It will provide guidance and information for staff to recognise, prevent and manage safely any incidents of aggression and violence. The Trusts provide both community and inpatient mental health services for the Portsmouth area, Kite Unit in Southampton and services on the Isle of Wight. These provide care and treatment for adults and children experiencing a mental health crisis who require both support and treatment with their mental health difficulties. The Trusts also provides community care for other, non-mental health services.

1.2 The Trusts recognise and accept their responsibility for the prevention and management of aggression and violence in accordance with relevant legislation and national best practice guidelines, including the Mental Health Units (Use of Force) Act (2018). The Trusts expect that all Directors will ensure that the risk assessment and management policy is applied in relation to violence prevention as per policy.

1.3 The responsible person who is accountable for ensuring the requirements of the use of force act is the Chief Medical Officer for Solent NHS Trust and the Director of Community, Mental Health & Learning Disabilities for Isle of Wight NHS Trust.

1.4 The policy is based on the principles of the Public Health Model advocated by the World Health Organisation to address workplace violence, and depicts a hierarchy of responses relating to risk. It sees prevention as having three dimensions: primary, secondary and tertiary (Krug et al 2002), with each dimension being important in its own right. For the Public Health Model, prevention requires action at the level of the organisation, the staff team, the individual worker & the service user and is outlined in the 'Positive & Safe Violence Reduction Programme', (PSVRP), which underpins all interventions, techniques and teaching in Prevention and Management of Violence & Aggression (PMVA) programme.

1.5 The Trusts recognise the potentially traumatic effect the use of force can have on both patients, staff and witnesses. In order to minimise the use of force, the PMVA training has a focus on primary prevention/intervention activities (see hierarchy of response in 3.4). A post incident response is required.

1.6 When making decisions about the appropriate use of physical intervention, practitioners must give due regard and consideration to the Mental Health Act Code of Practice 2015 (available at Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk)), particularly the five guiding principles:

(i) Least restrictive option and maximising independence
Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient must not be detained. Wherever possible a patient's independence must be encouraged and supported with a focus on promoting recovery wherever possible.

(ii) Empowerment and involvement
Patients must be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, must be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals must explain the reasons for this.

(iii) Respect and dignity
Patients, their families and carers must be treated with respect and dignity and listened to by professionals.

(iv) Purpose and effectiveness
Decisions about care and treatment must be appropriate to the patient, with clear therapeutic aims, promote recovery and must be performed to current national guidelines and/or current, available best practice guidelines.

(v) Efficiency and equity
Providers, commissioners and other relevant organisations must work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services must work together to facilitate timely, safe and supportive discharge from detention.

2. SCOPE & DEFINITIONS

2.1. This policy applies to permanent, and fixed term contract employees (including Bank and Agency clinical staff) who hold a contract of employment or engagement with the Trusts in the Mental Health inpatient services, which includes services at St James Hospital, Portsmouth, Kite Unit at Western Community Hospital Southampton, Sevenacres on the Isle of Wight and services which are supported by Mental Health Divisional staff at St Mary's Hospital on Isle of Wight (including Emergency Department, acute medical wards and children's ward).

2.2. In recognition that national data highlights the disproportionate use of restrictive interventions have been disproportionately used with some groups who share a protected

characteristic under the Equality Act 2010 this policy forms part of The Trusts commitment to the principles of Equality and Diversity, and elimination of unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

2.3. See section 10 for Glossary of acronyms used throughout this document.

2.4. **Advocacy:** The Advocacy Service ensures that the views, wishes and feelings of those using health and social care services are promoted to service providers. Patients within the Trusts have access to the advocacy service, Independent Health Complaints Advocacy Service, Independent Mental Health Advocates (IMHA) and Independent Mental Capacity Advocates (IMCA).

2.5. **Formal Patients:** A formal (or detained) patient is admitted under the Mental Health Act (1983, amended 2007) and the care and treatment provided for this person has to be in accordance with this Act. Where practicable, engagement with the patient to seek their views and opinions about the care and treatment they receive must be included in care planning.

2.6. **Informal Patients:** An informal (or voluntary) patient consents to receive care and treatment in an inpatient setting, or a patient that lacks capacity to consent and does not object and is not deprived of their liberty. As such, engagement with them and having their consent and agreement to receive the care and treatment planned and offered is paramount. If the professionals providing this care and treatment feel that that the informal patient no longer has the capacity to consent to this care and treatment, the use of the Mental Health Act (1983, 2007) must be considered.

2.7. **Mental Health Act (1983, amended 2007):** An act of Parliament which primarily deals with the detention in hospital of people with mental disorders. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients.

2.8. **Mental Health Units (Use of Force) Act (2018):** An act of Parliament written with the intent to improve the care and treatment of those receiving mental health inpatient care in England. The use of force can be a frightening, traumatising and humiliating experience for patients, which has long lasting effects. The use of force can also have serious, and potentially fatal consequences, and must only be used proportionally and as a last resort. The aim of the act is to set out measures that reduce the use of force, ensuring accountability and transparency when it is used. It encourages working with patients in a trauma-informed, person-centred way, and developing therapeutic environments which ensure that force is used proportionately and only ever as a last resort.

2.9. **Code of Practice Guidelines (2015):** This Code provides guidance to registered medical practitioners (doctors), approved clinicians, managers and staff of providers and approved mental health professionals (AMHPs) on how they should proceed when undertaking duties under the Act. Chapter 26 specifically refers to safe and therapeutic responses to disturbed behaviour and underpins the treatment and management of our patients.

2.10. **Multidisciplinary Team (MDT):** A group of staff from a variety of professional backgrounds who contribute to the care and treatment that a patient receives.

2.11. **Rapid Tranquilisation:** The use of medication to calm/ sedate patients and thereby reduce the risks to themselves or others by achieving a reduction in agitation and arousal. Medication may be given either orally or via intramuscular (IM) injection, though the oral route must always be the first line of treatment. Further information can be found in the Management of Security and Violence and Aggression Policy and the Rapid Tranquilisation Guidelines.

2.12. **Responsible Clinician:** The Responsible Clinician (RC) replaces the term Responsible Medical Officer (RMO). The RC is an approved clinician with overall responsibility for the care and treatment for persons detained under the Mental Health Act. This is usually a Consultant Psychiatrist but can also include clinicians from other professional groups.

2.13. **Monthly Mental Health Act Monitoring Group (Solent NHS Trust):** This is a group made up of the Head of Access and Unplanned Care Mental Health, Mental Health Act and Mental Capacity Act Lead, Physical Intervention Lead, Modern Matron the Orchards and Lead Nurses from The Orchards. This group reviews all uses of the Mental Health Act including use of sections, use of section 136, restrictive interventions, which includes physical intervention, and any breaches or misuse thereof, in order to establish that the Trusts are operating proportionately and within the law.

2.14. **Mental Health Act and Deprivation of Liberty Safeguards Scrutiny Committee (Solent NHS Trust):** This is a committee that meets quarterly to scrutinise, monitor and review the way that functions under the Act are exercised, to ensure that the powers are only used as the law allows, to consider the implications of the Code of Practice and to promote best practice in these areas. It is a sub-committee of the Board and consists of executive and non-executive directors as well, lay people and service leads.

2.15. **Mental Health Act Committee (Isle of Wight NHS Trust):** This is a monthly meeting that meets to review the use of the mental health act on the Island and is attended by key Mental Health and Learning Disabilities Divisional staff.

2.16. **Seclusion:** The supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. Seclusion will only be practiced in the designated seclusion suite on Maple and Seagrove Wards and for this sole purpose.

2.17. **Teamwork techniques:** Teamwork approach is a designated system of techniques which employs a minimum of three persons during interventions. It promotes best practice in relation to the containment and restraint of the unarmed individual – taking into account the legal, statutory, ethical, moral obligations and risks associated with restraints.

2.18. **Breakaway techniques:** A set of physical and non-physical skills to separate or break away from an aggressor in a safe manner. They are emergency techniques that can be used in a one-to-one scenario in order to disengage from an aggressor.

2.19. **Restrictive Interventions include:**

I. physical restraint: the use of physical contact that is intended to prevent, restrict or subdue movement of any part of the patient's body. This would include holding a patient to give them a depot injection

II. mechanical restraint: the use of a device that is intended to prevent, restrict or subdue movement of any part of the patient's body, and is for the primary purpose of behavioural control

III. chemical restraint: the use of medication that is intended to prevent, restrict or subdue movement of any part of the patient's body. This includes the use of rapid tranquillisation (see National Institute for Health and Care Excellence (NICE) guideline [NG10] Violence and aggression: short-term management in mental health, health and community settings)

3. PROCESS/REQUIREMENTS

3.1. **Care Planning:** It is essential that patients, their carers and any independent advocates are included in the care planning process, using the Trusts' relevant care planning process (for Solent NHS Trust see MH03 Admission, Discharge and Transfer of Care Policy and for Isle of Wight NHS Trust see MHLD Clinical Risk Assessment and Management Policy for details of how staff use and follow care plans,). It should be recognised that it will not always be appropriate to involve family or carers, for example for survivors of domestic abuse and / or where safeguarding may be of concern. The patient's wishes and preferences must be taken into account. Care plans must be person centred, and take account of the patient's unique circumstances, their background and any history of trauma, their priorities, aspirations and preferences. Preventative strategies to the use of force must be considered, as should any advanced statements. Care plans should support patients to develop alternative coping strategies in response to behavioural disturbance, accessing evidence-based treatments appropriate to their assessed needs and preferences; in addition to being recovery focused, the care plan is aimed at reducing the need for restraint.

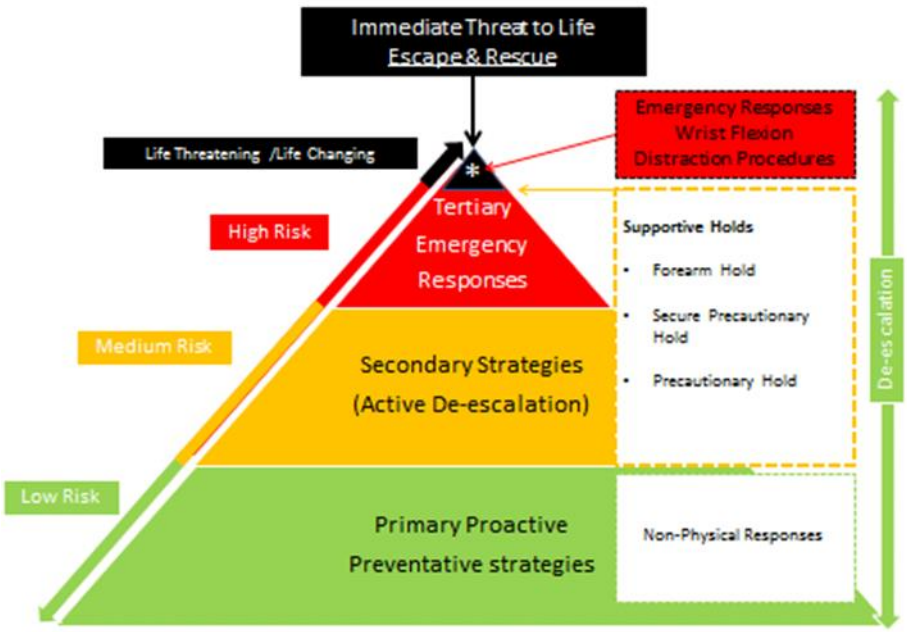
Where Use of force has been used, or repeat use of negligible force, a restraint reduction plan will be developed to include:

- why it is necessary to use this type of force and what other less restrictive options have been considered or already tried
- what the use of force consists of (a clear operational description)
- how frequently the force is likely to be used and in what circumstances
- what is the outcome for the patient if the activity that uses negligible force isn't carried out
- whether the patient consented to the negligible use of force
- how much discomfort it causes the patient
- any special health consideration, for example sensory issues, frailty or limited communication that makes the patient more vulnerable to the use of any force
- any measures that are being implemented to reduce the need for force to be used
- how the patient subject to the use of force (and where appropriate their families or carers) are involved in actively finding a solution to the need for the use of force
- how often the reduction plan will be reviewed and by whom
- what training is needed by staff to implement the negligible use of force safely and competently

In all circumstances, the emphasis is, and must remain, on de-escalation of potentially violent situations and a consequent reduction in the use of restraint. Any use of force must be seen as exceptional. PMVA training ensures staff awareness and practice of de-escalation techniques.

3.2. It is to provide staff with the best available options to keep them and those they care for as safe as possible. In an exceptional circumstance where staff have used a technique or strategy without an approved technique, there must be clarity that this use of force was a necessary and proportionate response within the boundaries of law, professional practice and had due regard to eliminating the inappropriate or disproportionate use of force.

3.3. The 'Hierarchy of responses triangle, used in PMVA training, illustrates how the risks associated with an intervention increase as the behaviour moves up the hierarchy from primary through secondary and then to tertiary. It is important for staff to keep interventions as far as possible in the primary section, moving where necessary to secondary interventions.



3.4. **Primary Prevention/Intervention:** These are preventative de-escalation strategies including skilled communication, distraction techniques, therapeutic engagement, guiding, advance directives and good communication.

3.5. **Secondary Intervention: Primary intervention tried / considered.** This is when staff have to physically intervene with an individual and utilise the hierarchy of holds and seated de-escalation. **Tertiary Intervention:** This is an emergency situation and could include physical intervention on the floor, secure wrist hold and seclusion. **Hierarchy of holds:** This is a series of physical intervention holds which are used dependant on the level of aggression present. Secondary-level holds are called precautionary, secure precautionary and forearm. The Tertiary-level hold is a secure wrist hold and can be used as a pain-compliance technique if the situation is of such high risk that it is deemed necessary. Although the vast majority of situations can be managed without use of pain-compliance techniques there are certain high-risk situations where their use may be justified. This should therefore be considered if they

are reasonably considered to carry a lower degree of risk both to service users and staff than other methods that might be used.

3.6. **Escape and Rescue techniques:** these are techniques that have always been taught within the PMVA course programme and are what are referred to as 'pain compliance techniques'. The RRN have recognised that there may be times in extreme circumstances that these techniques will have to be used and the criteria for their use would be where there is an actual or potential risk to life or a life-changing injury. These techniques can cause pain or discomfort; they will not cause any injury if used correctly, although if there is an underlying medical condition, they could exacerbate it. (Appendix C).

3.7. The use of restraint carries inherent risks, not least in terms of trauma, however any intervention that includes restraint in a prone position increases the risk to the patient being restrained to a level that can be considered unacceptable. The Trusts' strongly advocate for the use of a safety pod as opposed to a prone restraint, as this reduces the risk to the patient's cardiovascular and respiratory systems and allows for better communication. A safety pod is a adult-sized, firm bean-bag in which a supine restraint can be undertaken safely. In the event that an intervention is required, this must not interfere with the patient's airway, breathing or circulation by applying pressure to the rib cage, neck or abdomen or obstructing the nose or mouth. Additionally, interventions should not be carried out in a manner that interferes with communication, for example by obstructing the eyes, ears or mouth. Visibility of vital signs must be maintained by staff.

3.8. During times of national or 'Gold Command' emergency, if physical intervention is required staff must continue to use taught PMVA holds and procedures. PPE must be worn which will consist of face mask and gloves only and if this is dislodged during the incident, responding staff must relieve those staff ensuring they are wearing PPE themselves. Post incident, staff must adhere to doffing techniques, change their uniform and ensure they wash their hands and other areas that were exposed, e.g. arms. For planned restraints, staff must ensure the intervention team are wearing PPE, understand their roles and there are other PMVA trained staff wearing PPE available to relieve if necessary.

3.9. **Safer staffing:** Solent NHS Trust and Isle of Wight NHS Trust both recognise the importance of having adequate staff on duty on their wards. Having the right number of people working in our inpatient environments, with the right level of skill, can have a very positive impact on reducing the need for restrictive interventions. Likewise, too few or poorly trained staff can result in an increase in restrictive interventions. Both organisations have processes in place to monitor safe staffing numbers, and any incidents in which staffing had a negative effect must be entered onto the relevant incident recording system and consideration for investigation made, as per 7.2.

3.10. **Police involvement:** the need for police involvement in an incident of violence and aggression occurring in a mental health unit is very rare, and only appropriate in circumstances when hospital staff are unable to safely manage the patient's behaviour, constituting a significant risk to the patient or others. In the event that police support is required, the Nurse in Charge of the unit remains in charge of the incident, and must work with the Police to ensure their intervention is as short as possible to make the situation safe and allow hospital staff to take over at the earliest possible opportunity. Staff should be aware that police are required to wear and use their body camera. Police should refer to The College of Policing Memorandum

of Understanding: “The Police Use of Restraint in Mental Health and Learning Disability Setting”. The police should be involved in any post-incident review meeting.

3.11.1 Op Cavell is a Hampshire Police Led operation working in partnership with NHS trusts to improve the support provided to staff, investigate and detect more crime that is committed against NHS staff from patients. Offences such as Assault, Abuse, Hatred have now been recognised with new legislation and in 2018 Assault against Emergency worker Act was created. This allows the NHS to work in partnership with police forces trying to improve outcomes against staff who fall victim of an assault, abuse or hatred while working for the NHS. It is designed to improve outcomes and take more cases to a suitable conclusion or restorative resolution and the partnership working with UK police forces means we can hold more people to account

3.11.2 **Post incident support to staff**: it is recognised that the organisation has a key role in ensuring that appropriate support is provided to staff following an incident that involves the use of force. It is important that support is offered post-incident to staff, in the form of structured reviews and support given in a positive manner. Confidential advice and support is available to all staff through the Health & Safety Manager, Local Security Management Specialist, Human Resources department. Depending on the severity, managers may also support a staff member who has been involved in an incident by contacting a relative/family member; offering supervision; staying in contact with the employee if they are off work as a result of the incident; offering a change of role/work place; arranging a phased return to work. Managers and staff should be fully aware of the organisation counselling and support services, as well as immediate support offered at ward/department level. Where an incident has been reported to the Police, then the staff member may also receive support from Victim Support, a registered charity which specialises in providing support to victims of crime. The organisation will support and advise staff who find themselves the subject of complaint or legal action, if they have followed and acted within the scope of relevant Policies and Procedures, provided that the action taken was in good faith for the benefit and safety of themselves, Service Users, colleagues or members of the public.

Post incident Support for Patient involved and witnesses:

Recording

3.11. All incidents of physical intervention are reported via the incident reporting system.

3.12. Negligible use of force does not need to be recorded. The criteria for ‘negligible’ are:

where it involves light or gentle and proportionate pressure.
It is the minimum necessary to carry out therapeutic or caring activities (for example, personal care or for reassurance).
It forms part of the patient’s care plan.
Valid consent to the act in connection with care and treatment

Reporting must include:

- the reason for the use of force
- the place, date and duration of the use of force
- the types of force used on the patient
- whether the types of force used on the patient formed part of the patient's care plan
- the name of the patient on whom force was used
- a description of how force was used
- the patient's consistent identifier
- the name and job title of any member of staff who used force on the patient
- the reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient
- the patient's mental disorder (if known)
- the relevant characteristics of the patient (if known)
- whether the patient has a learning disability or autistic spectrum disorder
- a description of the outcome of the use of force
- whether the patient died or suffered any serious injury as a result of the use of force
- any efforts made to avoid the need for use of force on the patient
- whether a notification regarding the use of force was sent to the persons (if any) to be notified under the patient's care plan

3.13. This data is analysed and collated in a monthly report completed by the Physical Intervention Lead. The requirements of reporting include the demographics of patient, type of intervention, the duration of the intervention and outcome including if any injuries were sustained.

3.14. Information provided in incident reports will be analysed and presented thematically at the Mental Health Act Monitoring Group, Mental Health Act Scrutiny Panel, Mental Health Service's Integrated Governance Board and Mental Health Service's Violence & Aggression sub-group. The reports will be scrutinised to ensure that all aspects of restrictive intervention were lawful, that there was not the opportunity for alternative interventions to be tried or that all alternatives had been tried. Thematic analysis will also enable a discussion on violence reduction, such as the identification of trigger points at certain times of day or locations on the ward. The information gleaned will also be utilised in updating this policy.

4. ROLES & RESPONSIBILITIES

4.1. All staff, managers and directors have a professional responsibility to be alert to the disproportionate use of force and, if witnessed or suspected, must reported this to the Matron for the unit and complete an incident report using the relevant Trusts' incident reporting procedure. All staff must be familiar with the Trusts' Safeguarding Policies.

4.1.1. **The Chief Executive Officer**, (CEO), has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

4.1.2. The **Chief Nurse** is responsible for ensuring that this policy meets patients' needs and safeguarding requirements according to best practice.

4.1.3. **The Head of Access and Unplanned Care Mental Health** is responsible for ensuring that this policy is cascaded to The Modern Matron as appropriate for dissemination and implementation within the inpatient environments.

4.1.4. **Lead Clinicians** are accountable for ensuring that this policy is adhered to and implemented by their staff teams. They are responsible for ensuring that staff receive appropriate support and guidance on how to follow this policy. They will monitor for breaches of this policy and take appropriate action to rectify this (see also 7.2 Monitoring Effectiveness). The use of restrictive interventions can have an emotional impact on staff, and therefore action may be required in line with the organisation's wellbeing policy, including access to supervision, appropriate de-brief/post-incident support, employee assistance programme and occupational health.

4.1.5. Both Trusts have a dedicated Physical Intervention Lead who has responsibility for maintaining the standards set out in this policy by ensuring that all staff are trained both in restraint and breakaway techniques. The Physical Intervention Lead will review all incidences of restraint and provide a report, which will be shared with staff; this report will also contain seclusion reports. The Physical Intervention Lead will also be responsible for reviewing practice and developing strategies that will support both staff and patients and provide governance and standards levels. **The Physical Intervention Lead** is responsible for ensuring the standards of training are maintained and that any new processes or techniques are incorporated into the training. The Physical Intervention Lead is also responsible for ensuring that all PMVA instructors attend annual refresher training at West London Mental Health Trust where our senior tutors are based.

4.1.6. **Inpatient staff** are responsible for following the guidance within this policy at all times and need to be aware of what is required of them. They must raise potential clinical problems that may arise from this policy with the Modern matron for their area to enable a review of its contents and suitability. They are also responsible for ensuring that new starters to the team and Bank and Agency staff are aware of this policy.

5. TRAINING

5.1. The Trusts recognise the importance of appropriate training for staff. For training requirements and refresher frequencies in relation to this policy subject matter, please refer to the Training Needs Analysis (TNA), Appendix B).

5.2. In order for staff to provide effective and safe patient care whilst patients under the care of the NHS Trusts, staff to whom this policy applies must have attended training in the following areas:

- Risk Assessment and Management for all staff
- Essential Life Support for unregistered staff, (or Basic Life Support training).
- Restraint training, (PMVA) for all clinical staff.
- Diversity
- Health and safety at work

5.3. The PMVA training consists of an initial 4 day training schedule which is underpinned by theories around violence and aggression, physical risks associated with restraint, alternative strategies involving less restrictive interventions, psychological impact of restraint on patients staff and witnesses. The course also entails the teaching of

approved physical PMVA techniques and when it is appropriate to use which level of intervention. A two-day refresher training programme is mandatory for staff to attend yearly.

5.4. During times of national or 'Gold Command' emergency where there is a risk of cross – infection, the training will be amended to the 'non-contact' programme and will be comprised of theory and video presentation. This will cover all staff for a period of 6 months or until full contact training can resume. Additional support will be provided in clinical areas by the PMVA instructional team in regard to providing skill slot training sessions, or bespoke teaching sessions. Those staff who have not undertaken the full contact teamwork induction training must not be involved in any planned restraints and must be relieved by an appropriately PMVA trained staff if involved in an emergency.

5.5. Breakaway training will be provided for all staff with direct contact with the public and/or patients. It is designed to help staff recognise the potential for violence and aggression in an individual and how to prevent it escalating into an actual incident of violence. It also contains practical techniques in order to break away from an aggressor in a safe manner and proportionate to the situation.

5.6. All staff members must maintain individual responsibility for maintaining their current knowledge of PMVA best practice by attending relevant training sessions. The training needs and records of staff are liable for reporting to the Mental Health Act Scrutiny Committee

5.7. It is vital that Modern Matrons, Lead nurses and Senior Nurses who are accountable for inpatient services can demonstrate that their staff members have attended the induction, refresher and breakaway training courses and have the necessary level of competence to use appropriate restraint techniques. This will be achieved through reviews and audits of individual and team training records.

5.8. On-the-job shadowing, mentoring and support will be given to all new starters, Bank and Agency members of staff in addition to mandatory training. This will ensure that they are aware of this policy and that they can be supported to achieve high standards of inpatient care. Where appropriate, competence checklists to support this practice will be utilised.

5.9. All PMVA instructors and assistant instructors will be required to meet the standards of training within the Restraint Reduction Network, (RRN), to achieve accreditation. B The accreditation process is assessed by BILD and is completed every 2 years. (Appendix B).

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1. The Equality Impact Assessment and Mental Capacity Act Assessment identified that this policy is unlikely to lead to discrimination against any particular group and that it accounts for the situations of service users who lack capacity to make decisions. The Impact Assessment can be seen in Appendix A.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1. The success criterion for this policy is the minimal amount of physical intervention to meet patients' needs, managing their risks and preventing harm to others. With a view to continual overall reduction of use of restraint techniques. This will include:

- Patients are only restrained when all other less restrictive interventions have proved unsuccessful
- Patients are only restrained as a last resort.
- Patients' Human and Legal rights are protected and supported
- Patients will only be restrained for the minimum amount of time and every effort must be made to keep the patient in the kneeling or standing position. Placing the patient on the floor in restraint must only be used when they cannot be safely managed standing, kneeling or sitting and must be for the minimum amount of time. 'NICE' guidelines recommend no more than 10 minutes; however this depends on the physical wellbeing of the individual patient and any pre-existing medical problems they may have.

7.2. In order to monitor the effectiveness of this policy and to ascertain that it successfully achieves its aims, a number of auditing and benchmarking standards will be used by managers and matrons. This will include the following:

- All episodes of restraint will be reviewed by the Physical Intervention Lead and reported in a monthly monitoring report. This report will be discussed at the monthly monitoring group and any issues arising from the group will be taken forward to an Incident Review Meeting to consider whether as a HRI (High Risk Investigation) or SI(Serious Incident) investigation is required. This will ensure that the restraint was a proportionate response to meet the needs of the patient at that time and was undertaken in a safe manner using approved PMVA techniques.
- The monthly report will include details of the use of force on people who share protected characteristics under the Equality Act (2010).
- The Trusts are committed to the elimination of the inappropriate use of force, and therefore take seriously any concern that force may have been used disproportionately. As such, any concern that force has been used disproportionately or inappropriately is to be reported to the Matron for the unit, for consideration of whether the Trusts' relevant Human Resources/People Management policy applies to the situation.
- Inclusion of this policy and guidance on its implications for clinical practice in all local induction packs for new staff/students/temporary staff including The Kite Unit.
- Review of incidents that are raised via the online reporting system, the monthly restraint report or via the Learning from Incidents & Deaths process to enable trends to be identified and/or lessons learnt to improve practice
- Feedback and/or complaints from people or families of those who use the service

7.3 Patients, their families, carers and independent advocates are able to raise concerns about the use of force in accordance with the relevant Trust's Management of Complaints, Service Concerns and Feedback Policy, available on the organisation's website.

7.4 This policy is to be published on the Trusts' external websites, and the accompanying patient information leaflet will be provided to patients on admission to the service.

- Discussions between individual staff with their line manager through the supervision format.

8. REVIEW

8.1. This document may be reviewed at any time at the request of either staff side or management representatives but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

8.2. The review of this policy must take place with patient groups, in accordance with the principles of co-production.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1. REFERENCES

- Department of Health (1983) 'Mental Health Act'. HMSO. London.
- Department of Health (2002) '*Mental Health Policy Implementation Guide: National Minimum Standards for general adult services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments'.* London
- Department of Health (2015) The Code of Practice – The Mental Health Act (1983) TSO London
- Mental Health Chief Psychiatrists Guideline (2002) *Chief Psychiatrist's guidelines: High Dependency Unit Guidelines*. Accessed at www.health.vic.gov.au/mentalhealth/cpg/hdug_guidelines.pdf
- NICE Guideline [2005, revised 2006] *Violence: The short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments.* London
- V2 – Violence Reduction and Management 14th March 2016 © West London Trust.
- Violence reduction and Management programme, © Ashworth Hospital, Broadmoor Hospital, Rampton Hospital, The State Hospital Scotland (2015)
- Restraint Reduction Network – Training standards 2019
- The Police Use of Restraint in Mental Health and Learning Disability Settings – accessed at: https://rcem.ac.uk/wp-content/uploads/2021/11/Police_Use_of_Restraint_in_Mental_Health_and_LD_Settings.pdf

9.2 Other Documents

Solent NHS Trust

- HS02 Management of Security and Violence and Aggression Policy
- MMT008 Rapid Tranquillisation Guidelines.
- IPC07 Infection Prevention and Control Standard Precautions Policy
- GO27 Safeguarding Children, Young People and Adults at Risk Policy
- MH03 Admission, Discharge and Transfer of Care Policy
- Incident Reporting, Investigation and Learning Policy

Isle of Wight NHS Trust

- Mental Health Services Seclusion Policy
- Safeguarding Adults Local Policy
- Safeguarding Children and Young People policy
- Mental Health - Inpatient Rapid Tranquilisation Protocol

- Incident Management Policy
- MHLD Clinical Risk Assessment and Management Policy
- Supportive Observation and Engagement policy for MHLD inpatients

10. GLOSSARY

PMVA	Prevention and Management of Violence and Aggression
MH	Mental Health
OPMH	Older Persons Mental Health
LD	Learning Disabilities
NR	Neurological Rehabilitation
MDT	Multi-Disciplinary Team
RC	Responsible Clinician
RMO	Responsible Medical Officer
NIC	Nurse in Charge
PPE	Personal Protective Equipment
NHS	National Health Service
TNA	Training Needs Analysis
NHST	National Health Service Trust
CEO	Chief Executive Officer
RCN	Royal College of Nursing
NHSLA	NHS Litigation Authority
RRN	Restraint reduction network
BILD	British Institute for Learning Disabilities
Physical Intervention	A restraint technique undertaken in line with taught PMVA procedures
Restrictive Intervention	An intervention that restricts the freedoms or choices of an individual in order to prevent harm
Safety Pod	A large, adult-size firm bean bag used to safely undertake a supine restraint

Appendix: A **Equality Impact Assessment**

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims		
Service Line / Department	Adult Mental Health Inpatient Services.	
Title of Change:	Use of Force policy	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	Solent Policy Review	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			X	
Gender reassignment			X	
Disability		X		Ensure any known medical conditions that could be exacerbated by certain restraint positions are care planned in a way that they are not to used on the individual.
Age			X	
Sexual Orientation			X	
Pregnancy and maternity			X	
Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	Yes	Healthwatch Portsmouth, Service Engagement Groups, Patient Safety Partners
Have you taken into consideration any regulations, professional standards?	Yes	Mental Health Units (Use of Force) Act 2018 Restraint Reduction Network Training Standards 2019 NICE guidance

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	☐	■	☐
What action needs to be taken to reduce or eliminate the negative impact?	By having this clear operational policy and ensuring the guidance and practice laid out within it is applied to all inpatients at all times, it ensures that no group could be unlawfully treated favourably or unfavourably compared to another. Also to ensure training standards are maintained, reviews of all physical interventions are undertaken and national standards are maintained.		
Who will be responsible for monitoring and regular review of the document / policy?	Ben Martin-Lihou, Head of Quality & Professions, Mental Health		

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy /

procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	*Ben Martin-Lihou*	*Date:*	*09/10/2022*

Additional guidance

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (eg, 18-30 year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	" The expression of gender characteristics that are not stereotypically associated with ones sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it but belief includes religious and philosophical beliefs, including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding	Further guidance can be sought from: Solent HR team

		employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Childcare responsibilities • Flexibility	

Appendix B

PMVA Training Needs Analysis Pro-forma
Adult Mental Health – Solent NHS Trust

Organisation Name: Solent NHS Trust – Adult Mental Health/Older Persons Mental Health & Neuropsychiatry.

Date of Assessment: 07/02/2022

Completed by: Luke Conroy – Physical Intervention Lead

Review Date: 07/02/2023 *(As a minimum requirement, must be completed annually)*

1.0 Introduction

Solent NHS Trust is committed to providing high quality care to the users of its services and the wellbeing of its staff.

The Trust is also responsible for and committed to ensuring that all staff are appropriately trained to enable them to undertake their duties and to protect the wellbeing of themselves and users of Trust services.

In order to minimise risk to both Service users and staff, all staff are required to attend the relevant mandatory training to deliver a safe effective service in their area of work.

This Training Needs Analysis (TNA) has been completed for the period of 1st September 2019 – 31st December 2021 (2 years) for the follow purposes.

- To examine the entire recorded incident forms for ***Physical Assaults*** and ***Restraint*** to identify the current risks posed to service users, staff and stakeholders.

- To analyse this information to identify: themes, trends, severity and frequency of such incidents.

- To use this information to inform the selection of Secondary & Tertiary physical responses contained within the developed Positive & Safe Violence Reduction.

- To identify any **Gaps** and provide recommendations and/or solutions to ensure that the training meets the needs of the service and -conforms with national guidance and legal frameworks.

- To provide assurance to the trust board and commissioners that the foreseeable risks have been carefully considered when selecting the technical physical procedures that will inform the necessary design and delivery of staff restrictive interventions training programmes.

2.0 Methodology used

The following sources of information have been used to complete this TNA;

- Review of all electronic recorded incident forms relating to incidents of assaults & restraint
- Review of completed Local Team Reviews (learning from lessons) reports
- RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reports
- Case examples (high risk incidents of physical assault/self-harm and weapons
- Analysed Incident Footage captured on CCTV
- Trainers and participant feedback (skill slots/post incident reviews)
- Completed PMVA Training course evaluation forms (identify trends)
- NHS England Benchmarking data (2017/18)
- Clinical visits / CPA's / MDT's etc.
- Trust policies & Emergency Contingency Plans
- Human Rights Framework for Restraint (March 2019)

Supporting National Guidance and Standards

- Restraint Reduction Network (RRN) Training Standards 2019
- Positive and Safe Violence Reduction Manual (NICE Endorsed)
- Use of Force Act

*(**Note:** These key documents are imbedded with the legal and ethical frameworks and available best practice guidance of which will form the basis of this TNA)*

3.0 Type of Service and Clinical Delivery

The Secretary of State for Health has a duty under Part One, Section 4 of the National Health Service Act 2006, to provide hospital accommodation and services for persons who:

- Are liable to be detained under the Mental Health Act 1983 (c20)

Local services provide inpatient treatment for those in mental health crisis and can either be treated voluntarily or under detention of the mental health act. There are 4 areas provided by Solent NHS Trust, Psychiatric Intensive Care Unit, (PICU), adult admission, Older Persons Mental Health, (OPMH) and Neuropsychiatry services. Solent NHS also provides community based services including a CRISIS service.

All services must be recovery-orientated and outcome-focused

The core objectives are to:

- Assess and treat mental disorder
- Provide a safe and therapeutic environment
- To maintain dignity through individualised compassionate care
- To improve health and wellbeing (including physical, mental and spiritual)

The Principles of care are:

- Patient centred care pathways
- Focus on recovery
- Robust evidence-based interventions/treatment
- Efficient pathway management
- Pro-social therapeutic environments
- Structured rehabilitation activities
- Effective multidisciplinary team working
- Trauma informed

4.0 Patient population (and risk)

- Local services provide care and treatment to those adults who are in mental health crisis and require care and treatment in an inpatient environment if the risk they pose makes them unable to be cared for at their home.
- Solent NHS Trust hold a bed capacity of 60 x beds for both Male and female patients over 5 inpatient units.

- Solent NHS Trust employs an ageless service therefore individuals are placed in the unit that best meets their needs and not dictated by age.

4.1 Training Related Passports

- **Clinical 1 staff** – Bands 2 - 7 (ward based) i.e. Health Care support workers, Activity Co-ordinators, Staff nurses, Senior nurses, Lead Nurses.
- **Clinical 2 staff** – Bands 5 -8 (part - ward based) i.e. Assistant Psychologists / Psychologists / OT staff
- **Medical Staff** – Consultants, Associate Specialists
- **Non- Clinical 1 & 2 staff -** Less than 50% of time in direct patient contact *(Porters, Domestics, Ward hostesses, Security, Reception staff, Administrators)*
- **Non- Clinical 3 staff -** No direct patient contact, (*Mental health act team, bed manager.)*

5.0 Staff population

Staff Population February 2022	RMN	HCSW
Maples Ward	16	26
Hawthorns Ward	20	22
Brooker Ward	20	31
Kite Ward		
CRHTT	10	19
Total		

6.0 Wards and Services

The Trust consists of the following services.

- Psychiatric Intensive Care Unit, (Maple ward 14 beds).
- Inpatient Adult acute care pathway, (Hawthorn ward 14 beds).
- Neuropsychiatry Rehabilitation Unit, (Kite unit 10 beds).
- Brooker OPMH (Organic 14, functional 8)
- Crisis
- Recovery Teams
- Occupational and therapeutic services

7.0 Individualised Care

- Specific packages of care (including violence management strategies) will be developed by clinical teams
- PMVA team will work to support and advise clinical teams to develop individualised packages of care
- This work includes issues around gender, cultural issues and any physical disabilities
- In reviewing previous data it's clear that individualise plans play an important role providing a service that is sensitive to individual needs with special consideration around history of trauma
- Teams to be the sensitive to the risk of any restrictive practices and restraint

- Plans of care should be co-produced with service user (and whenever possible families and carers)
- Team should consider any advance directives related to prevention and management of violence including issues around restraint

8.0 Use of managing violence and aggression

- The findings from the above review indicate that there is a risk of extreme violence
- Violence can often be impulsive as well as planned
- There is a risk of sustained violence which requires staff intervention
- Staff and patient are both at risk of being assaulted with a high frequency of patient to staff assault
- There is a risk of prolonged restraint as patient who become violent are often not amenable to de-escalation and can be highly aroused and will not follow requests
- In circumstances where there is a risk of prolonged restraint with an aroused aggressive patient distraction techniques may be required to assist in relocating the patient and discontinue the restraint. This may take the form of seclusion.
- In circumstances where a patient is harming self and or others (e.g. biting themselves or others) and the patient not following staff requests, distraction techniques maybe required to disengaged, thus preventing serious harm or injury to self and or others

9.0 Findings

Statistical information on restraint

Physical intervention data from January 2021- December 2021

Ward	Prone	Supine	Standing	Escort	Sitting	Safety pod	Kneeling	Medication given	Total wards
Maple	**28**	**5**	**33**	**44**	**14**	**2**	**1**	**51**	**105**
Hawthorn	**4**	**8**	**4**	**10**	**9**	**3**	**3**	**12**	**33**
Brooker	**1**	**3**	**22**	**22**	**13**	**0**	**1**	**16**	**55**
136 suite	**2**	**3**	**2**	**3**	**3**	**1**	**0**	**1**	**6**
Total	**35**	**19**	**61**	**79**	**39**	**6**	**5**	**80**	**199**

Statistical information on Seclusion

Seclusion data from January 2021- December 2021

Seclusion type	Number of incidents	Location
Tertiary	39	Maples
Secondary	3	Maples
Long term Segregation	4	Maples
Total patients secluded	24	Maples
Total episodes of seclusion	33	Maples

Type of Service
Mixed adult inpatient acute services and community-based care.
Patient Population & Characteristics
Patients who require care in an inpatient setting conducive to their needs. Patients who can be safely managed at home supported by the CRISIS and Recovery teams. Admitted either following a mental health act assessment, agreeing to informal admission or via the police using section 136. Individuals can pose a high likelihood of serious injury or harm to self and/ or others. Who at times can exhibit unique and complex needs *(Mental illness and drug/alcohol misuse).* Predominantly white British ethnicity, but other ethnicities are represented.

Patient Diagnosis Summary
• Organic, including symptomatic mental disorders • Mental and behavioural disorder due to psychosis • Substance misuse • Schizophrenia, Schizotypal and delusional disorders • Manic Episode / bipolar affective disorder • Depressive disorders and other affective disorders • Disorders of adult personality and behaviours • Acquired brain injury and other neurological disorders

Incident Data (24 months) Trends/Themes				
Actual Physical Assault Typology (please list)			***Activities leading to Assaults / Restraint (please list)***	
• Punching	*P*		• Patient to staff assaults	*P*
• Kicking	*P*		• Patient to patient assaults	*P*
• Grabbing	*P*		• Acts of self-harm	*P*

• Charging	*P*		• Enforced treatment	*P*
• Scratching	*P*		• Urgent physical health	*P*
• Spitting	*P*		• Providing meaningful activities for LTS patients	*P*
• Biting	*P*		• Concerted indiscipline	x
• Weapons (fashioned)	*P*		• Escorting *(Hospitals/Courts etc.)*	x
• Strangulation	*P*		• Electroconvulsive Therapy (**ECT**)	x
• Head Butting	*P*		• Nasal Gastric **(NG)** *Feeding / Clozapine etc.*	x
• Damage to Property	*P*		• Hostage Taking	*x*
• High Risk Escorting	*x*		• Roof Top *(protest, attempted escape)*	*x*

Incident Locations				
• Day Areas	*P*		• Side rooms	*P*
• Seclusion suites	*P*		• Dining areas	*P*
• Garden facilities	*P*		• Visit complex	*P*
• Court settings	*x*		• Kitchens / serveries	*P*
• Clinical rooms	*P*			
• Activity areas (on ward)	*P*			
• External Treatment Facilities *(A&E, Hospitals etc.)*	*x*			

Audit of Challenges (presenting risks)

	Impacting on				*Frequency*			
Challenges	***Employees***	***Service Users***	***General Public***		***Rare***	***Occasional***	***Regular***	***Frequent***
Disruptive Behaviour	*P*	*P*	*P*					*P*
Verbal Hostility	*P*	*P*	*P*					*P*
Aggression & Violence	*P*	*P*	*P*					*P*
Self-Harm	*P*	*P*						*P*
Injuries	*P*	*P*						*P*

Please identify any elevated risks to populations and individuals *(please P)*
1. *Range of age, gender identity, cultural heritage, diagnosis?* **Please see section 7.0: Individualised care** **This takes into consideration the individuals specific needs, gender, cultural and physical needs when building a package of care. Evidence available for individual patient needs. (Evidence of PMVA involvement in MDT teams for planning care and treatment regarding individual patient needs.** 7.0 is individualised care, not benchmarking
2. *Any known sensory processing issues that may elevate the risk of harm to a person if a restrictive intervention is used?* ***Cognitive impairment; Acute mental health symptoms; Learning disabilities*** **and Substance Misuse**
3. *Any known physical characteristics or health problems that may elevate the risk of harm to a person if a restrictive intervention is used?* ***BMI; Physical Disabilities; Underlining physical Conditions (circulatory / breathing etc.); blood conditions (reduce oxygen); Organic impairment; Previous injuries; Obesity; Infections;*** **pregnancy**
4. *Any known emotional or psychological characteristics or current and potential issues and problems that may elevate the risk of harm to a person if a restrictive intervention is used. This should include, if known, reference to any past trauma?* ***Previous Trauma ACE's; Capacity to understand the situation; staff trauma (previous assaults/ fear/ anxiety)***
5. *Any known developmental issues that may elevate the risk of harm to a person if restrictive intervention is used?* ***Skeletal structure / development; cognitive development;***

9.1 Theoretical Delivery to Prevent and Reduce the use of RRP (Essential learning)

Overall Risk of Organisation/Service Setting *(Please P relevant sets)*							
Low risk service		Moderate risk service		**High risk service**	***P***	**Extreme risk service**	*P*

Clinical indicators of risk based on above review			
Patients presentation (mental state)	*P*	*Impulse control*	*P*
High prevalence of treatment resistant illness	*x*	*Recognised Trauma (ACE's)*	*P*
Impulsive Behaviour (Aggression & Violence)	*P*	*Long History of institutions (learnt behaviour)*	*P*
Small population of frequent and severe self-harm	*P*	*High Co-morbidity (Mental Illness & PD)*	*x*
Risk of collusion (subverting security)	*P*	*Risk of serious injury/ life changing injuries if not immediate intervention (case studies)*	*P*
Risk to vulnerable patients from others	*P*		*P*

RRP Theoretical Delivery (PSTS: Class Room / Matted Area)			
Interpersonal communication and de-escalation	✓	*Trauma informed care*	✓
Staff attitudes and service culture	✓	*Use of force*	✓
Working in a person-centred way (recovery)	✓	*Safeguarding*	✓
Assessing and Managing risk (hierarchy of responses)	✓	*National Decision Making Model*	
Individualised Approaches (Advanced wishes)	✓	*Positive and Proactive Care*	✓
Legal and Professional issues	✓	*Best Practice Guidance (NICE, MHA, MCA. RRN)*	✓
Restraint related risks	✓	*Human Rights Based Approach*	✓
Trust RRP Strategies / Policies	✓	*Staff Support / Counselling – welfare checks*	✓
Pending Signs of Aggression & Violence	✓	*Reporting & Recording*	✓
Briefing & De-briefing	✓	*Learning from Lessons*	✓
Restraint & Assault Data (trends)	✓	*Duty of Candour*	✓
Expert by Experience (Personal Account)	✓	*Raising complaints about training*	✓

10.0 The following physical PMVA /PPE Procedures have been selected based on the findings of the above TNA:

Physical Management Strategies: Personal Safety / Disengagement skills *(Please List the chosen Skill sets from the Violence Reduction Manual to Manage The Foreseeable Risks Identified from your TNA)*
Skill Set 1: *Primary Prevention (non-physical) Personal safety strategies*
Skill Set 2: *Wrist grabs (low risk)*
Skill Set 3: *Wrist Grabs (high risk)*
Skill Set 4: *Fix & Move*
Skill Set 5: *Bowling*
Skill Set 6: *Protection from upper and lower limb strikes* (standing)
Skill Set 5*:* Protection from upper and lower limb strikes (victim on the floor)

PMVA Physical Management Strategies: *(Please List the chosen Skill sets from the Violence Reduction Manual to Manage The Foreseeable Risks Identified from your TNA)*
Skill Set 1: *Primary non-contact (guiding)*
Skill Set 2: *Core skills - Low level Precautionary holds (secondary supportive holds)* • *Precautionary hold A & B* • *Secure Precautionary C* • *Forearm hold*
Skill Set 3: *Standing containment including reliefs*
Skill Set 4: *De-escalation Seated & Standing*
Skill Set 5: *Core skills (head management/protection)*
Skill Set 6: *Hierarchy of Seclusion* (Primary & Secondary)
Skill Set 7: Open Door reviews ***(bedrooms/seclusion rooms)***
Skill Set 8: Supporting a patient out of a contained area (standing core skills)
Skill Set 9: Disengagement (although patient to stand on their own) – (From Prone & Supine)

Teamwork Tertiary Emergency Escape & Rescue Responses **(Distraction Technquies & High Risk Procedures)** *(Please List the chosen Skill sets from the Violence Redcution PMVA Manual to Manage the Foreseeable Risks Identified from your TNA)*
Rationale for these taught skills: Where there is an immediate risk to life (last resort) when all other least restrictive options have been exhausted and/or precluded (based on evidence from data risk (likelihood and Impact) • Prolonged resistive restraint in any (position) • Immediate rescue of self and others **NICE Guidance (NG10) & RRN standards (2019)**
Skill Set 1: Close Proximity Escape and Rescue distraction techniques x 6 ***(All staff)***; *(Mandibular angle/Sternum push /intercostal pressure/finger & thumb compression/septum / clavicle). These procedures have been included within the syllabus based of the observations of the previous 2 x year's data review (trends) to provide staff with safe escape and rescue procedures to release from grips/bites/strangles to remove themselves and/or others from life threatening situations (serious assaults/self-harm/weapons etc.).* ***WLHT***
Skill Set 2: Tertiary Hold (wrist Flexion) ***(Clinical 1& 2 staff only)*** *(only to be used in emergency situations for the shortest and safest time possible when all over least restrictive alternatives have been exhausted and/or precluded to safely manage acute levels of violence and resistance likely to lead to harm to self and others and/or prolong positions of restraint).*
Skill Set 3: Standing from Prone (resistive) ***(Clinical 1&2 staff only)*** *(only used when it has been deemed unsafe to release the service user to aid a safe supportive standing process to relocate to a place of safety, to reduce prolong periods of resistive restraint, and promote autonomy as quickly and safely as possible.*
Skill Set 4: Standing from Supine (resistive) ***(Clinical 1&2 staff only)*** *(only used when it has been deemed unsafe to release the service user to aid a safe supportive standing process to relocate to a place of safety, to reduce prolong periods of resistive restraint, and promote autonomy as quickly and safely as possible.*
Skill Set 5: *Controlled decent to a surface area (floor/bed etc.)* ***(Clinical 1&2 staff only)*** *(Only used when it has been deemed unsafe to remain in the standing position (high levels of resistance/serious assaultive behaviour/environmental challenges etc.). Necessary to safely position the service user to enable staff to administer prescribed treatments /physical health assessments etc. and/or provide safe opportunities for staff to release and disengage to a place of safety.*
Skill Set 6: *Resistive Seclusion exit procedure (prone)* ***(Clinical 1&2 staff only)*** *(Reserved only for the rapid need to safely end prolonged and resistive incidents of restraint where all routes of de-escalation have been exhausted and/or precluded due to the risks presented.*

Physical Management Strategies: Weapons / Severe threat of physical harm **(PPE) Personal Protective Equipment** *(Please List the chosen Skill sets from the Violence Reduction PPE Manual to Manage the Foreseeable Risks Identified from your TNA)*
Skill Set 1: Supporting a patient out of a contained incident area
Skill Set 2: Side room entry skills (compliant & Non-complaint)
Skill Set 3: Diamond Team formation / Reversed team formation
Skill Set 4: Entering / searching a building
Skill Set 5: Removing a weapon / searching
Skill Set 6: Method Of Entry (MOE)
Skill Set 7: Protection of the First At The Scene Incident /Hostage Communicators
Skill Set 8: Skirmish line (Controlled & rapid)

Exploring options

Clinical Holding Strategies: Enforced treatments *(All of the Above Selected Primary, Secondary & Tertiary Core Skills to Manage The Foreseeable Risks Associated with the follow Clinical procedures)*			
Skill Set 1: *Medication (e.g. Depot's)*	*P*	***Skill Set 6:*** *Bloods*	*P*
Skill Set 2: *ECT*	*P*	***Skill Set 7:*** *NG Feeding / Medication*	*P*
Skill Set 3: *Physical Health Care (treatments)*	*P*	***Skill Set 8:*** *Physical Health Care (assessments)*	*P*

11.0 Executive Summary

- Adult Mental Health provides care and treatment for patients who are in mental health crisis and some of whom may pose a significant risk to themselves or others.

- The examination of the data and methodology resource information, confirms the risks status of these patients

- The injuries sustained are observed to be as a result of the direct assault and/or sustained during the initial struggle to contain acute levels of violence and resistance. Staff, are more likely to be assaulted than patients.

- During this period there have been significant incidents of: *Self-harm; patient to staff violence*; *patient to patient violence and incidents involving weapons,* that have led to the

necessity of staff receiving emergency medical treatment and subsequently requiring long-term periods of staff sickness/recovery.

- By the very nature of the service provided, staff are at times assaulted during the course of their duties when providing care and treatment and whilst to responding to those in need.

- Physical Assaults can be life changing and life threatening, unless early staff intervention.

- The selected physical interventions have been carefully chosen to provide staff with the safe systems of work to manage the identified and foreseeable risks (planned and unplanned responses)

- All techniques and procedures take into account the patient and staff populations and risks. All training has been designed within the principles of least restriction, and must only be used when absolutely necessary and proportionate to the circumstances.

- During this period, there were no injures directly observed to have been sustained by a PMVA technique.

- As a last resort: ***(Emergency Escape and Rescue)*** procedures/techniques have been selected to provide staff with a range of responses when there is an immediate risk to life, when all other least restrictive options have been exhausted and/or precluded.

- Robust governance and monitoring process are in place to observe the use of all restrictive practices.

- These observations are reported directly to the Clinical Governance group, NHS England Commissioners and National Oversight Group (NOG).

- Reports are shared locally with the individual units and included during all staff PMVA training sessions to raise awareness and encourage where practicable, to take proactive steps to reduce incidents of this nature.

- To prevent and reduce the likelihood of using restrictive practices, the underpinning theory (see 9.1) will be delivered to all staff during PMVA Induction and refresher programmes to ensure that staff are suitability equipped with the underpinning knowledge to predict and prevent behaviours that may lead to incidents, that may require the use of a restrictive intervention. This training will prioritise the use of primary responses to collaboratively support the service users to meet their needs and to develop strategies to avoid the use of restrictive interventions when experiencing behavioural disturbances and/or situations when they feel that their needs are not being met.

- During times of national or 'Gold Command' emergency where there is a risk of cross – infection, the training will be amended to the 'non-contact' programme and will be comprised of theory and video presentation. This will cover all staff for a period of 6 months or until full contact training can resume. Additional support will be provided in clinical areas by the PMVA instructional team in regard to providing skill slot training sessions, or bespoke teaching sessions. Those staff who have not undertaken the full contact teamwork induction training must not be involved in any planned restraints and must be relieved by an appropriately PMVA trained staff if involved in an emergency.

NOTE: *Staff will not be permitted to attend any physical PMVA skills training until that they have completed a fitness test and have completed the Trust induction. This will be closely monitored by the Learning development centre, their individual line managers and the Physical Intervention Lead. In addition to this, the electronic training booking system has further safe guards in place to ensure that when a member of staff books onto a physical PMVA course (online), further questions are generated to establish compliance with this expectation.*

Professional Sign off on behalf of the Organisation

Name:

Title: Physical intervention lead

Professional Sign off on behalf of the Organisation

Title: Head of Quality and Professions – Mental Health Services

Executive Sign off on behalf of the Organisation

Title: Chief Nurse

Appendix C

Solent NHS Trust

Physical Restraint Procedures:

<u>The Use of Pain for Escape and/or Rescue Purposes</u>

An Organisational Position Statement*

**This document has been produced following a review of Trust policy and practice undertaken as a result of participation in the Restraint Reduction Network Training Standards national training pilot.*

3.0 Introduction

Solent NHS Trust provides community, mental health and learning disability care for Hampshire. They are committed to providing high quality care to the users of its services and the wellbeing of its staff.

The core objectives of the Trust are:

- Involving service users in shaping care and always learning from their experiences
- Working closely with partners to join up care
- Treating people with respect, giving equal emphasis to physical and mental health
- Ensuring we provide quality services, which are safe and effective

The principles of care applied in order to meet the core objectives are:

- Patient centred care pathways
- Focus on recovery
- Robust evidence-based interventions/treatment
- Efficient pathway management
- Structured rehabilitation activities
- Effective multidisciplinary team working

4.0 An Organisational Commitment to Restraint Reduction and Restraint Minimisation

Solent NHS Trust is committed to meeting its core objectives and applying its principles of care. In order to do so it is also committed to reducing the use of restrictive interventions including physical restraint.

Restraint reduction involves activities designed to reduce the number of occasions that physical restraint is used

Restraint minimisation involves activities designed to reduce the restrictiveness and duration of any physical restraint use.

5.0 An Evidence Based Approach

Solent NHS Trust is committed to ensuring that there is clear explicit governance around restrictive practice (analysing data, meetings/reviews, leadership), and that the Adult Mental Health service takes responsibility on reducing restrictive practice work within their specific area.

The Monthly Mental Health Act Group is responsible for highlighting trends in data* on restrictive intervention use and communicating the actions to address issues to the clinical leadership and Trust Scrutiny committee, local reports should be available for trust wide monitoring.

The Prevention and Management of Violence and Aggression (PMVA) lead for Solent is The Physical Intervention Lea, and is responsible, (and other trainers), for ensuring the training

curriculum taught to our staff reflects the principle of least restriction and is focused primarily on the prevention of conflict and distress.

**This includes data relating to the outcomes of physical restraint including injuries to users of the service.*

6.0 Managing the Risks to Users of Services and to Staff

Solent NHS Trust is committed to responding to those users of the service whose behaviours may escalate, in caring and therapeutic ways. In order to provide support, care and/or treatment there will be occasions when staff will first be required to manage aggressive and violent behaviours. This requires staff to manage the risks arising from the behaviours as well as any responses to it including use of physical restraint.

Risks to users of our services arising from aggressive and violent behaviours (including self-injurious behaviours) include:

- Distress and/or pain
- Minor treatable injury
- Re-traumatisation
- Life changing and/or life-threatening injuries

Risks to users of our services arising from physical restraint include:

- Distress and/or pain
- Minor treatable injury
- Re-traumatisation
- Life changing and/or life-threatening injuries

Risks to our staff involved in responding to any violence and aggression include:

- Distress and/or pain
- Minor treatable injury
- Re-traumatisation
- Life changing and/or life-threatening injuries

The physical restraint techniques (and breakaway techniques) authorised for use within safe systems of staff working have been selected on the basis that they enable staff to manage foreseeable risks to all involved in an equitable, ethical and safe manner. All techniques and procedures are furthermore authorised and used with due regard to individual patient history, health status and current wellbeing.

All PMVA training enabling the use of such techniques has been designed within the principles of least restriction, and must only be used when absolutely necessary and proportionate to the circumstances.

7.0 Delivering Authorised PMVA Training

The Prevention and Management of Aggression and Violence (PMVA) training provided to trust staff is person centred, focuses on the rights of the individual subject to any physical restraint, and is aimed at preventing unlawful breaches of rights, as well as ensuring positive steps are taken to protect rights.

The training has been authorised by the Chief Nurse of who holds responsibility for restrictive intervention governance, reduction and minimisation.

This authorised training is based on a full TNA including a review of the past two years of incident data and considers the foreseeable risks posed to all stakeholders.

This authorised PMVA training incorporates the following:

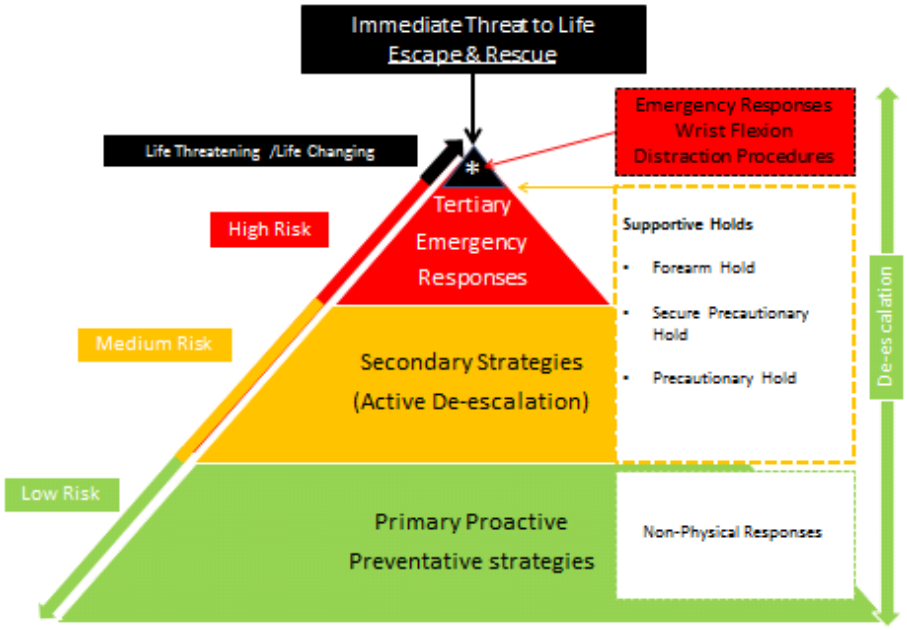
- Department of Health (2014) Positive and Proactive Care: reducing the need for restrictive interventions
- Department of Health (2014) A Positive and Proactive Workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health
- Department of Health (2012) Compassion in Practice – nursing, midwifery and care staff – our vision and strategy
- National Institute for Health and Care Excellence (2015) Violence and Aggression: Short term Management in Mental Health, Health and Community Settings (NG10)
- Code of Practice: Mental Health Act 1983 (revised 2015) Chapter 26 – 'Safe and therapeutic responses to disturbed behaviour'
- Restraint Reduction Network (RRN) Training Standards (2019) - see 9.0
- Use of force act

The 'Positive and Safe' Violence Reduction and Management Programme Instructors Manual used by the PMVA team was formally endorsed by the National Institute for Health and Care Excellence in 2016. The manual provides an explicit training and governance framework; on which services can; recruit, train and quality assure PMVA trainers and training programmes.

The development, management and content of PSVR training is the responsibility of The Physical Intervention Lead and will be governed by the Head of Quality and Professions. This includes the risk assessment of all physical restraint techniques (and breakaways) included within it.

8.0 Using the Hierarchy of PMVA Responses

The 'Positive and Safe' manual outlines the Solent NHS Trust PMVA Hierarchy of Responses



The Hierarchy of Responses ensures that the main focus of staff activities must always be on primary proactive preventative strategies.

In the event behaviour escalates active de-escalation may require the use of supportive holds in order to move a person to a lower stimulus space where the sole focus can be on de-escalation.

In the event behaviour further escalates it may be necessary to use emergency responses in a very small number of incidents in order to manage any risks that develop.

The majority of the risks to users of the service and staff can be safely managed using Primary (non-physical responses) and Secondary (including supportive holds) responses

All levels of staff responses must involve a continuation of the de-escalation process.

The use of 'Escape' and 'Rescue' procedures as a measure of very last resort and are only authorised for use when there is an immediate risk of significant injury or death, and all other interventions have been explored and found ineffective.

9.0 The Use of Techniques That Cause Pain

The use of techniques that cause pain to gain compliance

Solent NHS Trust does not under any circumstances endorse the use of pain base techniques for the purpose of obtaining compliance from users of the service. This would likely represent an infringement of individual human rights.

The use of techniques that cause pain for escape or rescue purposes

Solent NHS Trust does acknowledge that in some situations, where there is an immediate risk to life (of life-threatening injuries), and/or of significant injury (of life changing harm), the use of techniques that cause pain, may as a last resort, be necessary for 'escape' or 'rescue' purposes*.

a) In circumstances where a user of the service is harming themselves and/or others (e.g. biting themselves or others) and they do not respond to de-escalation (including reasonable requests to stop) and/or other physical restraint (or breakaway) techniques prove ineffectual, distraction techniques may as a last resort be required for rescue or escape purposes, in order to prevent serious harm or injury to self-and/or others.

b) In circumstances where there is Acute Behavioural Disturbance and there is the risk of a prolonged restraint with a highly aroused and/or aggressive individual, and where clinical staff express concerns that the behaviour and/or the prolonged restraint is likely to lead to some form of medical emergency**, distraction techniques may be required as a measure of last resort to facilitate a rapid transfer into a restraint procedure which does not rely on pain to facilitate urgent medical treatment. Solent NHS Trust would regard this as rescuing the individual from foreseeable serious harm or injury

In both examples the use of any technique that causes pain must be extremely brief, and used only to avert the immediate harm, and/or to rescue of the individual (staff or user of the service who is in immediate danger) and/or to escape from danger.

Staff will then be expected to either maintain a retreat to safety, and/or rely on techniques that don't cause pain, to safely relocate the individual, and/or facilitate treatment whilst they continue with the process of de-escalation.

All uses of such techniques must be fully recorded using the Trust online Incident Reporting System. See 8.0

**As defined in the RRN Training Standards (2019) and recognised within the NICE Guidelines (NG10) which refers to the use of techniques with may cause pain-based stimulus to mitigate risks to life.*

***The 'Guidelines for the Management of Excited Delirium / Acute Behavioural Disturbance' (2016) published by the Royal College of Emergency Medicine state that the hyper-adrenergic autonomic dysfunction associated with Acute Behavioural Disturbance can in extremis lead to significant tachycardia, marked metabolic acidosis and hyperthermia which in turn can be associated with multi organ failure and death.*

10.0 Monitoring and Governance of Restraint Techniques and Techniques That Cause Pain

Robust governance and monitoring processes are in place to observe the use of all restrictive interventions including physical restraint techniques within the context of the organisational commitment to reduction and minimisation (see 2.0).

The scrutiny of any techniques which can cause pain are a particular focus of such monitoring and governance.

Safeguard reports and/or video evidence (e.g. CCTV) will be reviewed by The Physical Intervention Lead or PMVA trainers, with a view to determining whether staff responses are in line with Trust policy. Where appropriate further investigation will be undertaken, and if required action will be taken to support improvement in practice. Organisational learning in this area of practice is essential, and also includes the dissemination of best practices that are identified through the PMVA training structures.

To prevent and reduce the likelihood of using physical restraint the underpinning theory delivered to all staff during PMVA Induction and refresher programmes is designed to ensure that staff are suitability equipped with the underpinning knowledge to predict and prevent behaviours that may lead to incidents, which may require the use of some form of restrictive intervention. This training will prioritise the use of primary responses to collaboratively support the users of the service to meet their needs and to develop strategies to avoid the use of any restrictions when experiencing behavioural disturbances and/or situations when they feel that their needs are not being met.

9.0 A Commitment to the RRN Training Standards

The RRN Training Standards provide a benchmark against which training in the management of violence and aggression, and the use of restrictive interventions including physical restraint are now evaluated.

Solent NHS Trust is committed to developing and delivering PMVA training that is in line with these standards.

Solent NHS Trust is committed to restraint reduction and restraint minimisation, and this includes all physical restraint techniques including techniques that can cause pain.

Solent NHS Trust through their affiliation with West London Trust Violence Reduction Department, the High Secure Services Positive & Safe Steering Group, and the operation of the NICE approved 'Positive and Safe' Violence Reduction and Management Programme are committed to developing and disseminating best practice in this important area of practice.