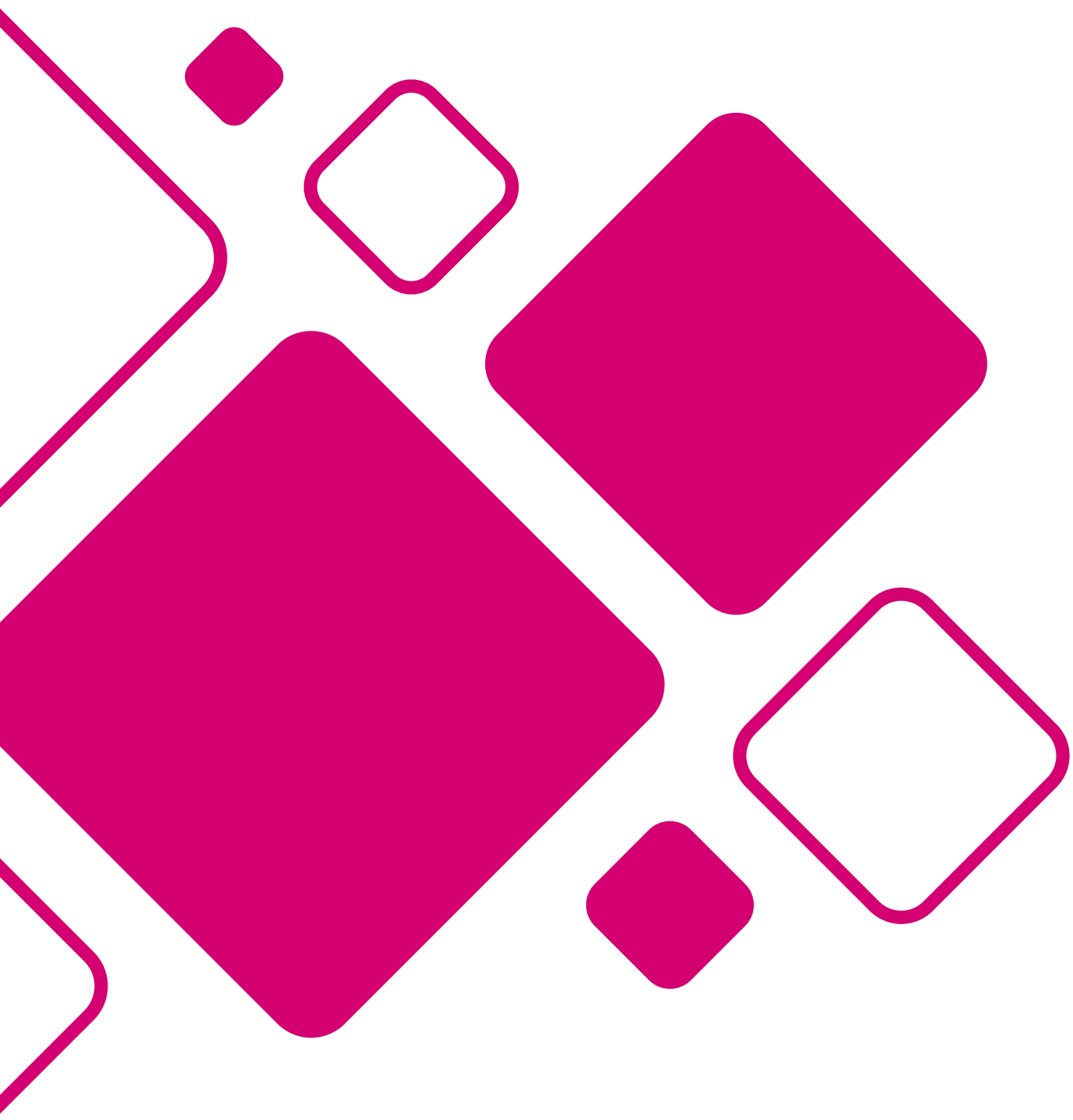
NursingDirect

POLICY NUMBER: **100**

POLICY TITLE: **REDUCING PHYSICAL INTERVENTION POLICY & PROCEDURE**

WHO MUST ABIDE BY THIS POLICY? **ALL TEMPORARY WORKERS**



REDUCING PHYSICAL INTERVENTION POLICY & PROCEDURE

1. THE PURPOSE OF THIS POLICY

1.1 To provide a framework within which adult health and social care services can develop a culture where restrictive interventions are only ever used as a last resort and then only for the shortest possible time.

1.2 To create a culture of positive and proactive care to reduce the need for restrictive interventions and set out mechanisms to ensure accountability to reduce the use of restrictive practices, including effective governance and transparent reporting and monitoring.

1.3 To support Nursing Direct Healthcare Limited in meeting the following Key Lines of Enquiry:

KEY QUESTION	KEY LINES OF ENQUIRY
EFFECTIVE	E2: How does the service make sure that staff have the skills, knowledge and experience to deliver effective care and support?
EFFECTIVE	E7: Is consent to care and treatment always sought in line with legislation and guidance?
SAFE	S2: How are risks to people assessed and their safety monitored and managed so they are supported to stay safe and their freedom is respected?
WELL-LED	W1: Is there a clear vision and credible strategy to deliver high-quality care and support, and promote a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people?
WELL-LED	W2: Does the governance framework ensure that responsibilities are clear and that quality performance, risks and regulatory requirements are understood and managed?

1.4 To meet the legal requirements of the regulated activities that {Nursing Direct Healthcare Limited} is registered to provide:

- Criminal Law Act (1967)
- Criminal Justice Act (2003)
- Autism Act 2009
- The Care Act 2014
- Equality Act 2010
- Human Rights Act 1998
- Management of Health and Safety at Work Regulations 1999
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice
- Mental Health Act 2007
- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012

2. SCOPE

2.1 The following roles may be affected by this policy:

- All staff
- Registered Manager
- Other management
- Nurse
- Care staff
- Activities

2.2 The following Service Users may be affected by this policy:

- Service Users

2.3 The following stakeholders may be affected by this policy:

- Family
- Advocates
- Representatives
- Commissioners
- External health professionals
- Local Authority
- NHS

3. OBJECTIVES

3.1 Protect people's fundamental human rights and promote person-centred, best interest and therapeutic approaches to supporting Service Users when they are distressed.

3.2 Improve the quality of life of those who may, in extreme circumstances, require physical intervention to keep them and those supporting them safe.

3.3 Reduce reliance on restrictive practices by promoting a positive culture and practices that focus on prevention, de-escalation and reflection.

3.4 Increase understanding of the root causes of behaviour and recognise that many behaviours are the result of distress due to unmet needs.

3.5 Where required, focus on the safest and most dignified use of restrictive interventions including physical intervention.

4. POLICY

4.1 In line with NICE recommendations, staff in community settings should avoid the use physical intervention, also known as manual restraint and the use of mechanical restraint.

However, manual restraint may be agreed as part of a multidisciplinary decision and also agreed at Senior Management level in exceptional circumstances. This will be for the least time possible and only for someone who lacks capacity and this is deemed as a necessary and proportionate Deprivation of Liberty.

Nursing Direct Healthcare Limited will embed a positive and proactive approach to care and support for all Service Users to ensure that any discussion regarding physical intervention are agreed as part of a best interest decision.

4.2 Where applicable all staff must have Positive Behaviour Support training within learning disability/autism services before undertaking any training that requires physical intervention.

In other services, similar training should be undertaken which evidences a positive and proactive approach in supporting distressed behaviours.

4.3 This policy should ONLY be implemented in services where the use of physical intervention for distressed Service Users have been agreed.

Physical intervention should only be used when an approved, accredited trainer has delivered the training. An approved list can be found here: Certified organisations - Bild - Association of Certified Training (bildact.org.uk)

4.4 All training will be reviewed on an annual basis.

4.5 The policy will follow the five principles of the Mental Capacity Act 2005 and any decision made to consider the use of restraint will only be made under legal best interest with relevant parties who can represent the views and wishes of the individual Service User as well as any other healthcare professionals involved in their Care.

4.6 Care Plans will focus on avoiding or reducing the need for restraint by ensuring that there is a detailed personal history and an up-to-date risk assessment in place for individual Service Users.

4.7 Care Plans will contain details of techniques and strategies, such as diversion, prevention, or consideration of allowing the Service User to have their preference used before any type of restraint is considered as an option.

4.8 Before any staff use physical intervention, other than short-term restriction of the Service User's freedom of movement or in an unforeseen emergency, they will receive training and be competent. Knowledge and practice will be reviewed on an annual basis.

5. PROCEDURE

5.1 **Positive Behaviour Support**
Positive Behaviour Support (PBS) provides a framework that seeks to understand the context and meaning of behaviour in order to inform the development of supportive environments and skills that can enhance a person's quality of life. Evidence has shown that PBS-based approaches can enhance quality of life and also reduce behaviours that challenge, which in turn can lead to a reduction in the use of restrictive interventions including physical intervention (please refer to the Positive Behaviour Support Policy and Procedure). All staff should be familiar with the Positive Behaviour Support Policy and Procedure and have undertaken relevant training on ensuring a positive and proactive approach to managing distressed behaviours.

All staff will undertake training in Positive Behaviour Support/ Management when supporting Service Users with stressed or distressed behaviours. PBS is commonly used in learning disability and autism services, but is also effective in supporting any Service User with stressed or distressed behaviours. Refer to the Positive Behaviour Support document in the Forms section.

5.2 **Care Planning and Involvement**
To help protect the interests of Service Users with whom restrictive interventions are used, it is good practice to involve the Service User, and wherever possible, family members, advocates and other relevant representatives (e.g. the attorney or deputy for a person who lacks capacity) in planning, monitoring and reviewing how and when they are used. This includes ensuring all reasonable adjustments and that documentation is in a format the Service User understands. If a Service User is not involved, this should be fully documented and justified.

Care Plans must always include clear evidence of health and social needs assessment, and must be created with input from the Service User, their carer's, relatives or advocates. This should identify:

- The context within which behaviours of concern occur
- Clear primary preventative strategies which focus on improvement of quality of life and ensuring that needs are met.
- Secondary preventative strategies which aim to ensure that early signs of anxiety and agitation are recognised and responded to.
- Tertiary strategies which may include detail of planned restrictive interventions to be used in the safest possible manner, and which should only be used as an absolute last resort.

If the Service User is able to be involved in their Care Plan, it is important to capture their views on what support they require when distressed.

Refer to the Positive Behaviour Support Policy and Procedure for effective Care Planning.

5.3 **De-Escalation, Disengagement and Breakaway Techniques**

In line with NICE recommendations, staff in community settings should not use physical intervention. However, in some circumstances, physical intervention may be agreed as part of a multidisciplinary decision and also agreed at Senior Management level in exceptional circumstances.

Staff have a legal right to defend themselves and a professional duty to protect others from harm.

De-Escalation, Disengagement and Breakaway techniques are suggested for community settings (NICE, 2015). This must be delivered through an accredited training provider. The training must focus on an awareness of the physical environment, strategies to keep safe, and reduce the likelihood of assault or harm. Further information on how to recognise and manage escalating behaviours appropriately at the earliest opportunity, how to minimise the risk of assault, and how to call for help in an emergency should also be included.

Section 3 of the Criminal Law Act (1967) allows all citizens the right to use force that is reasonable in a threatening situation. However, this must be proportionate to the perceived threat. In situations of high risk, staff must remove themselves from the situation and, if there is immediate risk to life, contact the Police.

Strategies to de-escalate distressed Service Users and how to disengage safely should be included in the overall Positive Behaviour Support plan.

5.4 **Training**
Before delivering any training, Nursing Direct Healthcare Limited will ensure that the accredited training provider carries out a training needs analysis to obtain as much information as possible about the needs and characteristics of staff and Service Users. This will ensure that any physical intervention is appropriate, proportional, meets identified needs, and that any elevated risks are highlighted and adjustments made where needed. De-escalation and breakaway techniques may be the appropriate training required without the need for physical restraint training.

Any training in physical restraint must only be delivered after all relevant staff have completed an appropriate level of immediate life support training (including required refresher training). This should be in accordance with the guidelines of the UK Resuscitation Council for immediate life support.

The accredited training provider or in-house trainer must ensure that the training identifies:

- Who the training is intended for
- Aims, objectives and learning outcomes for each programme
- Training methods
- Timings assessment methods
- Rationale that justifies the inclusion of each restrictive intervention in the programme. This may be in any format, but must include the following as a minimum:

    - RRN Training Standards - Name and description of restrictive intervention (diagram or photo)
    - Rationale for use (why and in what situation)
    - How the intervention will be taught to staff and how competence will be tested
    - General safety issues for staff during teaching and practice
    - Any person-specific safety issues for staff during teaching and practice (where information has been provided, and adjustments need to be made)
    - Any issues that may compromise the fidelity of the technique between the taught version in the classroom and its application in practice. This must include a description of how any identified issues may compromise both safety and effectiveness
    - General safety guidelines, supporting those restrictive interventions authorised for use at population level
    - Person-centred safety guidelines, supporting personalised restrictive interventions
    - A statement that the restrictive intervention must be used as taught and not modified, unless authorised by the accredited training provider

Training providers must ensure that any form of mechanical restraint that they are requested to teach the use of has been agreed at Board level. **Mechanical restraint must only be considered for use in exceptional circumstances in specific settings and under very specific circumstances.**

5.5 **A Human Rights Approach to Physical Intervention and Restrictive Practices**
Restrictive practices, including physical intervention, can be characterised as an exercise of power over another individual. In order to ensure this power is never abused, comprehensive safeguards must always be in place. It is essential that such safeguards eliminate any risk of discrimination, harassment or victimisation. Nursing Direct Healthcare Limited must ensure that no Service User is exposed to any restrictive practice because of their age, mental health status, mental capacity, physical impairment, race/ethnicity, religion and belief, gender (including transgender), HIV/AIDS status, sexual orientation, political opinion, socio-economic background, or spent convictions.

5.6 **Capacity and Consent**
Staff must ensure that they assess the Service User's mental capacity, as consent for the use of any type or method of restraint must be gained from Service Users, unless they lack the mental capacity to make the decision.

To summarise:

- If a Service User has capacity, does not consent, and there is no risk of harm to other people, then physical intervention is not acceptable and could result as civil or criminal assault
- If a Service User lacks capacity, staff at Nursing Direct Healthcare Limited must follow the MCA guidance to assess and record decisions that are being made on a Service User's behalf. **This will ONLY be agreed as part of a wider multidisciplinary approach and also agreed at Board level in community settings**
- For Service Users who lack capacity in relation to their behaviour and physical intervention, Nursing Direct Healthcare Limited must have a Deprivation of Liberty agreed which is deemed necessary and proportionate to carry out this level of restriction in specific circumstances

5.7 **Planned Physical Intervention**
Staff will be familiar with the definition of physical intervention and the types of physical intervention. Only staff who have had approved, accredited training will be involved in any type of physical intervention. They will also be clear that, in accordance with the Mental Capacity Act 2005, when considering using any form of physical intervention with a Service User who lacks capacity, the following two conditions **must both** be met:

- The Care Worker taking action must reasonably believe that physical intervention is necessary to prevent harm to the person who lacks capacity, and
- The amount and type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm
- A multidisciplinary approach has been taken and a Deprivation of Liberty is in place to include this restriction

The following must be assessed:

- The Service User's behaviour
- The Service User's underlying condition and treatment
- The Service User's mental capacity in relation to making decisions about their behaviour which is leading staff to consider using physical intervention. This is to include completion of the Mental Capacity Assessment records and a best interest meeting
- The communication needs of the Service User
- The impact of the use of the type of restraint on the Service User

It is unlawful to physically restrain a Service User in a way that deprives them of their liberty unless the procedures set out in the Mental Capacity Act (MCA) 2005 Policy and Procedure and the Deprivation of Liberty Safeguards (DoLS) Policy and Procedure at Nursing Direct Healthcare Limited are followed.

Assessing staff will ensure that they have considered all other options to ensure the Service User's safety and well-being and this is the last resort. Staff can refer to the Physical Intervention Flow Chart included in the Forms section of this policy which provides a guide to decision making.

5.8 **The Safe and Ethical Use of Physical Intervention**
- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation
- There must be a real possibility of harm to the Service User or to staff, the public or others if no action is taken
- The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm
- Any action taken to restrict a Service User's freedom of movement must be the least restrictive option that will meet the need
- Any restriction should be imposed for no longer than absolutely necessary
- What is done to people, why and with what consequences must be subject to audit and monitoring, and must be open and transparent
- Restrictive interventions should only ever be used as a last resort
- A Service User's carer and advocate involvement is essential when reviewing plans for restrictive interventions

When confronted with acute behavioural disturbance, or highly stressed or distressed behaviours, the choice of restrictive intervention must always represent the least restrictive option to meet the immediate need. It should always be informed by the Service User's preference (if known), any particular risks associated with their general health and an appraisal of the immediate environment.

Individual risk factors which suggest a person is at increased risk of physical and/or emotional trauma must be taken into account when applying physical intervention. For example, this would include recognising that for a person with a history of traumatic sexual/physical abuse, any physical contact may carry an additional risk of causing added emotional trauma; or for a person known to have muscular-skeletal problems such as a curvature of the spine, some positions may carry a risk of injury.

Physical intervention refers to 'any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person'.

- A member of staff should take responsibility for communicating with the person throughout any period of physical intervention in order to continually attempt to de-escalate the situation
- Staff must not cause deliberate pain to a person in an attempt to force compliance with their instructions
- People must not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, ribcage and/or abdomen
- **There must be no planned or intentional physical intervention of a Service User in a prone/face-down position on any surface (not just the floor).** This will best be achieved through the adoption and sustained implementation of restrictive practice reduction programmes and the delivery of care pathways that incorporate PBS. If, exceptionally, a person is physically restrained unintentionally in a prone/face-down position, staff should either release their holds or reposition into a safer alternative as soon as possible
- Staff must not deliberately use techniques where a person is allowed to fall, unsupported, other than where there is a need to escape from a life-threatening situation
- In all circumstances where restraint is used, one of the support staff must monitor the person's airway and physical condition throughout the restraint to minimise the potential of harm or injury. Observations that include vital clinical indicators such as pulse, respiration and complexion (with special attention to pallor or discolouration) must be carried out and recorded, and staff should be trained so that they are competent to interpret these vital signs. If the person's physical condition and/or their expressions of distress give rise to concern, the physical intervention must stop immediately
- Support staff must continue to monitor the individual for signs of emotional or physical distress for a significant period of time following the application of physical intervention Nursing Direct Healthcare Limited does not, under any circumstances, endorse the use of pain-based techniques for the purpose of obtaining compliance from Service Users.

5.9 **Post-Incident Debrief**
Nursing Direct Healthcare Limited must ensure that where appropriate, lessons are learned when incidents occur where restrictive interventions, including physical intervention, have had to be used.

Ms Leanne Harris or a delegated other should carry out a post-incident analysis (refer to the Forms section of this policy) with all staff involved as soon as possible after the incident, ideally before staff finish their shift.

Individual staff may also require a separate review due to sustaining injuries, psychological distress or anxiety around the incident. Whilst all staff should attend the group debriefs, staff should also be encouraged to have an individual refection to raise any specific concerns that may not be appropriate to do so in a group forum.

In addition, all Service Users who have been involved in the incident should be encouraged to reflect with staff. This includes the Service User who was involved in the physical intervention but also any other Service User who may have witnessed the event. The aims of post-incident reviews are to:

- Evaluate the physical and emotional impact on all individuals involved (including any witnesses)
- Identify if there is a need, and if so, provide counselling or support for any trauma that might have resulted
- Help Service Users and staff to identify what led to the incident and what could have been done differently
- Determine whether alternatives, including less restrictive interventions, were considered
- Determine whether service barriers or constraints make it difficult to avoid the same course of action in future
- Where appropriate, recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training
- Where appropriate, avoid a similar incident happening on another occasion

Service Users with cognitive and/or communication impairments may need to be helped to engage in this process; for example, by the use of simplified language or visual imagery. Other people may not be able to be involved due to the nature of their impairment.

If the Service User wishes to raise a formal concern or complaint they should be reminded how to access the local complaints procedure of Nursing Direct Healthcare Limited. Staff or Service Users who have sustained injuries or have been subjected to a serious assault should be supported and consideration should be given to involve the Police.

All post-incident reviews should be analysed by a clinical lead, which should form part of the overall governance and oversight of restrictive practices in the service and within Nursing Direct Healthcare Limited.

5.10 **Notifications**
Due notifications will be made to the CQC in accordance with its notification expectations.

Local Authorities, CCG's and other service users safeguarding teams will also be duly notified where any concerns are raised regarding the inappropriate use of physical intervention that affects a Service User's safety and well-being or has been used without authorisation.

Families, commissioners and family members may also be required to be informed according to individual Care Plans.

5.11 **Recording and Reporting**
Nursing Direct will monitor and maintain a register of all incidents of physical intervention. This register will be used to review practice and allow for the opportunity to reduce and eliminate the need. This will also be reviewed as part of overall governance at Nursing Direct Healthcare Limited.

Nursing Direct will oversee and ensure that any Service User having any form of physical intervention or restrictive practice in place has the necessary procedures and authorisation as detailed within this policy. Following any occasion where a restrictive intervention is used, whether planned or unplanned, a full record should be made. This should be recorded as soon as practicable (and always within 24 hours of the incident). The record should detail:

- The names of the staff and people involved
- The reason for using the specific type of restrictive intervention (rather than an alternative less restrictive strategy)
- The type of intervention employed
- The date and the duration of the intervention
- Whether the Service User or anyone else experienced injury or distress (a body map should also detail any injuries)
- What action was taken

5.12 **Injuries Sustained Through the Use of Physical Intervention**
Any injuries or suspected injuries should be dealt with as soon as it is practical and safe to do so.

The person responsible for managing the incident must check with staff and the Service User to ascertain their well-being after the incident and whether they may have any injuries. All injuries must be recorded as part of the post-incident debrief and reporting and a body map should be completed.

5.13 **PPE During the Coronavirus Pandemic**
As part of the Service User's overall positive behaviours support plan, staff should continue to follow all proactive strategies, and use de-escalation and disengagement, which is particularly important due to the increased risk of prolonged close contact in a potential physical intervention with other staff and the Service User.

In order to promote de-escalation, reduce environmental hazard and prevent the spread of infection, only staff that are required to be present for the safe deployment of physical intervention should be present in a room or the immediate environment.

One additional staff member (an incident coordinator) may be required to help maintain a safe environment and summon for additional support, or possibly help to ensure that PPE stays in situ during the physical intervention.

Before engaging in any physical intervention, staff should be familiar with the latest guidance on the use of PPE during the COVID-19 pandemic. Any Service User that has a planned physical intervention plan should have a risk assessment included in relation to PPE.

When PPE is to be used, take into consideration that the Service User seeing staff 'getting ready' to physically intervene by putting on PPE (or being approached by staff wearing PPE) can increase their stressed or distressed behaviours and can further exacerbate the situation. Staff should be aware of this and provide mitigation through reassurance and verbal de-escalation. It is advised that staff begin discussing the changes in practice with Service Users as part of key worker meetings or when reviewing their Care Plans and risk assessments, involving them where possible.

Nursing Direct Healthcare Limited will ensure that adequate stocks of PPE are accessible for staff and where possible, staff should carry gloves with them at all times in case of an emergency physical intervention. This should be subject to an individual risk assessment. Masks, aprons, eye goggles and additional gloves should be easily located. Spitting and throwing of body fluids is not considered to be aerosol generating (AGPs) for which an FFP3 mask and long sleeved disposable gowns would be required. However, if the risk of exposure to body fluids is considered a possibility, staff should wear goggles as part of PPE prior to the intervention, and can undertake an individual risk assessment to determine PPE requirements.

The donning of PPE must be balanced with safety considerations, i.e. in unplanned/emergency situations and ensuring overall safety needs are prioritised. Should intervention without PPE become unavoidable, staff must follow procedures for disinfection such as hand washing.

5.14 **Good Governance and Corporate Accountability**
Nursing Direct Healthcare Limited will ensure that robust governance oversight, monitoring and regular review are in place where Service Users who are exposed to restrictive interventions have access to high quality behaviour support plans that are designed, implemented and reviewed by staff with the necessary skills, and that restrictive interventions are undertaken lawfully. Nursing Direct Healthcare Limited will ensure that its effective governance frameworks are founded on transparency and accountability.

Nursing Direct Healthcare Limited will ensure that there is an identified Director or equivalent who takes a lead responsibility for restrictive intervention reduction programmes. Service Users and families will be informed of who this is.

Senior Management Team who authorise the use of restrictive interventions in the service should also undertake appropriate training in the use of PBS and physical interventions to ensure they are fully aware of the techniques their staff are being trained in.

5.15 **Restraint Reduction**
- Nursing Direct Healthcare Limited will have restrictive intervention reduction programmes based on the principles of effective leadership, data informed practice, workforce development, the use of specific restrictive intervention reduction tools, Service User empowerment and a commitment to effective models of post-incident review
- Restrictive intervention reduction programmes will be reviewed on an ongoing basis. As a minimum, there must be evidence of at least an annual full evidence-based review of control measures leading to revision and update of corporate action plans. All restrictive intervention reduction programmes and evidence of associated reviews must be made available for inspection for the regulators
- Any Service User with a behaviour support plan advocating the use of restrictive interventions should have clear proactive strategies including details of primary and secondary preventative strategies (refer to the Positive Behaviour Support Policy and Procedure)

- There must be assurance mechanisms in place which routinely examine the quality of training provided to staff about positive behavioural support, de-escalation and the use of restrictive interventions
- There will be arrangements for staff with differing degrees of specialism and seniority to maintain the competence associated with their role (i.e. the competencies required to deliver an effective behaviour support plan are qualitatively and quantitatively different than those required by a specialist practitioner who undertakes complex assessments and devises behaviour support plans)
- Nursing Direct Healthcare Limited will acknowledge and seek to minimise the risks associated with any restrictive interventions taught to staff
- Services must maintain accurate information that allows them to readily identify which Service Users have behaviour support plans that include the use of restrictive interventions as tertiary strategies

6. DEFINITIONS

6.1 **Restrictive Practice**
- Making someone do something they don't want to do or stopping someone doing something they want to do - (Skills for Care & Skills for Health)
- Restricting practice risks a breach of the following human rights:
  - The right to freedom from torture, inhuman and degrading treatment
  - The right to liberty and security
  - The right to respect for private and family life, home and correspondence
- Examples of restrictive practice include:
  - Use of blanket rules (routine locking of doors, observation levels, use of seclusion, restraining an aggressive Service User, sedation with medication)

6.2 **Restrictive Interventions**
- This is a specific set of interventions. They are deliberate acts (that could be seen to restrict a Service User's movement, liberty or freedom to act independently) placed on a person to:
  - Take immediate control of a dangerous situation (where there is the risk of harm to the person or others if no action is taken) and
  - End or reduce significantly the danger to the person or others
- Examples could include:
  - Physical interventions and restraint (including mechanical restraint)
  - Seclusion
  - Personal and other searches
  - Enhanced supervision
  - Withholding of information or equipment
  - Blanket restrictions

6.3 **Coronavirus**
- Novel coronavirus is a new strain of coronavirus first identified in Wuhan City, China. The virus was named severe acute respiratory coronavirus 2 (SARS-CoV-2). The disease it causes is called COVID- 19

6.4 **Pandemic**
- A pandemic is the worldwide spread of a new disease. COVID-19 was characterised as a pandemic on 11th March 2020

6.5 **Breakaway Techniques**
- Physical skills to help separate or break away from an aggressor in a safe manner that does not involve the use of restraint - (The National Institute for Clinical Excellence, 2015)

6.6 **De-escalation**
- A combination of strategies, techniques and methods to reduce a person's agitation and aggression

6.7 **Physical Intervention**
- A term used to cover the use of direct or indirect force through bodily, physical or mechanical means, to limit another person's movement

6.8 **Stressed and Distressed Behaviours**
- Stress is a state of mental or emotional strain or tension resulting from an adverse or demanding circumstance
- Distress is a state of extreme anxiety, sorrow or pain

6.9 **Mechanical Restraint**
- Any restrictive device (e.g. seatbelt, lap-belt, 5 point harness, bed rails, or physical confinement) used to restrict a person's free movement, most commonly used in emergency situations)

KEY FACTS - PROFESSIONALS

Professionals providing this service should be aware of the following:

- If restrictive physical intervention is used it must not include the deliberate application of pain
- The Care Plan must detail specific behaviour, de-escalation techniques, alternative approaches to reduce the need for physical intervention and clearly state that restrictive physical intervention must only be used as a 'last resort'
- The use of any physical intervention must be accurately recorded and shared with the management of Nursing Direct Healthcare Limited and, if ongoing, must be subject to regular review
- When physical intervention is used, this must be used for the shortest time possible and with the minimum possible restriction by staff with the relevant training through an accredited provider
- The capacity of the Service User must be considered and action must be taken in line with the five principles of the MCA
- Staff must not deliberately physically restrain a Service User in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface (not just on the floor)
- Breakaway and de-escalation techniques are recommended for community settings. However, any situations where physical intervention is used in the community must have board approval and include a multidisciplinary team approach
- A Board level (or equivalent) lead must be identified for increasing the use of recovery-based approaches including, where appropriate, positive behavioural support planning, and reducing restrictive interventions
- Nursing Direct Healthcare Limited must maintain and be accountable for overarching restrictive intervention reduction programmes
- Nursing Direct Healthcare Limited must approve the increased behavioural support planning and restrictive intervention reduction to be taught to staff
- Governance structures and transparent policies around the use of restrictive interventions must be established by Nursing Direct Healthcare Limited
- Post-incident reviews and debriefs must be planned so that lessons are learned when incidents occur where restrictive interventions have had to be used
- Nursing Direct Healthcare Limited must report on the use of restrictive interventions to service commissioners, who will monitor and act in the event of concerns

KEY FACTS - PEOPLE AFFECTED BY THE SERVICE

People affected by this service should be aware of the following:

- If you experience stressed or distressed behaviours, staff will have relevant training to support you in a positive way allowing you freedom, choice and control over your own life
- Care Plans are used to enable Nursing Direct Healthcare Limited to capture your preferences and wishes and provide staff with clear guidance about how they provide you with Care. These Care Plans include your views and wishes that relate to areas that could have the potential to restrict your freedom or choice
- We will always talk to you after any incidents of physical intervention so we can explore ways to reduce this happening again
- In some rare situations, we may need to physically hold you to keep you and other people safe. This will only be done when you and other people involved in your care and support agree this is in your best interests if you lack capacity
- This policy only applies to Service Users who lack capacity in relation to their behaviour and any agreement to physical intervention and only if you have a Deprivation of Liberty in place authorising us to do this to keep you and others safe

FURTHER READING

As well as the information in the 'underpinning knowledge' section of the review sheet we recommend that you add to your understanding in this policy area by considering the following materials:

RCN - Let's talk about restraint - Rights, risks and responsibility:
http://restraintreductionnetwork.org/wp-content/uploads/2016/11/Lets-talk-about-restraint.pdf

Restraint Reduction Network:
https://restraintreductionnetwork.org/

Nursing Times (2014):
https://www.nursingtimes.net/clinical-archive/patient-safety/reducing-need-to-restrain-vulnerable-patients-11-07-2014/

BILD - Positive Behaviour Support:
https://www.bild.org.uk/positive-behaviour-support-pbs/

OUTSTANDING PRACTICE

To be 'outstanding ' in this policy area you could provide evidence that:

- There are minimal recent incidents of physical intervention at Nursing Direct Healthcare Limited despite the fact that Service Users have a history of presenting behaviours that have resulted in physical intervention in the past
- Nursing Direct Healthcare Limited can demonstrate that it is open and transparent in the area of physical intervention, learning from individuals and their relatives or friends about how it can be avoided
- A culture of positive and proactive care and positive behaviour support is embedded into Nursing Direct Healthcare Limited which is evidenced in policies, procedures, training, staff attitudes, governance oversight and Service User outcomes. Governance data shows a decrease in any incidents of physical intervention as a result of the culture and ethos
- Service Users and their representatives are extremely satisfied with the way that care and support is provided by Nursing Direct Healthcare Limited
- All relevant staff are fully aware of the issues surrounding physical intervention and understand the implications
- Stakeholders are satisfied with the service
- The wide understanding of the policy is enabled by proactive use of the QCS App
- There is no evidence of blanket restrictions related to the service and each Service User's Care Plan shows involvement, goal planning and a truly person-centred approach to each Service User's individual needs, preferences and wishes

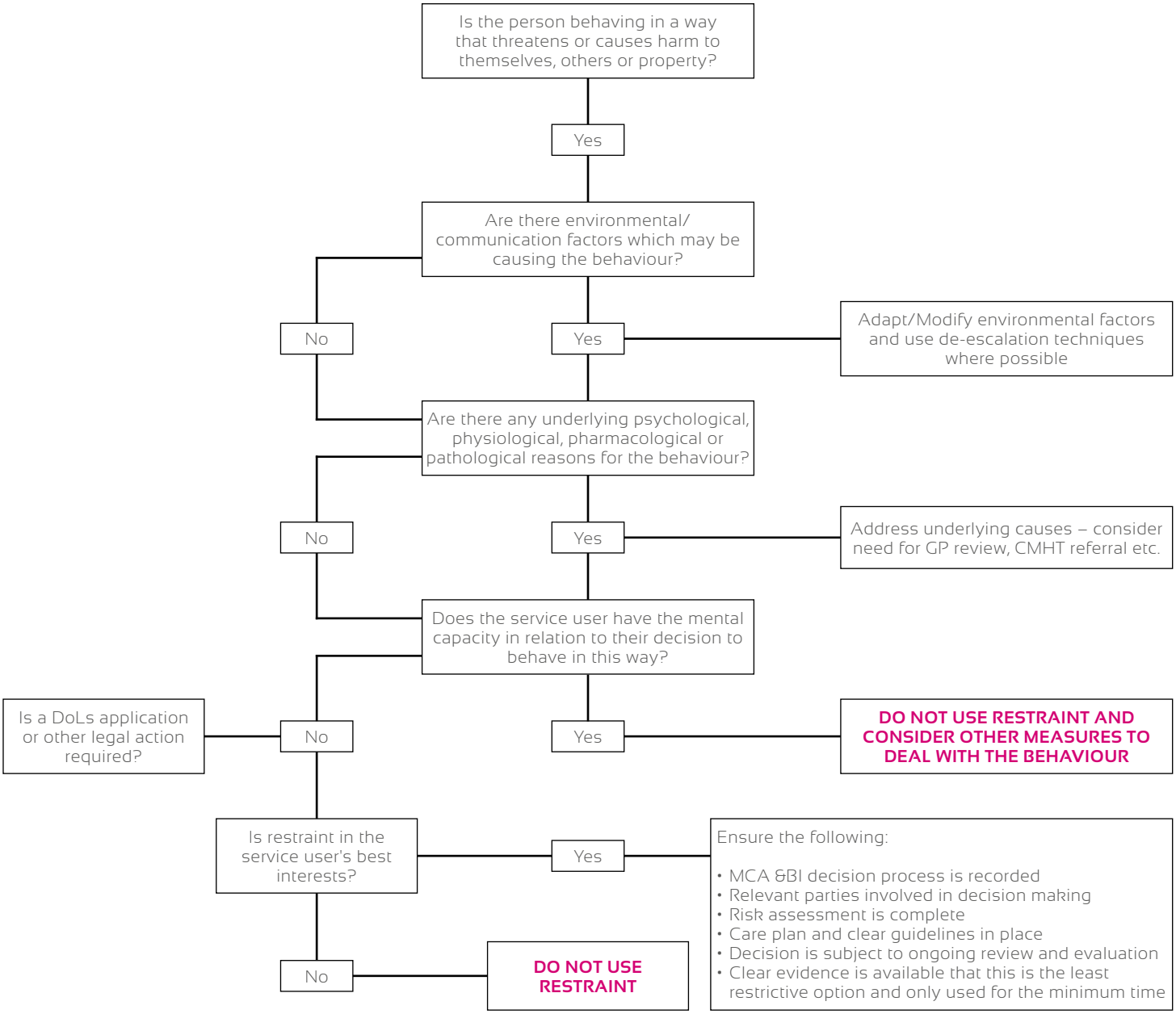
FORMS

The following forms are included as part of this policy:

Title of form	When would the form be used?	Created by
Restraint Register - CR17	To provide evidence to support practice improvement and reduction of restraint.	QCS
Physical Intervention Flow Chart - CR17	To guide decision making before using considering any restrictive physical intervention.	QCS
Post De-Brief Analysis - CR17	Post event this form should be completed as an opportunity for reflective learning and demonstration of continuous improvement.	QCS
Individual Staff Post-Incident Support Checklist - CR17	This form should be completed as part of the post-incident staff support measures.	QCS
Safe Holds Easy Read - CR17	To support enabling service users to understand safe holds.	QCS
Positive Behaviour Support - CR17	A poster that can be displayed to raise awareness.	British Institute of Learning Disabilities (BILD)
Service User Debrief - CR17	This form is to be used following an incident. It should be completed with the service user to aid reflection.	QCS

NAME OF SERVICE USER	DATE, TIME AND DURATION OF PHYSICAL INTERVENTION	REASON FOR RESTRAINT	TYPE OF RESTRAINT	ACTIONS TAKEN AS A RESULT OF THE PHYSICAL INTERVENTION	NAME OF PERSON/ PEOPLE INVOLVED IN THE PHYSICAL INTERVENTION	SIGNATURE OF PERSON/ PEOPLE INVOLVED IN THE PHYSICAL INTERVENTION

FLOW CHART TO GUIDE DECISION MAKING



ATTENDANCE BY ALL STAFF INVOLVED IN THE INCIDENT

Person carrying out post- incident debrief with staff: _____

Names of staff involved in post physical analysis:		**Ref number:**	
Attendees at post intervention analysis:		**Date:**	

Name of Service User who had physical intervention:	
Location, time and date of incident:	
Description of the stressed or distressed behaviour leading up to the physical intervention:	
Who made the decision to physically intervene?	
Staff involved with actual physical intervention:	
Did the Service User struggle or become more distressed during the physical intervention?	
What occurred during the physical intervention? (Details around de- escalation, any medication used or any concerns during the physical intervention)	
How long the person was physically restrained for?	
Were any injuries sustained by the Service User or staff?	
What happened after the person was released from physical intervention?	

Views and opinions on whether the decision to physically intervene was necessary, proportionate to the level of risk, or whether a less restrictive option could have been carried out?	
Opinions on whether the incident was well managed?	
Any other issues to be addressed, e.g. Service User concerns, training?	
Comments of interviewer:	
Have all staff involved received the relevant training and are up to date with this and deemed competent? (Provide details)	
Further action required:	
Signature of Manager:	
Date:	

INDIVIDUAL STAFF POST-INCIDENT SUPPORT CHECKLIST

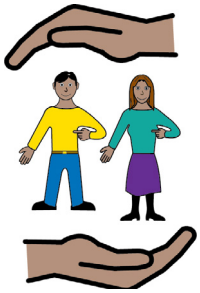
Date of Physical Intervention:			Ref Number:	
Brief Description of Incident:				
Name/Position of Staff Receiving Support:				
Name/Position of Staff Providing Support:				
Were any physical injuries sustained? (Please tick)	YES		NO	
If yes, what injuries?				
What first aid/medical attention was needed?				
Does the staff member require time out, and if so what has been provided?				
Is the staff member able to complete their shift or continue to attend work?				
How is the staff member feeling post incident?				
Does the staff member require further support (if so, what support)?				
Is further debriefing needed for the staff member and/or related to incident? If yes, describe?				
What changes can be made to reduce further incidents, i.e. review risks assessments, PBS plans etc?				
Have staff identified any further suggestions to reduce risks or personal support needs?				
Sent to Manager (Tick to confirm)			Date:	
Signature of Staff Member Receiving Support:				
Signature of Staff Providing Support:				
Further Action Taken by Manager:				
Signature of Manager:				
Date:				

LET'S TALK ABOUT SAFE HOLDS

WHY WOULD WE NEED TO HOLD SOMEONE?

No one should hit another person.

Sometimes a service user may hit out because they may be really angry or upset.



Staff cannot let this happen and must keep everyone safe.

So if a person hits or hurts someone, staff may have to hold that person.

Staff will try and move the person away from others.

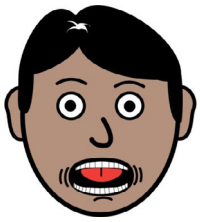
We will try and support the person privately away from others.

HOW WE WILL SUPPORT YOU

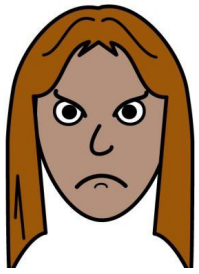
Safe holds will never be used to punish people; only to keep people safe.

It can be hard to understand what is happening.

It can be very busy, noisy and scary.



You may feel frightened.



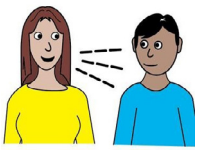
You may feel angry with the person

Or

You may feel angry with staff.

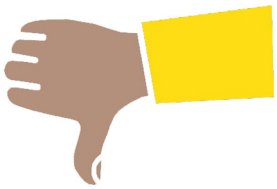
It is best to walk away. No one likes being watched when they are angry or upset.

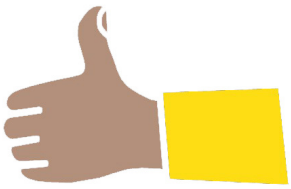
Remember, staff have training to support people who are upset or angry.



If you are confused, upset or angry, you can talk to a staff member you can trust.

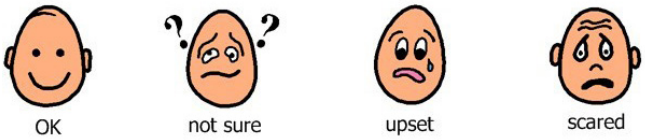
HOW WELL DO YOU UNDERSTAND SAFE HOLDS NOW?



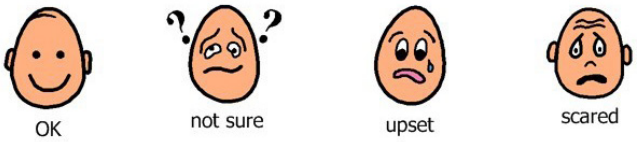


SERVICE USER DEBRIEF

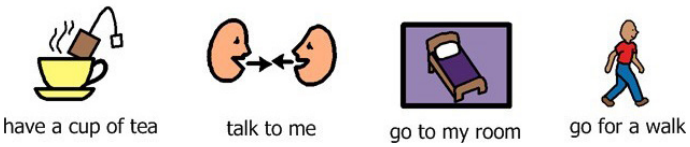
How did you feel during the incident?



How do you feel after the incident?



How could staff support you to feel better?



IS THERE ANYTHING YOU WANT TO TALK ABOUT?

☐ YES ☐ NO

Staff Member: _____ Service-User: _____

Date: _____

POSITIVE BEHAVIOUR SUPPORT

VALUES LED

PBS supports human rights and promotes respect, dignity, inclusion and a life without unnecessary restriction. PBS means treating people equally, celebrating diversity and working in partnership with the person and their family to make things better for everyone. PBS does not advocate the use of punishment or any aversive methods.

PROMOTING QUALITY OF LIFE

The overall aim of PBS is to improve the quality of a person's life and that of the people around them. This includes children, young people and adults, as well as older people. PBS provides the right support at the right time for a person so they can lead a life that is meaningful and interesting to them.

UNDERSTANDING BEHAVIOUR AND MEETING NEEDS

PBS uses different methods to gather information to work out what people's behaviour means if they are unable to express this. It improves support and empowers people to use better and less harmful ways to get their needs met. This often involves using a range of different approaches and personalised ways of supporting that enhance a person's life.

MAKING SYSTEMS WORK FOR THE PERSON

Giving the right support at the right time so people can thrive and fulfil their potential. This may mean changing the way the person is supported. Carers and staff may need training, and service structures and cultures may need to change. Continuous review is important to make sure support carries on working well for the person and those around them. We believe that systems and environments should change not people.

Developed by A MacDonald, E Jones, K Lowe, S Leitch and the UK APBS Alliance, 2019. Updated 2020.