Birmingham and Solihull Mental Health NHS Foundation Trust

Prevention and Management of Violence Policy

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Policy author *(if different from above)*	**ANP Averts**	
Exec Sign off Signature (electronic)	XXXX	
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

- This policy provides an overview of the Trust philosophy and overall strategy for managing and reducing violence in its services
- Provide primary, secondary and tertiary guidance to staff in keeping with current national violence reduction initiatives and evidence based guidance.

Policy requirement (see Section 2)

- As driven by the Department of Health Positive and Safe Agenda (DH, 2014), the Mental Health Act Code of Practice (DH, 2015), NG: 10 (NICE, 2015), the Mental Health Units (Use of Force) Act 2018 and the on-going work of the Restraint Reduction Network (RRN); this policy promotes and supports the implementation of primary, secondary and tertiary preventative strategy-based approach to violence reduction Trust-wide.

- The Policy will support the Trusts on-going violence reduction plan and annual quality account goals relating to a reduction in restrictive practices and assaults on service users and staff.

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1: Introduction

- **1.1 Rationale** (Why)
- The Trust recognises that occasionally some service users - because of the impact of illhealth on their social functioning - may behave in an aggressive or violent manner that requires effective management.
- The Mental Health Act Code of Practice (DH, 2015) states:
- 'Providers who treat people who are liable to present with behavioural disturbances should focus primarily on providing a positive and therapeutic culture. The culture should be aimed at preventing behavioural disturbances, early recognition, and de-escalation' (Ch. 26, p. 281)
- The Positive and Safe Agenda (Department of Health, 2014) provides a national framework to reduce the use of restrictive practices in health and social care settings. This agenda is now intrinsic to the management of violence in such settings in England.
- This policy will be used to support the Trust Positive and Proactive Care: Violence Reduction Strategy, and the Trusts commitment to meeting the RRN training standards
- The safety and wellbeing of the people in our care and those who provide this care are a priority for the organisation.
- The organisation acknowledges the over representation of individuals with a BAME background, in particular black African and Caribbean heritage detained within mental Health services (DH,2018) and the use of restrictive interventions with this population needs to be considered.
- The concept of Positive Behavioural Support (PBS) and its use in violence reduction is well established in Learning Disability settings. There is emerging evidence of its suitability and effectiveness in mental health acute admission settings.
- **1.2 Scope (**when, where and who):
- This policy applies to BSMHFT staff and service users including those contracted to work on trust premises on a transient or part time basis. External staff providing security oversight to buildings and site (for example Amey, and Engie) are not contracted to be involved in clinical incidents and are therefore expected to provide a presence but not to physically intervene with service users unless there is a legally cogent reason for doing so.
- This policy refers to inpatient service areas. Community based staff will follow the guidance to maintain their safety and wellbeing as laid out in the Policy for Lone Working.
- The definition of violence and personal safety used by BSMHFT is based on the HSE definition of workplace violence namely:
- "Any incident where staff, service users and visitors are abused, threatened, or assaulted in circumstances related to Trust activity or on Trust premises, involving an explicit or implicit challenge to their safety, well-being or health."
- Service users must always be treated with dignity and respect regardless of provocation and with due regard to an individual's race, ethnicity, religion, gender, sexual orientation, mental, or physical disability.

- HMP staff will be trained in line with prison training requirements as identified in the Risk Management Training Policy.
- This policy acknowledges and pays due regard to the personal protected characteristics as defined in the Equality Act 2010. Staff are expected to take these elements into consideration when planning, implementing, undertaking and reviewing observations.
- The Mental Health Units (Use of Force) Act 2018 received Royal Assent on 1 November 2018. The Act requires that Mental Health Units must have a policy on the use of force. The Safe use of Force policy can be found **here**.
- **1.3 Principles** (beliefs): this presents the major underlying beliefs on which the policy is based.
- The Trust does not endorse, through its policies, procedures or training programmes, the concept of a forced restraint (this is where a person standing up is forced to the floor – usually in a prone position – by staff).
- The use of tertiary restrictive interventions (for example: physical restraint) is always considered a measure of last resort, must be proven to be reasonable under the presenting circumstances, for the shortest of period of time possible, in order to minimise the risks to both the service user and staff.
- The Trust acknowledges and fully supports national guidance and adopts the position that wherever possible the use of the prone position is to be avoided. The Trust extends this belief and continues to work towards, where possible, the avoidance of all restraint.
- Unless there are cogent reasons for doing so the use of planned interventions that involve placing the person in the prone/face down/chest down position on any surface, not only the floor, must be avoided (DH, 2015, p. 295).
- 'Cogent reasons' may be informed by risk to the person or others, or form part of a service users preference in their advanced statement. Such issues should be discussed as an MDT and rationales clearly documented in the service user's aggression management care plan and/ or PBS plan or equivalent.
- The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.
- The Policy will support the Trust five year violence reduction plan and annual quality account goals relating to a reduction in restrictive practices and assaults to service users and staff.
- Safe Wards, an evidence-based violence reduction model will be used in all in-patient clinical areas to promote a culture of positive and proactive care with the aim of keeping service users and staff safe. The embedding of the model will be reviewed annually through the process of audit, results of which will be presented to the Trust board via Reducing Restrictive Practice Steering Group.

2: **The policy** consisting of:

2.1 When planning strategies to prevent and manage violence staff should apply the following process:

2.2 Staff should ensure that patients who are assessed as being liable to present with behavioural disturbance have a care or treatment plan which includes primary preventative strategies, secondary preventative strategies and tertiary strategies. In some services such care and treatment is referred to as a positive behavioural support plan (PBSP). These individualised care plans should be available and kept up to date' (DH, 2015, p. 284)

2.3 PBSP's (or equivalent) should take account of:

- Cognitive functioning

- Sensory impairment
- Neuro-developmental disorders
- Age in terms of psychological and emotional maturity
- Ethnicity
- Culture
- Religion or belief
- Gender
- Gender identity
- Sexual identity
- Physical frailty
- Communication needs

2.4 In acute services the principles of PBS (ie primary, secondary and tertiary interventions) will be applied to risk management plans relating to management of violence and aggression with service users who display such high risk behaviours.

2.5 All service users will have a minimum of a level 1 risk screen completed on admission into the service which will be reviewed regularly and updated on a need led basis. Clinical services may complete additional risk screening that is commensurate with the clinical service and individual needs of the service user.

3: The procedure consisting of:

3.1 **Primary Preventative Strategies**

Primary strategies seek to promote the following:

'Behavioural disturbance can be minimised by promoting a supportive and therapeutic

culture within the care environment' (DH, 2015, p. 285) This includes elements of:

Care Environment

Engagement with the service user and their family

Offering care and support

3.2 **Care Environment**

3.2.1 The Trust has invested in providing the environments that are conducive to care. However, when working with service users with a propensity for behavioural disturbance staff should take into account how these environments are managed on an operational basis. Unless specific justifiable reasons exist (e.g. for security or reasons of safety) staff should ensure that service users have:

- Predictable access to preferred items and activities.
- A unit where excessive environmental stimulation/noise is managed
- An appropriate number and mix of staff to meet the needs of the inpatient population
- An avoidance of areas where there is a reliance on compliance and the adherence of 'blanket rules' Please see the Trust's **Blanket restrictions policy** for further guidance.

If these elements have not been applied due to specific justifiable reasons then such reasons should be clearly documented in the Electronic Care Record. Decisions not to employ any of the above strategies should be made via the MDT and reviewed weekly based on presenting risks.

3.2.2 Engaging with individuals and their Families

3.2.3 The Trust has established policies and procedures that foster an environment conducive with working with service user families and carers. Unless justifiable reasons exist this includes

dedicated areas for private meetings and the means for service users to have private communication via telephone, email and letter.

3.2.4 Staff should actively engage service users in the identification of their own trigger factors and early warning signs of behavioural disturbance and how staff should respond to them. These should be clearly documented in the service user's PBS or care plan on RIO.

3.2.5 The PBSP (or equivalent) should be reviewed weekly at the MDT.

3.2.6 Unless justifiable reasons exists (e.g. consent or capacity to refuse consent, domestic abuse) staff are to actively engage the service user's nearest relative, family, carers and advocates when compiling PBSP (or equivalent) care and treatment planning.

3.2.7 If a service user refuses to contribute to their PBSP (or equivalent) this should be clearly documented in their care records.

3.2.8 In such instances staff should continue to periodically engage the person and encourage involvement, offering care and support.

3.2.9 Any PBSP (or equivalent) should be individually focussed and compiled using information from the service user, their nearest relative, family, carer or advocate, the MDT based on previous knowledge and risk history.

3.2.10 The service user is to be included in the decision-making process concerning their activity and therapy programme, based on identified needs.

3.2.11 Service users identified at being at risk of presenting with behavioural disturbance should be given the opportunity to have their wishes and feelings documented in an advanced statement. Details of how to do this can be found in the Advanced Statement & Decisions Policy.

3.2.12 Unless justifiable reasons exist, it is expected that service users avoid spending extended periods of time in their bedrooms at the detriment of planned therapeutic activities during the daytime.

3.3 **Secondary Preventative Strategies**

3.3.1 **De-escalation**

'De-escalation is a secondary preventative strategy. It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance' (DH, 2015, p. 288)

3.3.2 Staff should use the information gathered from the PBSP (or equivalent) as a basis for deescalation. This will include triggers and early warning signs provided by the service user, their nearest relative, carers or advocates, risk and medical history. Wherever possible members of staff should involve the person who has the best rapport with the service user.

3.3.3 De-escalation should always be employed when managing potential behavioural disturbance. Staff should use the 'Talk Down' model of de-escalation as taught on AVERTS courses. This can be found in appendix 3.

3.3.4 Unless justifiable reasons exist, staff must avoid dismissing genuine concerns or failing to act as agreed in response to reasonable requests from service users. This may contribute to exacerbating instances of behavioural disturbance.

3.3.5 Staff should explain any delays as to why service user's needs have not been met and involve them in any plans to redress such issues.

3.3.6 Staff should refer to the DE-ESCALATION MODEL that can be found in APPENDIX 3. This model is reinforced through the AVERTS training programme.

3.3.7 **Enhanced Observations**

3.3.8 Observations that are implemented based on an assessment of risks of violence and aggression should have a minimum of two staff. Details on the use of enhanced observation can

be found in the **Therapeutic Observations and Positive Engagement Policy** 3.4 **Reducing Restrictive Practice Steering Group (RRP)**

3.4.1 The RRP is the Trusts panel that drives the reduction of restrictive practices agenda within the organisation. The group meets on a monthly basis. It is chaired by the Deputy Medical Director for quality and safety and is co-chaired by the ANP AVERTS. The membership of the panel is multidisciplinary and has membership from across the organisation. Experts by Experience are integral to the group and are actively involved in the RRP workstreams.

3.4.2 The RRPSG facilitated the Trusts RRP QI collaborative and is instrumental in the scale up and spread of learning from the collaborative. The panel is also responsible for delivery on the organisational pledge made to the Restraint Reduction Network. The pledge can be found **here**.

3.4.3 Alongside the RRP QI workstream, the RRPSG oversee policy development around restrictive practices, monitor incident data from across the organisation and identify areas of good practice and the learning of lessons for dissemination across the Trust.

3.4.4 The group has identified workstreams that are refreshed annually using quality improvement methodology. Feedback and progress on the work of the RRPSG is reported to QPESc on a quarterly basis.

3.5 **Tertiary Preventative Strategies**

> 'Tertiary preventative strategies guide the responses of staff and carers when there is a behavioural disturbance' (DH, 2015, p. 285)

3.5.1 Staff will be expected to employ the process of de-escalation prior to any implementation of restrictive interventions and continue their use throughout the event.

3.5.2 On some occasions use of restrictive interventions may be needed to manage behavioural disturbances that pose significant risks or in an emergency situation. Restrictive interventions are defined as:

> 'Deliberate acts on the part of another person(s) that restrict a patient's movement, liberty and/freedom to act independently in order to:
>
> - Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken.
> - End or reduce significantly the danger to the patient or others' (DH, 2015, p. 290)

3.5.3 Methods of restrictive interventions are:

- Physical Intervention
- Mechanical Restraint
- Seclusion
- Rapid Tranquilisation

3.5.6 Restrictive interventions need to be reasonable and proportionate, used only as a last resort, for the shortest period of time possible to minimise risk to service users and staff.

3.5.7 Such interventions must never be used as a means to punish or intimidate. Such actions constitute abuse and will not be tolerated by the organisation.

3.5.8 Consideration should be given to the individual needs of the person exhibiting behavioural disturbance and any planned intervention should be, as far as practicable non-physical incorporating primary and secondary preventative strategies. Staff should refer to the individual care/ management plan for the person and any management plan devised should take into account any adaptations required to meet the individual's personal needs (communication, frailty, physicality etc.) The AVERTS consultants are able to assist in the formulation of management plans where required.

3.6 Physical Intervention

The Mental Health Units Use of Force Act (2018) defines physical restraint as "*the use of physical contact which is intended to prevent, restrict or subdue movement of any part of the patient's body*" this will be the definition used for the purpose of this policy.

3.6.1 Procedural arrangements for the effective management of violence and aggression will be established at local level that will include details on how to summon help and support should a crisis occur. This should form part of the local induction and orientation process. Whilst localised guidance will determine the operational nature and maintenance of alarm systems prevalent to a specific service, the following procedural standards should be in place in all settings where staff are expected to respond to personal alarms:

3.6.2 The nurse in charge on each shift must allocate a suitable staff member to respond to the personal alarm. Ideally this member of staff will be AVERTS trained.

3.6.3 If no AVERTS trained staff are available, the nurse in charge must use their clinical judgement to allocate the most appropriate individual and report it appropriately through the trust established incident reporting system.

3.6.4 Bank staff with limited clinical experience or new to the organisation should not be nominated without a localised induction and the roles and responsibilities explained.

3.6.5 Staff responding to alarms in another area should take their lead from the member of staff coordinating the incident unless clinical judgement or presenting risks to self or others otherwise dictate.

3.6.6 The staff member in each area responding to the alarms must be available at all times to respond immediately. If they are unable to respond due to rest breaks, undertaking observations or vital clinical activity, the nurse in charge must allocate another member of staff to be available to respond immediately.

3.6.7 Once the incident has been resolved, the decision to de-activate the personal alarm should be taken by the nurse in charge of the area that has activated it. Staff from responding areas can then be released by the nurse in charge to return to their own areas.

3.6.8 If a second alarm is raised from a second incident, each Suite will allocate a second member of staff to respond to the incident. Staff at the first incident will return to their host Suite as quickly as possible to ensure staffing levels are maintained.

3.6.9 Care must be taken by staff responding to the personal alarm. Staff must respond as quickly, but also as safely, as possible.

3.6.10 The choice of intervention must be guided by clinical need and the obligations owed to the service user (i.e. Advanced Statements, physical and cultural needs), other service users affected by the disturbed behaviour and to members of staff and any visitors.

3.6.11 Those staff who are expected to therapeutically engage on a continuous and direct basis with service users who pose a potential risk must receive mandatory training in the use of physical intervention upon commencement of employment and annually thereafter. All ward based nursing staff would routinely fall into this category.

3.6.12 All staff who employ physical interventions must receive mandatory resuscitation training according to the Trusts Training Needs Analysis (TNA).

3.6.13 All staff must consider the respect and dignity of the person being held. Consideration as to the implications for human rights should be assessed on an on-going basis.

3.6.14 Staff must only use those physical intervention techniques as taught on AVERTS training courses delivered by the AVERTS trainers and consultants. Should staff witness practices that are unreasonable to the circumstances or increase the potential risks to either the service user or colleagues then they are obligated to report such instances without fear of recrimination or reprisal.

3.6.15 Physical intervention should never be used as a punishment. It is considered a measure of last resort to minimise risks to the person, the staff and those in immediate danger, for the shortest

period of time possible. AVERTS training recognises that the employment of skills will be based on a proportionate response and least restrictive practice.

3.6.16 There are dangers inherent with continuous physical interventions in any position (i.e. Positional Asphyxia). To avoid prolonged physical intervention alternative strategies, such as Emergency Response Belt (ERB), rapid tranquillisation or seclusion, where available, should be considered.

3.7 Use of the Safety POD

3.7.1 The safety pod is a piece of equipment that can be used for primary and secondary prevention and tertiary intervention when attempting to avoid, reduce or safely manage aggressive behaviours likely to cause harm to self or others.

3.7.2 The safety pod is a specialist piece of equipment, other bean bags are not designed in the same way and therefore do not have the same levels of postural support. No other type of device should be used in place of the safety pod.

3.7.3 The safety pod can provide a supportive and pliant surface in which the person can sit, the POD will form around the person and provide support whilst also slowing the individual down as momentum is required to stand back up out of the pod.

3.7.4 The safety pod allows the person to be managed in a way that allows physical support to the head and neck, it improves spinal alignment and places the person in a seated position thus avoiding supine or prone floor restraint. The seated angle allows for expansion of the chest and lungs.

3.7.5 The safety pod can be used in a number of eventualities including but not limited to;

a. To help bring an end to prolonged physical intervention
b. To avoid the use of prone (face down) or Supine (face up) floor intervention.
c. To assist in the administration of IM medication in the deltoid.
d. To assist in the administration of naso-gastric feeds.
e. To help manage self-injurious presentation
f. Use within perinatal services
g. Assist in more invasive personal care procedures (barbering, nail care etc)
h. The safety pod can be used in conjunction with AVERTS holds and can assist in keeping staff and service user safe.
i. Used in conjunction with the Soft Restraint System (SRS) to manage serious self-harm (R&S 33 – Mechanical Restraint Policy)

3.7.6 The safety pod can be incorporated into a person's PBSP (or equivalent) and be used as a de-escalatory tool that the person can place themselves in (primary prevention), staff could advise a person to access the safety pod (secondary prevention) or staff may choose to utilise the safety pod as a device in which to hold a person to avoid the need for floor physical intervention.

3.7.7 Prior to use for restrictive physical intervention, the pod should be primed for use. This can be achieved by staff lifting the pod and dropping it onto the floor, this should be done at the 'head' of the pod. Successful priming allows for the head flap to be folded down and the pod appearing in a square position. See **Appendix 10**.

3.7.8 The safety pod can be used with the accompanying leg cushion; the leg cushion should only be used when there is a risk that the legs compromise the safety of the person being held or the staff involved in the intervention. To use the leg cushion, an additional 2 members of staff will be required.

3.7.9 Any use of the pod will require all staff involved to have received appropriate training and instruction from the AVERTS team. See policy section 3.4.45-3.4.60.

3.7.10 Only skills taught during AVERTS training should be utilised if using the pod alongside restrictive physical interventions.

3.7.11 When used with restrictive physical intervention, the safety pod should always be used as a seated intervention and documented as such within the Eclipse and RiO record.

3.7.12 **Under no circumstances** should a person ever be held in a prone position in the safety pod.

3.7.13 If an individual has used the safety pod for primary or secondary prevention, this should be documented in the persons RiO records and should then (if not already) be included in the persons PBS plan (or equivalent). Any management plan should be co-produced wherever possible.

3.8 Prone Restraint

The department of health defines prone restraint as:

> 'the use of restraint in a face down or chest down position. Incidents of restraint that involve a service user being placed face down or chest down for any period (even if briefly prior to being turned over), should be defined as prone restraint. Similarly if a service user falls or places themselves in a face down or chest down position during a restrictive intervention, this should be defined as prone restraint' (DH, 2014).

3.8.1 Wherever possible prone/face down/chest down restraint should be avoided.

3.8.2 Unless there are cogent reasons for doing so (e.g. security and safety – entering a seclusion room) there should be no planned or intentional restraint of a person in the prone position (whereby they are forcibly laid on their front) on any surface, not just the floor.

3.8.3 'Cogent reasons for doing so' should be discussed and agreed by the MDT and clearly documented in the service user's care records. As noted in section 1.8 of this policy, cogent reasons may include: risk and safety for the service user and staff or when it is the expressed view of the service user as part of their advanced statement or PBSP (or equivalent).

3.8.4 Restraint should never be used to threaten or intimidate. This constitutes abuse.

3.9 Mechanical Restraint

Mechanical restraint means the use of a device which 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. (DOH, 2018)

3.9.1 The Trust has the facility to use mechanical restraint in Secure and Complex Care Services and Psychiatric Intensive Care Units. Handcuffs are permitted for high-risk escorts outside of the hospital site. The Mechanical Restraint policy will provide detailed information.

3.9.2 The Soft Restraint System (SRS) (formerly known as the Emergency Response Belt (ERB)) is used to convey people to avoid prolonged restraint, and in extreme instances of sustained selfharm. This is usually from a clinical area to a seclusion area.

3.9.3 The use of Handcuffs and the SRS are determined by the Mechanical Restraint Policy and sign off for their use is outlined within the relevant sections of the policy.

3.9.4 Any use of mechanical restraint by third-party transport providers should fall in line with Trust policy and procedure and must be reported via Eclipse. This is in keeping with the Use of Force Act (2018) and the **Trust's Safe Use of Force Policy**.

3.10 Seclusion and Longer Term Segregation

3.10.1 Comprehensive and detailed guidance on the use of seclusion and longer-term segregation can be found in the **Seclusion and Segregation Policy**.

3.11 Rapid Tranquilisation

3.11.1 Comprehensive and detailed guidance on the appropriate use and post administration monitoring of rapid tranquilisation in the management of violence and aggression can be found in the **Rapid Tranquilisation Policy**.

3.12 Training

3.12.1 The safety of staff working in the Trust is paramount and is as important as the safety of service users. Members of staff require appropriate training to identify unsafe situations and how to manage those that may become unsafe. The Trust refer to such training as Approaches to Violence through Effective Recognition and Training for Staff (AVERTS). The AVERTS annual capacity plan determines, via a training needs analysis, the capacity required for the organisation. This plan is designed and submitted to the clinical governance committee on an annual basis.

3.12.2 The AVERTS syllabus incorporates a variety of evidence based strategies informed by national guidance and statute and positive practice standards. From April 2020 there is a requirement that all training in restrictive physical interventions meets the mandatory standards outlined by the Restraint Reduction Network (RRN) Training Standards (2019) and overseen by BILD ACT and UKAS.

3.12.3 RRN (2019) stipulate that training in the management of violence and aggression must ensure that the views and experiences of people with lived experience must inform and be explicit in training content.

3.12.4 The Trust employs a number of AVERTS Trainers and AVERTS consultants whose role includes the design and delivery of training to staff to prepare them to deal with potential and actual violence including restrictive physical intervention skills. The consultants advisory capacity is an important resource for the clinical environment and each care programme has its own dedicated consultant to offer operational clinical coaching, specialist advice, support and can deliver bespoke packages of training where required.

3.12.5 Training in the recognition, prevention and therapeutic management of violence and aggression including the use of non-physical and physical intervention techniques (e.g. deescalation skills) will be made available for all employees. Programmes have been developed to the specific needs of the Trust and its service users to ensure its appropriateness and acceptability, particularly concerning age, gender, racial and cultural diversity and disability issues.

3.12.6 It is a standard that all new staff working in PICU settings, where possible, will access AVERTS training on the next available course following commencement within the Trust. All other places will be allocated in line with the AVERTS training matrix (see appendix 2)

3.12.7 All staff are required to complete a health declaration prior to the commencement of any course containing physical skills.

3.12.8 Where there are concerns regarding an individual's ability to undertake training owing to health reasons there should be a consultation between the respective unit manager and the Occupational Health team. The AVERTS trainers should be alerted to any concerns held by the unit management team.

3.12.9 An individual's competency will be assessed during training. If an individual is unable to demonstrate a skill element their line manager will be notified via letter. It is the line manager's responsibility to discuss and manage such information with the individual upon their return to work.

3.12.10 A member of staff who is pregnant or has an injury preventing them from participating in the physical skills elements of the course and who has already completed and remains 'live' with regards to their AVERTS training may observe an annual 1 day refresher to remain in date. A staff member with an injury should re-book onto an annual refresher when cleared to do so by

Occupational health. The pregnant member of staff should complete their next annual 1 day refresher within the agreed time parameters and will then remain in date.

3.12.11 Any member of staff who fails to attend for their annual 1-day refresher will be required to re-complete a 5-day AVERTS course.

3.12.12 There is an e-learning component as part of the refresher/ update process. All staff must complete and pass the e-learning component prior to attending for the face-to-face component of the AVERTS refresher training.

3.12.13 All staff who attend AVERTS face to face training for their 5- and 1-day physical skills course will be automatically allocated an update space by the LDBookings Department. If the staff member is unable to attend the date allocated, they must negotiate with the LDbookings team for an alternative date. It is the staff member's responsibility to alert the unit manager or TSS manager of the date that they have been allocated.

3.12.14 All AVERTS course bookings will be managed by the Trusts Learning and Development department who will build and populate the classes. Classes will be built in advance in order to ensure staff are able to be allocated onto courses in a timely manner.

3.12.15 Staff are to update annually but in extenuating circumstances this can be extended to 15 months. Extenuating circumstances involves sickness and unexpected events beyond an individual's control. It does not cover a failure to follow the process as described in section 3.4.47 and attend training as allocated. Such matters will be addressed with the individual through the Regular Management Supervision (RMS) process.

3.12.16 Further advice and guidance for transient members of staff, including bank and agency staff, can be found in the Approaches to Physical Intervention and Restraint in Appendix 6.

3.13 Supervised Practice and Violence Reduction

Each division with have a reducing restrictive practice action plan part of which will include the continued embedding of Safewards. Each area will identify key staff to assist with the on-going implementation of the initiative. These staff will support and guide staff in the application of the violence reduction strategies associated with the Safe wards model. This will be supported by the ANP AVERTS and the dedicated AVERTS consultants for each service with oversight from the Reducing Restrictive Practice Steering Group.

3.14 Guidance for Families and Carers

Service users, families and carers will have access to information related to positive and proactive care via the information leaflet in Appendix 4.

3.15 Use of Weapons

Where a weapon is used during an aggressive or violent incident the staff who assumes control of the situation should ask for the weapon to be placed in a neutral location rather than handed over. On no account should an attempt to physically disarm any person be attempted. Staff should vacate an area where such an immediate risk is posed and attempt to secure the service user concerned if it is safe to do so. Police should be contacted in such instances under the auspices of the **Police Interventions Policy**.

3.16 Personal Protective Equipment (PPE)

3.16.1 There may be occasion when management of violence and aggression requires staff to utilize personal protective equipment to minimise infection control risks during the event.

3.16.2 Such equipment currently consists of: cut resistant gloves, protective eye-wear and full face visors.

3.16.3 Full face visors should be worn at the earliest opportunity in incidents involving those service users where an infection control risk exists and where there is a likelihood of spitting during a restraint.

3.16.4 Procedure, access and maintenance of such equipment is detailed in Appendix 5.

3.16.5 These items will be kept in a dedicated container/ pouch which is clearly labelled 'Personal Protective Equipment' and sealed until use.

3.16.6 It is important that all unit staff are made aware of the location of the PPE equipment. This includes bank and agency staff when they are inducted onto the unit.

3.16.7 It is the responsibility of the ward manager to ensure that equipment is well maintained and procured in a timely manner.

3.17 Reporting and Recording

3.17.1 All instances of physical intervention are reportable via the Eclipse electronic reporting system. Staff should follow the processes as described in the **Reporting, Management and Learning from incidents Policy.** All entries must ensure that they are Use of Force compliant as per safe use of Force policy that can be found **here.** Further information regarding Negligible use of force and the recording and reporting requirements laid out in the Mental Health Units Use of Force Act (2018) can be found in appendix 12.

3.17.2 Family and carers need to be notified whenever any use of Force is utilised, this needs to be documented in the person RiO progress notes.

3.17.3 If a restraint lasts for longer than 10 minutes a plan for how to end restraint must be developed. In normal working hours the senior care team (Nursing, medical AHP's) should be contacted to plan how to end restraint; outside of normal working hours, the senior medic on call, manager on call and duty senior nurse should be contacted and involved in the discussion and planning to end the episode of restraint.

3.17.4 All incidence of restrictive physical interventions must be recorded on Eclipse and the data required for Use of Force submissions must be recorded and reported.

3.18 Service User Support

3.18.1 Service users and carers should be kept fully informed of any incident reviews being undertaken by the organisation and any lesson learned disseminated accordingly as determined by the **Reporting, Management and Learning from incidents** Policy

3.18.2 Staff should ensure that service users involved in the incident and those who witnessed the event are offered the means to express or document their feelings.

3.18.3 All service users should be encouraged to complete the post incident support form located on RiO with a member of the care team.

3.18.4 It is important that service users share their experiences and if a service user feels that an incident was managed inappropriately the individual should have access to the appropriate means of raising a concern or complaint. Service users should have access to their dedicated See Me worker or an advocacy worker who can assist with the complaints process as per **Complaints Policy**.

3.19 Safeguarding

Incidents that identify safeguarding concerns will be escalated and managed with reference to the **Domestic Abuse Policy**, **Adult Safeguarding** Policy or **Safeguarding Children and Young People Policy.**

4: Responsibilities

Post(s)	Responsibilities	Ref
All Staff	All staff are to be aware and adhere to the principles of the policy Report all incidents of restrictive practice via Eclipse Attend AVERTS training as stipulated in their training statement on OLM Report policy breeches via their line management streams	
Service, Clinical and Corporate Directors	Ensure that the policy is consistently applied within their services and spheres of responsibility Ensure that violence reduction initiatives laid out in this policy are consistently applied Respond to data provided by information governance related to incidents of prone restraint and utilise AVERTS advisors for their respective areas.	
Policy Lead	Ensure that the policy is disseminated, reviewed and monitored accordingly.	
Nominated Positive and Safe Executive Director	Report to Trust board via CGC on the progress of the overall violence reduction strategy described in this policy Oversee the Trust Violence Reduction Strategy	
LSMS	Support staff who have been victim of assault in a timely manner & give feedback to the affected member of staff Liaise with the police in terms of the co-working arrangements with the Trust	
Post(s)	**Responsibilities**	**Ref**
Ward Manager	Ensure that all elements of this policy are maintained, and support staff who manage behavioural disturbance. Ensure that staff are fully compliant and have booked onto their AVERTS training course update. Ensure that incidents are accurately reported and recorded.	

5: Development and Consultation process consisting of:

Consultation summary

Date policy issued for consultation	07/08/2020
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	**Date(s)**
Positive and Proactive Care Expert Panel	11/02/2020 & 30/07/2020
Safeguarding Team	07/08/2020
PDMG	24/08/2020

Where received	Summary of feedback	Actions / Response
Dr Calthorpe	More emphasis on staff support in incidents requiring the police	Discussed with LSMS who stated additional policies were being developed that would address Dr Calthorpe's feedback
LSMS	The policy did not need any additional information as further policies were being developed to address the management of untoward behaviours	Feedback to Dr Calthorpe, a hyperlink will be inserted into the policy when the Management of unacceptable behaviours policy has been ratified.
Safeguarding team	The policy needs to reference the Domestic abuse policy and terminology around safeguarding needs to be amended. Also the inclusion of a service user's right to complain if they felt that they had been inappropriately managed.	Hyperlink to the Domestic abuse policy included; terminology amended and checked with the Safeguarding team. Pals and a hyperlink to the complaints policy included.
PDMG	Comprehensive policy with a few modifications required to include the monitoring of seclusion and to ensure that the correct committees are referenced and correct job titles displayed.	Corrections and modifications made. A hyperlink to the Management of Unacceptable Behaviours policy will be inserted once the policy becomes available.

Sue Adams	An e-mail was received with recommendations regarding the acknowledgement of the over representation of BAME individuals who are detained and subject to restrictive interventions. The monitoring of the protected characteristics of individuals subject to restrictive practices. Specific reference to the need for individualised plans of care taking into account individualised health needs if engaging in RPI.	Comments were reviewed and embedded into the policy where possible, further exploration by the GI team is required for the capture of protected characteristics.

6: Reference documents

- Bowers, L. (2014) A model of de-escalation. Mental Health Practice. 17(9), pp. 36-37.
- Department of Health (2005) **Mental Capacity Act London: TSO.**
- Department of Health (2014) **Positive and Proactive Care: Reducing the need for Restrictive Interventions. London: TSO.**
- Department of Health (2015) **NG10: Violence and Aggression in Mental Health, Health and Community Settings. London: NICE.**
- Department of Health (2015) **Mental Health Act (1983) Code of Practice (Revised) London: TSO.**
- Department of Health (2018) **Mental Health Units (Use of Force) Act 2018 London: TSO.**
- MIND (2013) **Mental Health Crisis Care: Physical Restraint in Crisis. London: MIND.**
- Restraint Reduction Network (2019) **Restraint Reduction Network (RRN) Training Standards. First ed. Norwich: Page Bros Ltd.**
- Department of Health (2018) **Modernising the Mental Health Act Increasing choice, reducing compulsion**: Crown copyright.

7: Bibliography:

- Rotherham & Doncaster & South Humber NHS Foundation Trust (2015) Positive and Proactive Care (Easy Read): Reducing the need for Restrictive Interventions and what it means for you. RDaSH: 2015.
- Rae, M., Carson, C. (2015) Independent Review of Restrictive Practice and Violence Reduction in Birmingham and Solihull Mental health Foundation Trust A list of works that

  the author has used as a source of information evidence or inspiration, but is not referred to directly in the text.

8: Glossary

- **Restrictive Practice**: Any practice that limits or inhibits a person's freedom of movement or will for the sole purpose of minimising risk to self or others. This includes: physical and mechanical restraint, seclusion and observation.

- **Positive Behavioural Support** (Or equivalent): A plan of care developed with the service user that documents how they deal with their frustrations, what strategies are effective at managing it and how staff should support them at points of crisis.
- **Prone Restraint**: Holding a person face down/on their front/ on any surface, including the floor.
- **Safety Pod** A specialist piece of equipment that reduces the need for floor restraint and allows a person to be managed in a seated intervention. The safety pod allows for the person to sit at a 135 degree angle and the pod provides ergonomic support and allows for greater chest expansion and lung function.

9: Audit and assurance consisting of:

- The Positive and Proactive care group will be responsible for reviewing effectiveness and will report to the Trust Integrated Clinical Risk Group will be responsible for reviewing effectiveness and will review and report to Trust CGC/Trust Board annually.

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements	Acting on Recommendations and Lead(S)	Change in Practice and Lessons to be shared
Number of incidents of violence and aggression	Medical Director	Incident Reporting	Monthly	Trust Board NHSE benchmarking UoF requirements	Policy Lead	Reducing Restrictive Practice Steering Group and QPES
Number of restraints and causation	Medical Director	Incident Reporting and deep dive	Quarterly	RRP Steering Group, Trust CGC & QPESC	Policy Lead	Reducing Restrictive Practice Steering Group and QPES
Number and type of seclusion episodes	Medical director	Incident reporting and deep dive	Monthly	RRP Steering Group, Trust CGC & QPESC	Policy Lead	Reducing Restrictive Practice Steering Group and QPES
Embedding of Safe Wards within all inpatient clinical areas	Medical Director	Positive and Safe Expert Reference Panel Audit tool devised by Len Bowers and adapted	Annually	RRP Steering Group, Trust CGC & QPESC	Policy Lead/	Reducing Restrictive Practice Steering Group and QPES
		for use within BSMHFT.				
Use of Safety Pods within clinical areas	Medical Director	Incident reporting (Eclipse) and deep dive into RiO records	Quarterly	Local CGC, RRP Steering Group, Trust CGC, QPESC	Policy Lead	Reducing Restrictive Practice Steering Group and QPES

10: Appendices

Appendix 1 Equality Analysis Screening Form
Appendix 2 AVERTS training matrix
Appendix 3 De-escalation Model (Bowers, 2014)
Appendix 4 Positive and Proactive Care Leaflet
Appendix 5 Restraint Information Leaflet
Appendix 6 Approaches to Physical Restraint Guidance
Appendix 7 PPE Procurement and Maintenance Sheet
Appendix 8 Safewards
Appendix 9 Withdrawing Services from Violent or Abusive Service Users
Appendix 10 Safety Pod use and maintenance
Appendix 11 Example Safety Pod SOP for clinical areas
Appendix 12 Guidance on the Negligible Use of Force and reporting/ recording requirements under the Use of Force Act (2018)

Appendix 1.Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	Prevention and Management of Violence Policy		
Person Completing this proposal	XXXX XXXX	**Role or title**	ANP AVERTS
Division	Corporate	**Service Area**	Learning & Development
Date Started	06/08/2020	**Date completed**	30/08/2020

Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.

This is a trust wide policy and will support staff and service users across in patient and community services.
The policy is commensurate with national guidance(NG10, Positive and Proactive care2015) and statute and complies with the MHA (1983) and the Use of Force Act (2018).
All clinical staff should follow the advice contained within the policy and the supporting documentation contained within the appendices in an attempt to manage and reduce the use of restrictive interventions and restraint within the organisation. All interventions need to be reasonable, proportionate and for the minimum time necessary which follows the legal and ethical parameters set out for the use of restrictive interventions and restraint.
The policy aims to ensure that staff work within a human rights framework and look to employ the least restrictive option when managing violence and aggression; staff should work collaboratively with service users (and family/ carers) are should be pro-active in their planning and implementation interventions. Service users should be involved in the planning of interventions and where this is not possible a documented reason should be made in the clinical documentation. Following incidents, staff should aim to learn lessons and work collaboratively with users of services to reduce the risk and prevent future incidents, all persons present should be involved in post incident support.
Birmingham and Solihull Mental Health NHS Foundation Trust is committed to providing a positive, therapeutic culture that focuses on the reduction of restrictive practices and if restrictions are requires they are legal, defensible, proportionate and absolutely necessary. The organisation acknowledges the research evidence that continues to show an over-representation of BAME communities who are subject to formal detention within care services and the evidence that suggests there is also an over use of restrictive physical interventions within this population.

Who will benefit from the proposal?

All service users and clinical staff

Impacts on different Personal Protected Characteristics – *Helpful Questions:*

Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment? Eliminate victimisation?*				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box or leave blank if you feel there is no particular impact.				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age				Staff will need to be aware of the communication needs of individuals at point of crisis and adjust their communication style accordingly. Staff will also need to adapt the AVERTS skills to the individual with whom they are working. Staff need to be aware of their actions should they remove a walking aid from an individual due to risk and how this can present as a restrictive intervention.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability				AVERTS Skills are adaptable to individuals with different physical health needs including frailty, disability, pregnancy, etc. Where staff are unsure or unclear they should contact their dedicated AVERTS consultant for further advice and support.
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender				Staff should ensure that they are practicing in a trauma informed way at all times and should ensure that all service users have a documented management plan for how they wish to be managed at point of crisis.

This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?

Marriage or Civil Partnerships				
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity				Suitable adjustments are in policy to allow for pregnant and post-partum staff. They are no longer negatively impacted by the training refresher requirements. There are specific skills and advice that the AVERTS team along with Camomile staff are able to provide to all areas who are working with pregnant women. Staff need to be aware of the impact of another person holding a baby if the individual is subject to restrictive physical interventions and need to be sensitive to the needs of the whole family.
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity				The Trust acknowledges the over representation of BAME, particularly black African and Caribbean individuals within mental health care services and the GI team will seek ways to monitor the protected characteristics. Local audits of the use of seclusion, searching and mechanical restraint will identify any over representation of restrictive practices.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief				
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				

Sexual Orientation				
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				

Transgender or Gender Reassignment				
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights				Staff are reminded about the Human Rights requirements when considering the use of restrictive physical interventions. Using the techniques in an ethical and legal manner should ensure that Human Rights are protected. All use of restrictive interventions should be based upon the Human Rights Framework.
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				

	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
How will any impact or planned actions be monitored and reviewed?
Seclusion, restraint, assault are all monitored through the use on monthly data generated by the GI team, the AVERTS consultants then complete a deep dive to get contextual narrative to support the data and give an account to Trust board and commissioners regarding practice within the organisation.
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

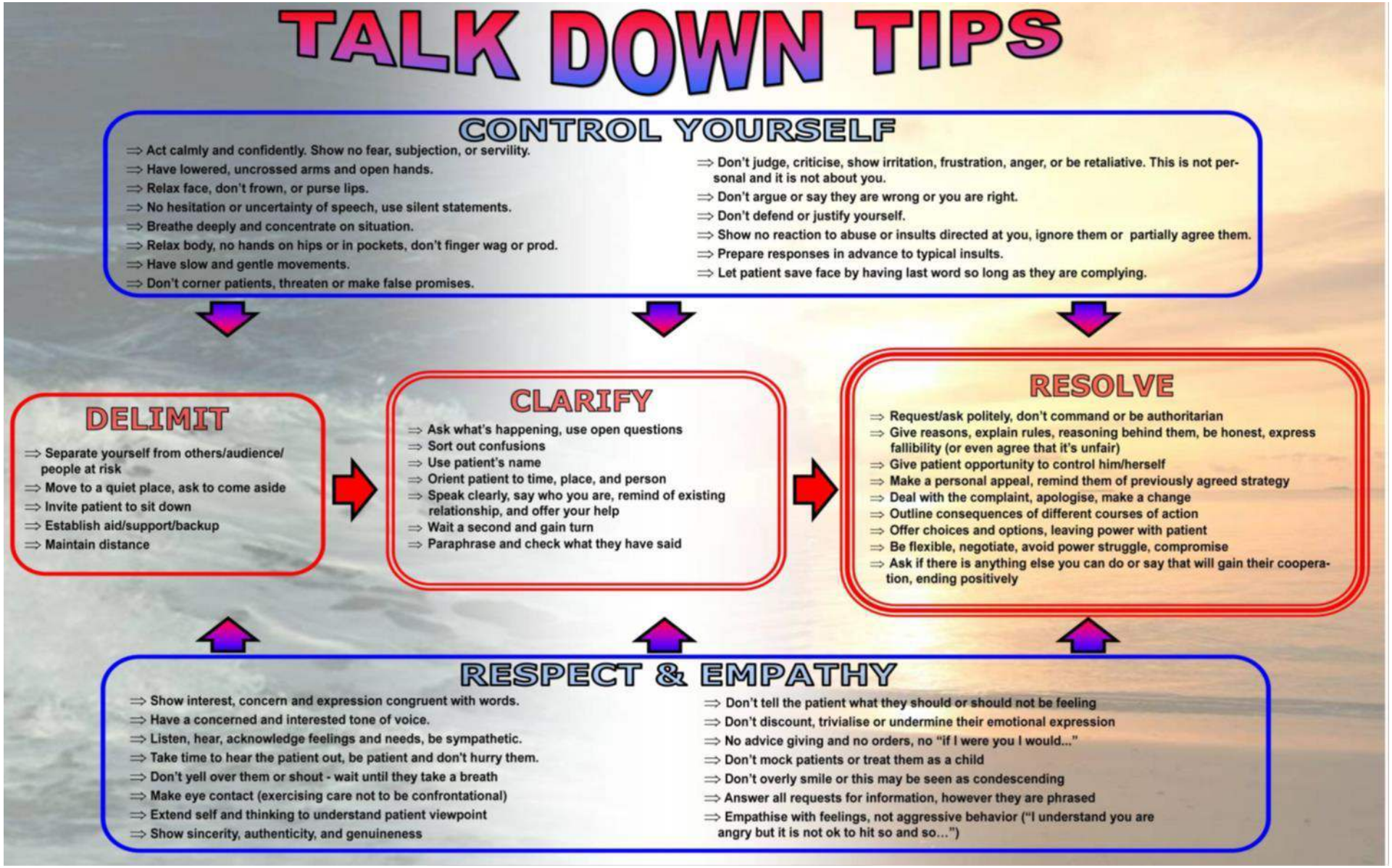
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** .

The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Appendix 2: Averts training matrix

CLINICAL AREA	PRIORITY LEVEL
All PICU's –EDEN, Caffra, Meadowcroft, Severn, Sycamore	Very High- where possible staff should receive training on the next available course when commencing within the trust.
Acute in-patient areas; Oleaster, Zinnia, Mary Seacole, Larimar House, Northcroft site	High – where possible training should be given as close to commencement within the trust as practicable
Ardenleigh Site; Coral, Citrine, Women's Blended, FCAMHS (Adriatic, Pacific, Atlantic)	High – where possible training should be given as close to commencement within the trust as practicable
Reaside and Tamarind Acute units; Avon, Blythe, Hibiscus, Myrtle, Laurel	High – where possible training should be given as close to commencement within the trust as practicable
Juniper Centre; Rosemary, Sage, Bergamot	High – where possible training should be given as close to commencement within the trust as practicable
Other Medium Secure SCCS units; Tourmaline, Kennet, Dove, Swift, Trent, Lobelia, Cedar, Acacia	Medium- if no spaces are immediately available, the staff should liaise with the AVERTS team who will hold an emergency waiting list and allocate places in order of priority. Staff should book onto the next available AVERTS 5 day course.
Stand alone acute/ complex care/ HDU units; Newbridge house, Ashcroft, Reservoir court, Dan Mooney House, Endeavour House, Endeavour Court	Medium- if no spaces are immediately available, the staff should liaise with the AVERTS team who will hold an emergency waiting list and allocate places in order of priority. Staff should book onto the next available AVERTS 5 day course.
SCCS Hillis Lodge Low secure	Low- a place will be allocated if available however staff will routinely be expected to book onto the next available AVERTS 5 day course. The AVERTS team will hold a waiting list and may be able to offer last minute cancellation places.
SCCS OT's, OTA's, Psychology assistants (Unless directly indicated to work on PICU.	Low- a place will be allocated if available however staff will routinely be expected to book onto the next available AVERTS 5 day course. The AVERTS team will hold a waiting list and may be able to offer last minute cancellation places.
Specialities based at Barberry; Cilantro, Jasmine and Chamomile	Low- a place will be allocated if available however staff will routinely be expected to book onto the next available AVERTS 5 day course. The AVERTS team will hold a waiting list and may be able to offer last minute cancellation places.
NAIPS; Rookery Gardens, Heartford House, Grove Avenue, David Bromley House, Forward house	Low- a place will be allocated if available however staff will routinely be expected to book onto the next available AVERTS 5 day course. The AVERTS team will hold a waiting list and may be able to offer last minute cancellation places.

APPENDIX 3: Safewards Talk-Down model.



Positive and Proactive Care: Service User and Carer Information Sheet

The Department of Health is in charge of health and social care in England. They want to make sure abuse **never** happens and that services must support people whose **behaviour is very difficult** and who might want to do things like:

- Hurt themselves.
- Hurt other people.
- Put themselves in harm's way.
- Smoke in hospital.
- Do something that can't be done safely without assistance.
- Run away.

What do we mean by restrictive interventions?

Staff might try and:

- Stop you doing something harmful or dangerous.

- Do something to make you better while you are not well enough to be able to make the choice.

This is called **Restrictive Intervention** (in this paper we use **RI** for short). Staff must only do this if there is no other way to keep people safe and they must:

- Understand other ways of supporting people when their behaviour is very difficult, and
- Only use RI when other things have not worked.

The advice will help staff care for people whose behaviour can be very difficult because of their:

- Mental health.

• Autism.
• Learning disability.
• Injury or brain disease.

Mental Health Act and Mental Capacity Act

Mental Health Act

The Mental health Act is a law that allows doctors and nurses to keep you in hospital in order to assess your mental health and, if needed, to treat it. If you are in hospital under the Mental Health Act you will legally be referred to as a 'detained' or 'formal' patient. If this is the case staff may have to use RI if:

- You try to leave hospital without agreement with the doctors and nurses
- Behave in a way that might hurt yourself or people around you

As a detained patient you should have access to full information about what this means for you and how to appeal against the decision to keep you in hospital. You should also have access to an independent advocate to discuss your experiences of being in hospital.

Any RI used by staff must be reasonable and justified. Yours thoughts and feeling about the use of RI should be given to staff and/or your advocate so lessons can be learned to see to prevent its use being needed again.

Mental Capacity Act

Mental capacity means being able to make your own decisions and this law is to help you do that. Staff must tell you about your care in ways you can understand and ask you if you agree with it.

You may be able to make some decisions but not others and the Act tells people what to do if you can't make some decisions for yourself.

Staff must support you to make your own decisions but if they have to decide for you, staff must think if this is what you would want. They must make sure you keep as many of your rights and freedom as possible. Staff need to understand why someone might hurt other people or themselves, and this might be because:

• Some people can't say what they need – this can make them upset or angry.

• Some people do not understand that what they are doing is harmful or dangerous.

• Some people are frightened and defensive in hospital.

What are Restrictive Interventions?

There are 4 main types of RI:

1. **Physical:** When you stop the person moving part of their body by holding them so they cannot hurt themselves or other people. Staff must keep talking to the person to calm them and check that they are safe.

   Or staff encourage someone to stop doing something they want to do e.g. getting up without assistance.

2. **Mechanical:** When you use something to stop the person using part of their body, for example: handcuff, soft cuffs or the Emergency Response Belt which is used to move people to a safer place. Staff should only do this when nothing else can stop the person hurting themselves or other people. It is very rare that these items are used unless behaviour is likely to seriously hurt you or those around you.

3. **Chemical:** When you make someone take medicine to calm down. Staff should only do this in a real emergency or when the doctor/nurse thinks it may help you get better and they must use as little medicine as they can and review it regularly.

4. Seclusion: When you keep someone away from other people, this could be in a locked room. It is usually so they cannot hurt themselves. Staff can only do this if the law allows it.

5. **The most important things to do and to know**

Making sure **RI** happens less. **RI** should happen less because:

• It can hurt people.
• Sometimes it does not need to happen.
• It stops people from doing what they want.

Staff should:

• Only use **RI** when nothing else will work.
• Think about **human rights** and the things every person has the right to expect.
• Understand laws about treating people equally and fairly.
• Support people to be safe without taking away all of their choices.
• Understand the way people behave and help keep them safe and help them do things that are important to them.
• Involve people and their family or carers whenever they can

Make care better – your behaviour support plan (or similar)

People who might need **RI** must have a **Behaviour Support Plan (or similar).** It should be about how to help them:

• Not get angry and upset so often.
• Calm down if they get angry or upset.
• See if anything could have been done better.
• Stop it happening again.
This information will be in your Behaviour Support Plan. It will help staff use **RI** less often.

Your plan must also:

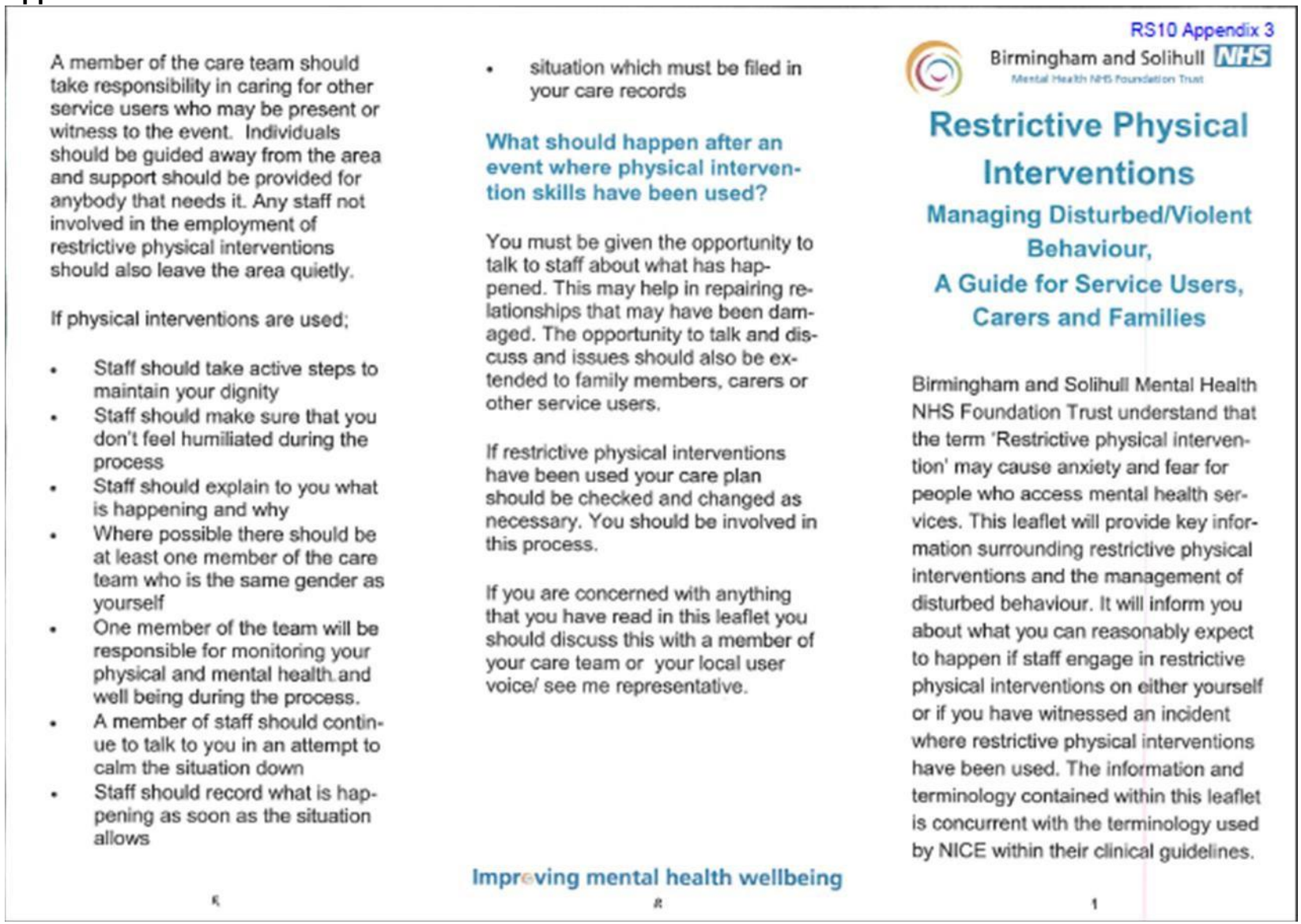
• Make sure you understand what the Mental Health Act & Mental Capacity Act says.
• Say what makes you angry or upset.
• Tell others how to help you not to get angry or upset so often and how to help you calm down.
• Be shared with your relatives and carers so they know how to help.
• Write down your conversations with staff after an incident so that you and staff can learn why it happened and how to stop it happening again.

If there is anything in this information sheet that you do not understand, you must ask a member of staff who will explain it to you or your relative/carer in detail.

Adapted from:

Rotherham & Doncaster & South Humber NHS Foundation Trust (2015) *Positive and Proactive Care (Easy Read): Reducing the need for Restrictive Interventions and what it means for you. RDaSH: 2015.*

Appendix 5



A member of the care team should take responsibility in caring for other service users who may be present or witness to the event. Individuals should be guided away from the area and support should be provided for anybody that needs it. Any staff not involved in the employment of restrictive physical interventions should also leave the area quietly.

If physical interventions are used;

- Staff should take active steps to maintain your dignity
- Staff should make sure that you don't feel humiliated during the process
- Staff should explain to you what is happening and why
- Where possible there should be at least one member of the care team who is the same gender as yourself
- One member of the team will be responsible for monitoring your physical and mental health and well being during the process.
- A member of staff should continue to talk to you in an attempt to calm the situation down
- Staff should record what is happening as soon as the situation allows

- situation which must be filed in your care records

What should happen after an event where physical intervention skills have been used?

You must be given the opportunity to talk to staff about what has happened. This may help in repairing relationships that may have been damaged. The opportunity to talk and discuss and issues should also be extended to family members, carers or other service users.

If restrictive physical interventions have been used your care plan should be checked and changed as necessary. You should be involved in this process.

If you are concerned with anything that you have read in this leaflet you should discuss this with a member of your care team or your local user voice/ see me representative.

Improving mental health wellbeing

RS10 Appendix 3

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Restrictive Physical Interventions

Managing Disturbed/Violent Behaviour,
A Guide for Service Users, Carers and Families

Birmingham and Solihull Mental Health NHS Foundation Trust understand that the term 'Restrictive physical intervention' may cause anxiety and fear for people who access mental health services. This leaflet will provide key information surrounding restrictive physical interventions and the management of disturbed behaviour. It will inform you about what you can reasonably expect to happen if staff engage in restrictive physical interventions on either yourself or if you have witnessed an incident where restrictive physical interventions have been used. The information and terminology contained within this leaflet is concurrent with the terminology used by NICE within their clinical guidelines.

What are Restrictive Physical Interventions?

A restrictive physical Intervention is a way of holding someone so that they are unable to move easily. The techniques are designed to be used as a last resort and restrictive physical intervention techniques should not be used unless it is absolutely necessary.

Restrictive Physical interventions will involve staff holding onto you for a short period of time so that you cannot hurt yourself or others around you. Before using restrictive physical interventions, staff should have tried alternative ways of managing the situation. If staff do use restrictive physical interventions they should also continue to try to calm the situation by talking to you. Staffs aim is to keep you safe.

When might Restrictive Physical Interventions be used?

There are a number of situations when staff may need to use restrictive physical interventions. It is important to remember that staff should only use restrictive physical interventions when all other ways of managing the situation have failed. Some examples of when restrictive physical interventions may be used include;

- If you become violent or aggressive towards other people. (This may include staff, other service users or visitors to the unit).
- If you attempt to hurt yourself or are at risk of accidentally injuring yourself.
- If you try to leave the unit but do not have the necessary leave.
- If you show dangerous or harmful behaviour towards property.

Staff training

The training that staff receive within BSMHFT is AVERTS. AVERTS stands for Approaches to Violence through Effective Recognition and Training for Staff. The name AVERTS was chosen by service users following consultation. The training is owned and developed by BSMHFT which allows for training to adapt to meet the current needs of the service and it's service users.

All staff that employ restrictive physical interventions have received training from the trust and none of the techniques taught are designed to deliberately cause pain. The trust provides a yearly update that staff must attend to make sure that their knowledge stays up to date.

As well as training staff in the safe application of restrictive physical interventions, the training focuses on alternative ways of managing situations which include Safe Wards philosophies. BSMHFT have identified that all units are to adopt Safe Wards. Please talk to staff and see the Safe Wards leaflet for more information.

What should happen if restrictive-physical interventions are used?

If staff are required to use restrictive physical interventions, they should think about your needs as well as managing safety.

If you have an advanced statement that covers how you would prefer to be managed this should be taken into consideration wherever possible. If following the statement would place yourself or others at even greater risk then staff may need to take a different approach. If staff take a different approach then they should record what they are doing and why they are doing it.

When deciding what should be done, staff will also need to take into consideration the effect of the situation upon other service users, staff and visitors and how to manage their safety as well as your own.

Appendix 6

Approaches to Physical Intervention and Restraint Guidance

Introduction

This guidance is intended to provide members of Trust staff (whether permanent or transient) with supplementary information in the Prevention and Management of Violence.

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) adopts the policy that all members of staff regardless of band or discipline are responsible for the safety of service users and each other. Duty of care in the context of this guidance extends beyond that of service users to include; all colleagues, students, voluntary sector workers and any other member of the public.

On this basis it is the duty of every member of staff to offer some assistance where necessary.

It is generally considered to be unsafe for anybody to try to restrain another person on his or her own. If individual staff members are faced with a difficult situation they should seek an escape route and summon assistance verbally or by an alarm system.

Should communication or language barriers prevail, every effort should be made to address these issues in the first instance. Staff should make every effort to deescalate the situation and use non-physical strategies. Physical intervention techniques should be used as a last resort.

Implementing Physical Intervention

It is not possible or desirable to outline specific physical intervention skills within this guidance. This information will be provided to all staff who attend the required level of training as determined by the trusts fundamental training matrix.

Wherever possible it is expected that staff members who have received AVERTS training should assume a lead role in the management of situations that require physical intervention.

Where staff who are considered ‘untrained’ in AVERTS are managing an incident in a safe and professional manner, it may not be desirable or prudent for staff considered ‘trained’ to take over unless requested to do so.

Wherever possible the planned use of physical interventions should only be undertaken by appropriately trained staff however, in extreme or emergency situations there is an expectation that all staff will assist and take their lead from the person co-ordinating the event.
When using physical intervention skills, consideration should be given to the following best practice points;

- Wherever possible the prone (face down) position should be avoided. It should not be considered as a planned event. Cogent reasons for doing so should be clearly documented.
- Staff should only employ physical intervention skills that have been endorsed by BSMHFT through the AVERTS training programme.
- Under no account should members of staff engage in any activity that is likely to force the intervention to the floor.
- Any physical intervention must be reasonable, proportionate and justifiable in the circumstances and constitute the least restrictive option available. The minimum amount of force should be used for the minimum amount of time that is necessary.
- There is no such thing as a 'safe' position with regard to physical intervention.
- Fewer well briefed staff are likely to be more effective than large numbers of staff working in an unorganised fashion. Nominated staff should be allocated roles and responsibilities. A minimum of three staff are required to initiate physical interventions.
- Ensure that one member of staff (the third person) is responsible for supporting the service users head and neck where required ensuring that the airway and breathing are not compromised and that vital signs are monitored using NEWS 2.
- The third person must be present throughout the intervention and must be included in any documentation relating to the incident.
- Staff should attempt to manage the service user's arms and have a third person present in a safe and swift manner. If legs are to be managed (only if the person is prone/supine), they are to be held together at all times by a fourth member of staff. Only one member of staff should be present on the legs with additional staff adopting a supportive role if required.
- Intervening staff ***must*** avoid any form of neck hold, or application of weight on the chest, abdomen, back or pelvic area.
- The deliberate application of pain has no therapeutic value and could ***only*** be justified for the immediate rescue of staff, service users and/or others if deemed appropriate under the legal tenet of *reasonable force*.
- When staff are attempting to leave a situation that has required physical intervention this should be done in a co-ordinated and timely manner in accordance with the advice provided to staff during AVERTS training programmes.

Broader Considerations

The Mental Health Units (Use of Force) Bill 2018 makes provision about the oversight and management of the appropriate use of force inrelation to people in mental health units. It sets statutory obligations upon Trusts and its employees with regard to the use of and accurate recording of restrictive physical intervetions. It makes clear that restrictive interventions should only be used if de-escalation and other preventative strategies have failed and there is the potential for harm to occur if no action is taken. Staff should continue to attempt de-escalation throughout any restrictive intervention (NICE 2015).

NHS England (2015) identify the importance of physical observations during and after restrictive interventions and physical intervention. This is supported by NICE guideline 10 (2015)

Staff should be alert to the risk of any respiratory or cardiac distress. **All staff** (including transient staff), should be aware of where the emergency resuscitation equipment, the personal protective equipment and the ligature cutters are kept on the units in which they work. This should happen as part of the local induction procedure. This equipment should be **readily accessible** by all staff members.

When physical interventions are used staff should;

- Document in RiO a clear rational and justification for their implementation, recording the decision and reasons for physical intervention along with a detailed account of the incident.
- An Eclipse entry **must** be made to include; the names of the staff members involved, the positions they adopted, any staff that 'took-over' and the duration and position of the restraint.
- As a minimum, staff members who are holding the arms and the third person **must** be documented (even if the third person isn't holding on).
- Post-incident, service users should be given the opportunity to document their version of events which can then inform future interventions (NICE 2015).
- Care plans should reflect both the needs and wishes of the service user in respect of theanticipation, prevention and management of violence and aggression. Every effort should be made to ensure service users should receive and sign a copy of the agreed plan of care.
- The service users care plan should be reviewed and risk assessment updated following any incident of violence or aggression. Wherever possible this should be done in full consultation with the service user.
- Any member of staff who has been injured/ harmed either physically or emotionally during the process of intervention should not be involved in any immediate decisions concerning to on-going care of the person being held.

Appendix 7

PPE - Item Description, Procurement and Maintenance

PPE – Item Description, Procurement and Maintanance

Disposable Vinyl Gloves:
These will offer the wearer's hands some protection to the risks of cross-infection from escaped body fluids. All staff should ensure that these are worn at the earliest opportunity when dealing with body fluids. These gloves do not offer adequate protection to the hands from grazes, lacerations, and needle stick or stab wounds. Hands must be cleaned with soap and water or alcohol gel immediately after the removal of gloves.

Full Face Visors:
Full face visors are to be used to protect the membranes of the, eyes, nose, and mouth from exposure to body fluids. The visors may be utilised to manage instances of spitting behaviour. Pro-active use should be limited to occasions where there is a known risk of infection from a contagious disease, the individual in question has a history of spitting whilst in restraint or is actively threatening to spit at staff prior to a physical intervention. In a reactive type situation where spitting occurs prior to the use of visors, visors should be made available to staff as soon as possible. It is not envisaged that the wearing of visors will be utilised prior to all physical interventions but **only** where the above circumstances are apparent. The visors will be used once only and then should be discarded. Once the incident has ended then all used visors should be disposed of via a clinical waste bag as per policy.
These visors can be ordered from the NHS Supply chain catalogue

Coverall Suits:
It may at times be appropriate, where fecal smearing or "dirty protests" have occurred, for staff to utilise protective cover-all suits to offer protection to their everyday clothes whilst managing/cleaning during such circumstances. The wearing of such equipment should be based on a risk assessment with regard to the perceived degree of possible contamination or cross infection. This item is for single use only and should be disposed of in the clinical waste bags. They can be purchased by individual wards/units and stored in an area which is known by all members of staff in the team.

These items can be obtained from the NHS Logistics catalogue Cut Resistant Gloves:
Cut resistant gloves are intended to assist staff to work more safely in dealing with a situation where a sharp edged type object is/may be present in an incident of selfharm. They will offer the wearer some protection from such objects but ***will not*** protect the wearer from needle stick or stab wounds from sharp pointed implements. Their protective ability would also be limited if subjected to repeated slashing or sawing actions using a sharp or serrated edged object. The cut resistant gloves do not provide protection from fluids as they are porous and a pair of vinyl should be worn underneath.

Cut resistant gloves should not replace the use of rapport, persuasion, or appropriate negotiation as a means of removing a sharp object from a person. Rather they are seen as a method of protecting all persons involved when all other strategies have been tried and failed, or when it is necessary to remove a sharp object quickly in the overall interests of health and safety for all involved in the management of aggressive/violent behaviours.
Replacement Cut resistant gloves (X5 Glove) can be ordered from Ultimate Industrial Ltd, www.ultimateindustrial.co.uk

NB. These gloves should not be used to manage an incident where a person is threatening to harm others with a sharp object or to attempt to disarm an individual that is brandishing any form of weapon.

Reporting
All staff must appropriately report instances when infection control has been an issue the management of violence and aggression via the trust electronic reporting system. (e.g.ECLIPSE).

Where there is a failure to apply these guidelines such instances should be reported to the ward manager for review and escalated through the line management structure.

Where there is an identified risk history relating to infection control issues during periods of violence and aggression these should inform action plans to manage such behaviors in the future. Where possible, service users should be involved in the development of such actions plans. See: **Care Management & CPA Policy.**

Training support / contacts and advice

Training in the use of protective equipment is delivered on the AVERTS five day program and refreshed annually via the dedicated update. Compliance with training is identified via the Risk Management Fundamental Training Policy.
For advice and information on any part this this guidance can be sought from:
AVERTS Trainers on: 0121 301 2886
AVERTS consultants on: 0121 301 3977/3979
AVERTS Advanced Nurse Practitioner on: 0121 301 3978
Booking training is administered through LD.Bookings@bsmhft.nhs.uk

Process for review / feedback
This guidance will be reviewed every two years by the Positive and Proactive Care Expert Panel and the Infection Prevention and Control Team.

References
- **Prevention and Management of Violence Policy.**
- **Guidance on the Use of Physical Interventions & Restraint.**
- **Infection Prevention and Control Overarching Policy**
- **Standard Infection Control Precautions**
- **Decontamination Policy**
- **Sharps Safety & Prevention Management of Occupational Exposure to Blood-borne Viruses**
- **Care Management & CPA Policy**

6. Mutual help Meeting

All wards are social communities and the help that service users can give to one another is highly valued.

A voluntary meeting of all service users and staff on duty should be held preferably daily but as a minimum 3 times per week and should have 4 standing agenda items;

- A round of thanks for anything that has been done since the last meeting
- A round of news - anything that has happened or changed or is going to happen.
- A round of suggestions
- A round of requests and offers (for help and assistance)

7. Know Each Other

Forming a therapeutic relationship is the foundation of good care. If staff provide non-controversial information about themselves can help facilitate conversations and relationship building.

This module can be done in reverse with service users also compiling a fact sheet about themselves describing likes and interests which can be given back to the person on discharge or destroyed if that is what the service user wishes.

8. Calm Down Methods

Staff can often identify if a service user is becoming unsettled or distressed. This module encourages individuals to develop and adopt their own coping strategies. Staff will put together a box of equipment that service users can access. Individuals can then identify strategies that may help during times of increased anxiety or distress.

9. Reassurance

Service users can react with fear or anger if there has been an event on the unit such as violence, absconsion, a disturbed service user or arguments. Following an anxiety provoking event every service user should be spoken to individually or in small groups and staff should make increased efforts to be more visible in the clinical areas to offer explanation and support to all service users.

10. Discharge Messages

On the day of discharge, service users are asked to write a message for a display. The message should say what the service user liked about the unit along with some positive and helpful advice for new admissions. This can help reassure new service users and increase feelings of hope.

Ideally service users will put their first name on the message so people can see who they are off. The messages can be displayed in a variety of ways such as on a 'discharge tree' or a notice board.

Further information

Safewards has its own dedicated website which contains further information regarding the Safewards initiative, the model, module guides and other helpful hints and tips.

Here is the website address;

http://www.safewards.net/

Improving mental health wellbeing

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Safewards

A Guide for Service Users, Carers and Families.

Safewards is a national initiative designed to help reduce the levels of conflict and containment within in-patient mental health units.

The Safewards model has 10 simple modules that have been clinically proven to reduce the number of aggressive incidents.

BSMHFT have committed to implement Safewards across its in-patient facilities as part of the reducing restrictive practices agenda.

Next Page

What is Safewards?

Keeping safe is a goal of any community.

The Safewards model is a set of interventions that have shown to contribute to a reduction in incidents on mental health in-patient units.

The model has been developed by Professor Len Bowers following years of extensive research and has demonstrated significant effectiveness in reducing incidents and a reduction in the use of restrictive physical interventions, seclusion and rapid tranquillisation in the UK.

BSMHFT have committed to implement the Safewards model throughout its in-patient facilities as part of the reducing restrictive practices agenda.

Why can units be unsafe?

In-patient units are busy places and are different in their size and layout, where they are located and the resources that they have. Within Safewards, behaviours that service users may exhibit that pose a risk to themselves or others around are referred to as areas of 'conflict'. These behaviours may include; aggression, rule breaking, substance or alcohol use, absconsion, self harm or suicide.

The actions that staff may take to manage 'conflict' are referred to as 'containment' strategies and may involve things such as; an increase in observation levels, PRN medication, Restrictive physical intervention (restraint) or seclusion.

Module Guide

There are ten straight forward interventions identified within the Safewards model .

Units are encouraged to implement the modules in a way that meets the needs of the individuals who are using the service and so you may see units giving modules different names to those identified in this leaflet.

Below is a brief introduction to the ten modules and their official Safewards titles;

1. Clear Mutual expectations

Sometimes, difficult and challenging behaviours are expressed because there is a lack of clarity regarding how individuals (both staff and service users) are expected to behave .

A set of mutually agreed standards will allow for consistency and clarify relationships. These can be reviewed on a regular basis. See Me workers can help work with staff and service users to identify mutual standards of behaviour that should be displayed for all to see.

2. Soft Words

If a service user is acutely unwell they may present staff with challenges regarding care and management. Staff have a responsibility to ensure that care needs are met and that people are kept safe.

This can sometimes result in flash points around limit setting. The soft words module provides ways for staff to avoid potential confrontation and aims to ensure that staff work collaboratively with service users to reduce the potential for hostility or violence.

3. Talk Down

Is a model of de-escalation and is a 3 stage process.

1. **De-Limit** establishing safety and getting started
2. **Clarify** hearing what the person has to say
3. **Resolve** addressing the issue seeking resolution

Whilst implementing 'Talk Down' Staff need to me mindful of their own behaviours and how they can impact upon the situation whilst displaying respect and empathy at all times.

4. Positive Words

At the start of the shift, staff are expected to attend 'hand-over'. In the report of what has happened over the shift, staff can often focus on the exceptional behaviour which may have been difficult to manage or which poses a risk.

In order to redress the balance, during handover, staff should say something positive about what each service user has been doing or draw attention to a positive quality that they have.

5. Bad News Mitigation

Research has shown that service users can impulsively leave services in anger following unwelcome news. Staff should be aware of occasions and events that may generate feelings of anger and decide as a team how support is going to be offered.

Staff should monitor for small signs of distress and offer time in a quiet place to discuss issues and allow individuals time to express their feelings and frustrations. This could be done along with a friendly gesture such as offering a cup of tea or a snack.

Appendix 9

WITHDRAWING SERVICES FROM VIOLENT OR ABUSIVE SERVICE USERS GUIDANCE

Introduction

The Trust has a statutory obligation under the Health and Safety at Work etc. Act 1974 to provide a safe and secure environment for its staff and others, as well as having a moral duty to take all reasonable steps to protect and support its staff of all disciplines and other service users.

This guidance is designed as a step in improving our ability to tackle incidents involving violence and abuse. The aim of this guidance is to detail the behaviours, which are unacceptable and the sanctions that are available to tackle the problem, including a mechanism whereby service users, who are extreme or persistent in their unacceptable behaviour, can as a last resort be temporarily or permanently excluded from services provided by the Trust.

The guidance also details the action to be taken in the event of unacceptable behaviours on the part of visitors/relatives/carers.

Reporting incidents of abuse, harassment and violence

All incidents of abuse, harassment and violence must be reported using the Eclipse reporting system, in accordance with the Trust policies concerned with the reporting and management of untoward and serious untoward incidents.

Incidents of serious abuse, including racial and sexual harassment and where actual harm to individuals occurs should be reported to the police where it is felt appropriate. All serious cases should be brought to the attention of the Executive Team, Associate Director of Governance and Associate Director of Operations.

Clinical application

This guidance applies across all Trust Directorates although it is recognised that the decision to withhold services is extremely complex and may vary in different clinical settings.

In each instance the patient's clinical risk assessment will be considered by the Clinical Team responsible for managing the care of the patient and a decision made regarding whether treatment can continue to be provided in a different way, in a different setting, whether an alternative placement should be sought, or if temporary withdrawal of services is the most appropriate course of action.

When withdrawing services may be required

We recognise that withdrawing services will only be appropriate when the risk or existence of significant threats, abusive or violent behaviour is likely to:

a. Prejudice any benefit that the service user might receive from care or treatment;

b. Prejudice the safety of those involved in the giving care or treatment;

c. Lead the member of staff offering the care to believe that he/she is no longer able to undertake his/her duties properly. (This may include incidents of racial or sexual abuse/harassment);

d. Result in significant damage to trust and personal property by the service user or as a result of containing him/her;

e. Prejudice the safety of other service users present at the time.

Exceptions

The following exceptions will apply:

1. Service users who, in the expert judgement of a relevant clinician, are not competent to take responsibility for their action as they become aggressive as a result of an illness or as a consequence of an injury. Whilst these service users are excluded from the policy in general it may still be appropriate to consider alternative placements, if this is considered to be beneficial to the service user and/or members of staff.

2. Service users who, in the expert judgement of a relevant clinician require emergency treatment. In the event a patient requires admission for emergency treatment, wherever possible, the patient should not be readmitted to the same ward where incidents of violence or abuse have occurred previously to staff which do not relate solely to the persons mental state.

3. Service users who are detained either under the Mental Health Act 1983, including those on Community Treatment Orders. Or, those detained through a deprivation of Liberty.

4. Where service users have dual diagnosis e.g. Learning disability and personality disorder the views of two or more clinicians should be sought.

Unacceptable behaviour

The following, are examples of behaviour which are not acceptable on Trust premises or when providing care in other settings including service users' homes.

This is not an exhaustive list but provides some guidance:

- Threatening and abusive language involving excessive swearing and offensive remarks;
- Derogatory, racial or sexual remarks;
- Racial harassment or abuse to staff or other service users;
- Malicious allegations relating to members of staff, other patients or visitors;
- Offensive sexual gestures or behaviours;
- Abusing alcohol and drugs on Trust premises;
- Illegal behaviour such as drug dealing or theft on Trust premises;
- Wilful damage to Trust or personal property, likely to present risk to others or involve significant financial outlay to rectify;
- Threats or threatening behaviour;
- Violence towards a member of staff, fellow service user or visitor.

Visitors/relatives/carers

Visitors/relatives/carers who display any of the above unacceptable behaviours/actions will be asked to stop and be offered the opportunity to explain their actions. The relevant team leader or local manager would normally undertake this in the first instance.

Action would also be taken against any visitor/relative/carer impeding the service users' recovery, for example people who have abused clients in the past, or are at risk of abusing the patient.

Continued failure to comply with the required standard of behaviour will result in a senior manager/nurse being contacted and where authorised by them, arrangements made for the removal of the offending individual from Trust premises. The excluded individual may request an immediate review of the exclusion by the site manager and should be informed of this.

Any visitor/relative/carer behaving in an unlawful manner will be reported to the police and the Trust will seek the application of the maximum penalties available in law. The Trust will actively support the prosecution of perpetrators of crime on or against service users, staff, Trust property or assets.

The relevant Associate Director / Clinical Director may decide to continue to exclude any individual removed from the premises or restrict their visiting only to specific times and if necessary under escort.

If a visitor/relative/carer is permanently excluded from Trust premises the Trust Legal Advisor, Trust Complaints Department and Trust PALS Officer should be informed.

Key Principles in relation to behaviour of a service user

1. Each case will be looked at individually to ensure that the need to protect staff is properly balanced against the need to provide healthcare to individuals.

2. Sanctions which will apply to violent and abusive service users include:

a. A verbal explanation by a member of staff of what is unacceptable behaviour and the possible consequences of further repetition. Staff will work with the patient to embed acceptable behaviours into any management plan developed to manage such behaviours thereafter?
b. A formal written warning with details of Trust procedures on withdrawing of services and a written contract between the Trust and service user is agreed and signed by both parties.
c. If a patient complies with the terms of the contract, he/she can expect that their clinical care will continue to be provided according to the details of the contract.
d. As a last resort, a final written explanation, exclusion from the premises and the withdrawing of services sent by the Chief Executive notifying the service user of the period of the ban, copied to the patient's GP and/or provider of local mental health services.
e. As noted above every case should be reviewed individually and the third level of action only applied in extreme circumstances, and after approval of the action by the Medical Director and Chief Executive.

3. Under exceptional circumstances, and because of the threat of serious and imminent danger or the serious nature of an actual incident, the immediate withdrawing of services may be decided by the clinician concerned, provided that they report their actions immediately to the Clinical Director, and that a more thorough assessment is made by the clinical team as soon as possible.

4. Any decision to withhold services must be based on a robust clinical assessment. Unless the decision to withhold services is made in an emergency situation, all decisions to withhold services must be sanctioned by the Associate or Clinical Director who is clinically accountable for the case..

5. The decision to withhold services will always be a last resort and strategies for preventing and managing violent and abusive behaviour must be in place and implemented.

6. Consideration must be given to the wider impact of restricting a service users access to services, which may increase the risk to society in general. Alternative options such as telephone assistance, written or e-mail contact, and the referral to / use of neighbouring Trust services should be explored.

7. All reasonable steps should b etaken to engage the family or carers, before a decision to exclude is made. Mechanisms for service users, their carers and/or advocates seeking a review of a decision to withhold services will occur via the local Patient Complaints procedure.

8 Services will not be withheld from a patient or service user as a result of the behaviour of the person accompanying or visiting them.

Action to take if an agreement is made to withhold services

1. The decision should be recorded in the service users' relevant case notes and on the patient administration computer system, and the service user must be informed.

2. Written notification should be sent to the service user confirming the withdrawing of services, the details of the suspension of services and an outline of procedures available for appeal, complaints, and/or opportunities for further discussion/review with the consultant psychiatrist clinically accountable for the case.

3. The service user should be given advice on how to contact independent advocacy agencies such as ICAS.

4. PALS may assist and provide direction in these cases but would not be able to represent the appellant.

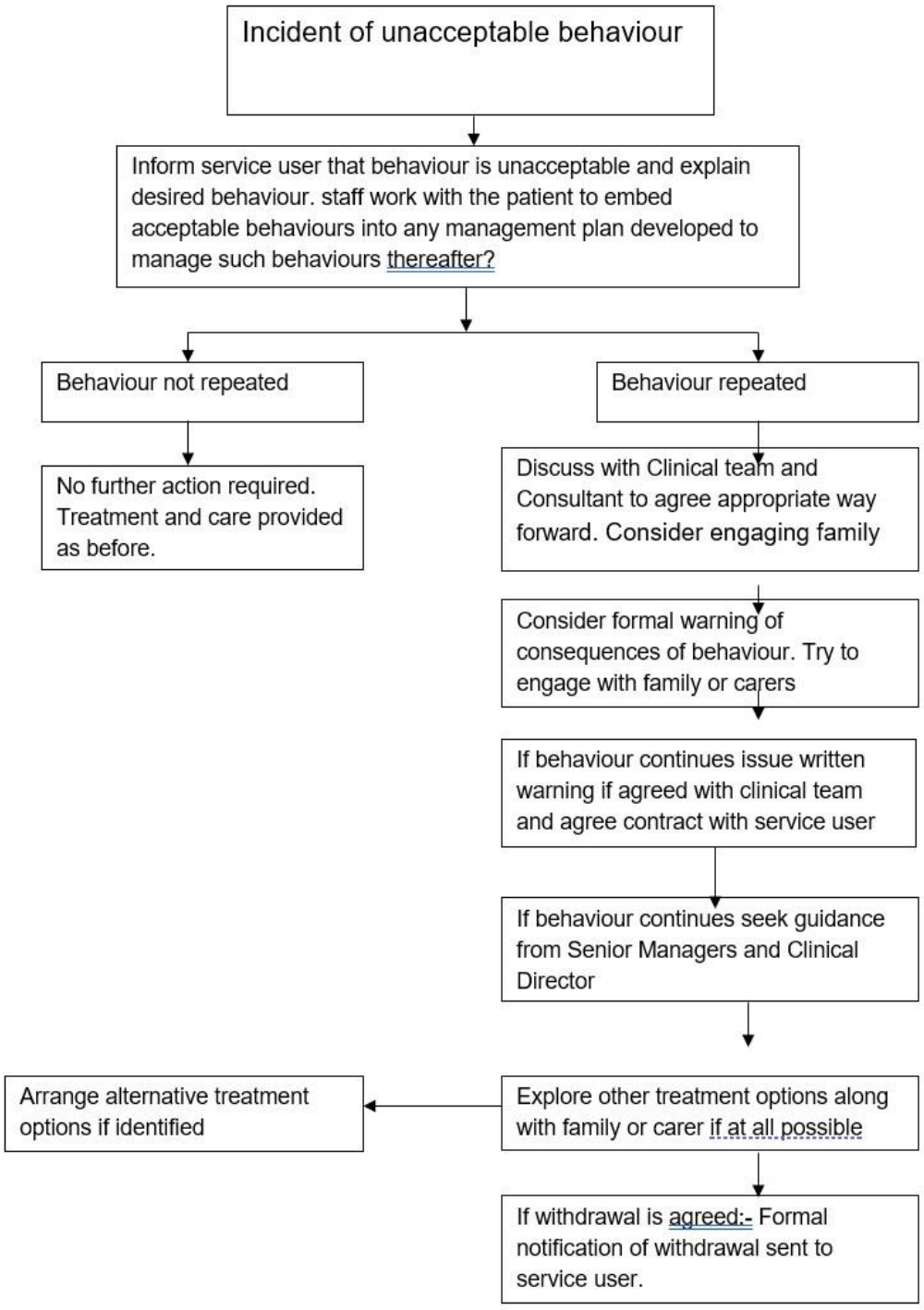
5. The appeal procedure needs to ensure that a written report of the alleged misconduct is available so that potential advocates are well informed before they undertake to represent those appealing against proposed or actual exclusion.

6. A senior manager from the relevant department should confirm that all procedures have been complied with.

7. Where appropriate, other local service providers and agencies should be informed of the decision to withhold services from the service user. This must include the referring agency.

8. The clinical team responsible for the service users care must review the withdrawing of services decision at an interval no longer than 6 months from when the decision was made. The Service Director is responsible for ensuring this happens.

FLOWCHART OF PROCEDURAL STEPS TO BE TAKEN IN RELATION TO SERVICE USER BEHAVIOUR



Appendix 10

Safety Pod use and maintenance

1. Safety Pods are a viable alternative to reduce the incidence of restraint and seclusion. Their use can be primary and secondary prevention or as a tertiary intervention. Primary and secondary prevention would be when the person chooses to use them independently or following a suggestion by a member of the clinical team as a method to aid de-escalation.
2. If staff are required to use restrictive physical intervention as a proportionate response to an immediate risk, a safety pod may be considered as a preferred option to floor intervention. Safety pods can also assist in communication and deescalation during restrictive physical interventions.
3. Areas wishing to utilise the safety pod should develop their own locally agreed protocols and procedures that should go through local governance procedures. Discussions and decisions can be recorded in a service specific SOP and example of which can be found in **Appendix** 11.
4. Any staff wishing to use the safety pod must have received appropriate information and instruction from the AVERTS team. Staff should maintain their training status as per section 3.4.46-3.4.60 of the prevention and management of violence policy.
5. Only skills taught and assessed in AVERTS training should be employed whilst utilising the safety pod to assist in restrictive physical interventions.
6. If using the pod alongside restrictive physical interventions, the lowest form of holds should be utilised. The leg cushion should only be utilised if the legs are posing a risk to the person being held or the staff involved in the intervention.
7. If the decision is made to utilise the safety pod whilst engaging in restrictive physical interventions, wherever possible, the safety pod should be taken to the person rather than attempting to move the person to the pod.
8. All units that have a safety pod should show it to individuals and their carers as part of the admission process.
9. Consideration should be given as to where the pod is situated when not in use. This will be determined by the unit layout and available space. Some units may choose to have more than one safety pod available depending upon level of need and accessibility.
10. Any use of the safety pod alongside restrictive physical interventions should be documented on the subsequent Eclipse form. If the pod has been used for primary or secondary prevention, this should be captured in the individuals progress notes.
11. If an individual wants to use the safety pod independently as a method of deescalation, staff need to ensure that the person can transfer autonomously into and out of the pod. If a person is not able to mobilise independently, a member of staff or multiple staff must remain present to assist with transfer into and out of the pod.

12. If there are issues with capacity, the person should be assisted from the safety pod as soon as restrictive physical intervention has ceased.

Cleaning and maintenance of the Safety pod

13. Safety pods can be cleaned using all current NHS approved cleaning solutions.
14. Safety pods should undergo a visual inspection after each use and should be inspected as part of the units' weekly checks. Any damage or faults should be escalated immediately to the NIC to ascertain if the safety pod is still safe for use. If in doubt, the safety pod should be removed from service until review.
15. Safety pods should be maintained with the correct level of fill. The company that provide the safety pods offer a refill service. Charges will apply to units to have the safety pod refilled.

How to Set up the Safety Pods™

Step 1 - Take hold of the hood next to the logo and shake the Safety Pod™ untill the hood is empty of inner contents

Step 2 - Place the hood of the Safety Pod™ and rest it onto the body of the Safety Pod™ as shown

Ready for use

Guidance

- PI Training is recommended before using the Safety Pod™, for more information please contact Info@ukpodsltd.co.uk
- Ensure the Safety Pod™ is set up before each use (set up instructions above)
- It is recommended that the Safety Pod™ should be placed in supervised areas at all times
- It is advised you check the Safety Pod™ on a regular basis to check for damage
- We advise a refill, if the Safety Pod™ appears flat or low to the ground. A refill service is available please contact Info@ukpodsltd.co.uk
- To achieve the best results, it is advised your Safety Pod™ is checked and maintained on a regular basis. Please refer to maintenance log provided.
- It is recommended the Safety Pod™ is not to be used on wet or slippery surfaces
- If you would like a copy of the medical review please contact Info@ukpodsltd.co.uk

Guidance

The Safety Pod is a piece of work equipment that has been specifically designed for physical intervention/pmva use as a least intrusive option and with the primary aim of reducing/eliminating the use of ground/prone (face down) restraint.

It is recommended that the Safety Pod™ is used in conjunction with all current legislation and guidance on the use of force specific to your industry sector.

We recommend that all staff expected to use the Safety Pod™ should be trained and in-date for their training, which should be provided as part of a credible and competent system of physical intervention/pmva and should follow their respective company policy on the use of physical intervention.

Cleaning

We have engineered our products with materials which offer the ultimate in stain resistance and clean-ability. All of our products have been tested with a wide range of cleaning products and are able to withstand the most rigorous cleaning regime.

Our Safety Pod's™ can be cleaned using all current NHS approved cleaning solutions such as Chlor-Clean, Haz-tab Milton and Tristel.

UK PODS LTD

Address: UK Pods LTD, 6 Wallis Road, Skippers Lane Industrial Estate, Middlesbrough, TS6 6JB
T:01642 453777 M:07969338233
E:Info@ukpodsltd.co.uk W:www.ukpodsltd.co.uk

Safety Pod™ Manual of Guidance

Appendix 11

Example service specific SOP for use of Safety Pod Safety Pod CAMHS Medium Secure Standard operational procedure

SOP NUMBER		
VERSION NO & DATE	01	Date: 13.06.2022
SOP LEAD	XXXX XXXX	
SOP AUTHOR	XXXX XXXX co Author XXXX XXXX	
APPROVED VIA:	SCCS Clinical Governance Committee	
ANTICIPATED REVIEW DATE:		

This Standard Operational Procedure (SOP) provides a detailed outline of the proposed rationale for the use of the Safety Pod within CAMHS Medium Secure Services within BSMHFT.

Contents

Executive Summary

The Safety Pod is a recent introduction to BSMHFT services, and resembles a large bean bag; the Safety Pod has been specifically constructed for its intended use, physically intervening with a person intent on harm to themselves or others; although new to BSMHFT services, the Safety Pod has been used in other organisations with some success.
The safety pod can be used to reduce the duration of prone and supine physical intervention, can be used as an alternative to prone and supine physical intervention, can be used independently of physical intervention as an alternative to being physically held.

This SOP sets out the rationale for use of the Safety Pod within the CAMHS Medium Secure Service of BSMHFT.

Duties and Responsibilities

The Chief Executive has ultimate responsibility for ensuring that mechanisms are in place for the overall implementation, monitoring and revision of SOP.

The Executive Director of Operations – holding text

The SCCS Clinical Directors – holding text

Associate Director SCCS is responsible for ensuring:

- In conjunction with the SOP lead, identifies resource implications to facilitate implementation and compliance.
- Training and monitoring systems are in place.
- Regular review of the SOP takes place.

Clinical Services Manager is responsible for implementation of the SOP within their own spheres of management and must ensure that:

- All new and existing staff have access to and are informed of the SOP
- Ensure that local written procedures support and comply with the SOP
- Ensure the SOP is reviewed regularly
- Staff training needs are identified and met to enable implementation of the SOP.

Safety Pod

Safety Pod Philosophy

The safety pod is designed with a view to keep the person safe in terms of posture to aid breathing, and to maintain stability of the spine.

The safety pod is not intended as a piece of mechanical restraint, rather it is a medical device, specifically designed for its intended use, that of maintaining the safety of the person independently of physical intervention, in conjunction with physical intervention, and/or in conjunction with mechanical restraint.

Whilst it is envisaged the safety pod would significantly reduce the need for floor based restraint it will not prove prudent or safe on all occasion, therefore it will be vital all current options remain in place.

Rationale for Use of Safety Pod

The safety pod can be utilised for the person without the need for AVERTS holds, they can seat themselves in the pod, and as noted, this will provide support and slow movement.

The Safety Pod can be utilised for the person whilst in holds, and we could foresee its use in a number of eventualities:

- To help bring to an end a prolonged Physical Intervention from a prone/ supine position
- To help administer medication via the deltoid route
- To help the administration of nasogastric feeds
- To help manage severe self- injurious presentation
- To be utilised in conjunction with SRS to manage severe self- injurious presentation
- To reduce risk of injury toward staff during planned interventions

Training

AVERTS team will work in conjunction with Matron and ANP for Security within the CAMHS Medium Secure Service to provide staff with training and guidance in the use of support of safety pod, how to deploy the safety pod and AVERTS holds that would be appropriate in conjunction with the safety pod.

Appendix 1 includes Pods UK info leaflet outlining how to check integrity of the Safety Pod, and safety pod refill, staff will receive guidance during face to face training.

Staff Responsibilities

Staff Roles and Responsibilities

Clinical staff have a responsibility to maintain their training competence in line with their traffic lights.

Clinical Staff have a responsibility to utilise their training in line with their competence.

Clinical staff have a responsibility to report any concerns they have, and any further support they feel they may need. In line with training, there needs to be a "third" person in situ who has the responsibility for maintaining the physical and psychological well-being of the person if AVERTS holds are being utilised.

There is a responsibility for Post incident support for Person and the staff involved in the use of the safety pod.

Staff have a responsibility to report all uses of physical intervention.

Staff have responsibility for ensuring the safety pod is cleaned in line with IPC standards.

In line with PUWER regulations, staff need to ensure the safety pod is safe to use prior to deployment, and after deployment of the safety pod.

Reporting and Recording

All uses of Physical Intervention need to be recorded via ECLIPSE, this is in line with the Use Of Force Act (2018) and subsequent Trust Use of Force Policy.

Where the safety Pod is used without Physical Intervention, best practice would indicate that this recorded in Progress Notes/ What Handover, and considered as an intervention within the Person's PBS Plan (or equivalent).

Health and Safety

All employees have completed H&S training appropriate to their work and operate within the guidelines of the Future HSC operational polices.

It is the responsibility of employees to ensure that their work, work environment and work related equipment complies with all the relevant legislation and Trust Policies.

Training and Development

Training in the use of Physical intervention is delivered by the AVERTS™ team with bespoke clinical advice, guidance and training delivered by the AVERTS™ Consultancy team.

Training in the use of the safety pod (deployment and set up, re-fill check) will be delivered as needed by the AVERTS™ training team; as needed on site, and as a core component of the AVERTS™ training programme when scale up and spread has been achieved.

Training around the use of work related equipment and Infection Prevention and Control (IPC) is available via relevant teams.

Lessons Learnt

All use of physical intervention is to be recorded via the Trust ECLIPSE reporting system, therefore, any injuries as a result of use of Safety Pod will be recorded; this will enable learning from the issues identified.

Post- Incident support for both the person being held and the staff holding onto a person can help identify any problems that need to be resolved, or for that matter, highlight any best practice points to be shared with other clinical areas who will be utilising the safety pod.

Where the safety pod has been used as part of the persons primary or secondary strategies, the use of good recording and post-incident support can help identify any problems or best practice points.

Monitoring and Audit Arrangements

Elements to be monitored	Method of monitoring	Responsible lead	Monitoring frequency	Assurance group / committee	Group responsible for completing actions
Injury to Service User	ECLIPSE	AVERTS	Quarterly	RRP Steering Group	
Injury to Staff	ECLIPSE	AVERTS	Quarterly	RRP Steering Group	
Service user feedback	Post Incident Support (RiO)	Matron	Quarterly	Local CGC and RRP	
Staff Feedback	Post Incident Support (RiO)	Matron			

Appendix 12 Guidance on the Negligible Use of Force and reporting/ recording requirements under the Use of Force Act (2018)

The duty to keep a record of the use of force does not apply if the use of force is negligible.

Only activities which are considered to be part of daily therapeutic or caring activities could possibly be considered as a negligible use of force, and only if they are outside of the circumstances in which the use of force can never be considered negligible as set out below.

If a member of staff's contact or touch with a patient goes beyond the minimum necessary in order to carry out daily therapeutic or caring activities then it is not a negligible use of force and must be recorded. Whenever a member of staff makes a patient do something against their will, the use of force must always be recorded.

One example of a negligible use of force is: the use of a flat (not gripping) guiding hand by one member of staff to provide redirection or support to prevent potential harm to a person. Using this example, it is important to note that the contact is so slight that the person can at any time override or reject the direction of the guiding hand and exercise their autonomy. It is essential that the guiding hand does not cause distress to the person.

It follows that the use of force can never be considered as negligible in the following circumstances:

- Any form of chemical or mechanical restraint is used
- The patient verbally or physically resists the contact of a member of staff • A patient complains about the use of force either during or following the use of force
- Someone else complains about the use of force
- The use of force causes an injury to the patient or a member of staff
- More than one member of staff carried out the use of force
- Negligible use of force is excluded only from the duty to record. Other parts of the Act and guidance apply to all uses of force.

Use of Force information to be Recorded

The Act requires that the record of the use of force used on a patient by a member of staff must include the following:

a. the reason for the use of force
b. the place, date and duration of the use of force
c. the type, or types of force used on the patient
d. whether the type or types of force used on the patient formed part of the patient's care plan
e. name of the patient on whom force was used
f. a description of how force was used
g. the patient's consistent identifier
h. the name and job title of any member of staff who used force on the patient
i. 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
j. the patient's mental disorder (if known)
k. the relevant characteristics of the patient (if known)
l. whether the patient has a learning disability or autistic spectrum disorder
m. a description of the outcome of the use of force
n. whether the patient died or suffered any serious injury as a result of the use of force
o. any efforts made to avoid the need for use of force on the patient
p. whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan

For (k) in the above list the patient's relevant characteristics are:

a. the patient's age
b. whether the patient has a disability, and if so, the nature of that disability
c. the status regarding marriage or civil partnership
d. whether the patient is pregnant
e. the patient's race
f. the patient's religion or belief
g. the patient's sex
h. the patient's sexual orientation

i. gender reassignment – whether the patient is proposing to reassign their gender, is undergoing a process to do so, or has completed that process

• Gender reassignment is a protected characteristic under the Equality Act 2010 and information about whether a patient has transitioned from one gender to another should also be collected.

For (d) and (p) in the list above references to care plans may also include Positive Behavioural Support Plans (or equivalent).

For (k) in the list above proactive steps should be taken to collect data about the patient's protected characteristics in order to comply with the Public Sector Equality Duty.

For (m) in the above list of recording requirements (a description of the outcome of the use of force) the description should include (as a minimum) the views of the patient, any psychological impact, details of any injuries the patient or staff involved may have suffered, whether the outcome of the use of force was segregation or seclusion, and whether the police were called to assist. If the police were called to assist the reason they were called, whether the incident was recorded by their body worn camera, and if not, why not, and who the relevant police contact is should also be recorded.

For (n) in the above list (whether the patient died or suffered any serious injury as a result of the use of force) there is no specific definition of what constitutes a serious injury in NHS settings. Current guidance in the NHS England and Improvement Serious Incident Framework 2015 should be followed to identify a serious incident. What injuries the patient suffered should also be recorded.

Serious injuries to a patient should also be reported to the Care Quality Commission if the patient was seriously injured while a regulated activity was being provided or their injury may have been a result of the regulated activity or how it was provided. The notification form provides detail of what might be considered a serious injury for the purposes of recording under this Act's requirements.

NHS and independent organisations (where providing NHS-funded care) must ensure that any death of a patient detained or liable to be detained under the Mental Health Act 1983 is reported to the Care Quality Commission without delay. The death must also be reported to the local Coroner (including voluntary or informal patients). It is for the Coroner to determine the cause of death. The requirement to record whether the patient died as a result of the use of force will need to be recorded once the Coroner has provided their conclusion. The responsible person must ensure that this is added into the record of the incident. It would also be good practice to notify the Care Quality Commission of the Coroner's conclusion.

For (o) in the above list (any efforts made to avoid the need for use of force on the patient) this should include details of what led to the use of force and provide a record of the de-escalation techniques which were employed.

For (p) in the list above (whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan) this must be with the patient's consent, in relation to adult patients, or with the consent of the person with parental responsibility in the case of a child or young person.

A notification should be sent to the person or persons (families, carers or independent advocates) identified in the patients care plan or positive behavioural support plan (or equivalent) following every use of force. This should occur inline with the guidance in Chapter 26 – 'Safe and therapeutic

responses to disturbed behaviour' of the Mental Health Act 1983: Code of Practice on notifications following the use of force.

The Act requires that the responsible person must keep the record of any use of force for 3 years from the date it was made. It is not permitted to record anything which would otherwise breach data protection legislation [footnote 2] or the common law duty of confidence. This is intended to preserve the patient's rights in relation to their information.

BSMHFT records the use of force within its internal incident reporting system Eclipse. It is current good practice to include the record of the use of force within the patient's electronic record. This is satisfied by the eclipse recording system being linked to RIO.

Openness and transparency about the use of force within an organisation is essential, but it is also important to recognise that the data only tells us part of the story. There are many factors which can impact the number of incidents reported such as staff reporting behaviours or the mix of patients which can impact the ward environment and relationships.

Organisations have a responsibility to consider the detail behind the data to evaluate if their wider approaches to minimising the use of force are effective. Success should not be measured on a reduction in the number of reported incidents alone.

BSMHFT will also consider the following:

- when force is used, does it meet the justification threshold of imminent or immediate risk of harm to self or others
- is there a reduction in the average duration when force is used
- was the level of force proportionate in all cases
- is there an overall reduction in the use of physical restraint
- is there a reduction in the use of prone and supine restraint
- is there a reduction in the number of complaints from patients and families or carers following the use of force
- is there a reduction in the number of injuries to patients and staff following the use of force

This data and its analysis will be vital in informing the BSMHFT's plan to reduce the use of force