Birmingham and Solihull Mental Health NHS Foundation Trust

Prevention and Therapeutic Management of Aggression Policy

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Executive director	**Lisa Stalley-Green CNO/Executive Director of Quality & Safety**	
Policy Lead	**Deputy Director of Nursing (Quality and Safety)**	
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Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

- This policy provides an overview of the Trust philosophy and overall strategy for the therapeutic management and reduction of violence in its services.
- Primary, secondary, and tertiary guidance for staff commensurate with current national reducing restrictive practice (RRP) 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, CQC policy statement (2023) and the on-going work of the Restraint Reduction Network (RRN); this policy promotes and supports the implementation of therapeutic primary, secondary and tertiary RRP strategies utilising quality improvement methodology
- The Policy will support the Trusts on-going reducing restrictive practice initiative and quality and safety account goals relating to a reduction in restrictive practices and assaults on service users and staff.

1: Introduction

- **1.1 Rationale** (Why)

- The Trust recognises that occasionally some service users - because of the impact of ill-health 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 intrinsic to the management of violence in such settings in England.
- This policy will be used to support the Trust's Reducing Restrictive Practice strategy and associated workstreams, and the Trusts commitment to maintain accreditation with BILD ACT regarding 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 individuals with black African and Caribbean heritage formerly detained within Mental Health services (DH,2018) and the use of restrictive interventions with this population needs to be monitored.
- The Human Rights Act (2008) is statute UK legislation that incorporates into domestic law the statute legislation outlined by the European Convention on Human Rights (ECHR). The Trust will ensure its processes follow the requirements of the Act and will ensure that any breaches are reported and investigated. Further detail can be found in the **Safe Use of force policy .pdf**
- The Articles commensurate with the use of restrictive physical intervention are.
    - **Article 2: Right to Life**
      This obliges the Trust to protect anyone under its care from risk to that person's life, whether self-inflicted or by another, whether by act or omission Article 2 imposes a procedural obligation on the Trust to conduct an investigation in circumstances including: where the person has attempted suicide while so detained and has sustained serious injury (or potentially serious injury); where the Trust owed a duty to take reasonable steps to protect the person's life because the person was under the Trusts control or care and the Trust knew (or ought to have known) there was a real and immediate risk to the person's life. This can also include voluntary patients.
    - **Article 3: Prohibition of torture, inhuman or degrading treatment.**
      No restrictive intervention should be used unless it is absolutely necessary to do. Action that is not proportionate or necessary may well breach a patient's

rights under article 3. ‘Inhuman or degrading treatment’ it does not have to be deliberate and can be unintentional.

- **Article 8: Respect for private and family life.**
  Restrictive interventions may breach a patient’s article 8 rights if they have a sufficiently adverse effect on the patient’s private life, including their moral and physical integrity.
- **Article 14: protects from discrimination.**
  In addition to what is set out above as in the Mental Health Units (Use of Force Act (2018) statutory guidance
- **Article 5: Right to Liberty**
  Restrictions that alone, or in combination, deprive a patient of their liberty without lawful authority will breach article 5 of the ECHR.

- BSMHFT and its staff are legally obliged to respect a service user’s rights and must take reasonable steps to protect those rights. The Mental Health Act (1983) and the Mental Capacity Act (2005) are designed to ensure that proper processes are followed and that any use of force considers the outlined processes. Any use of restrictive physical intervention must be necessary and proportionate to the (perceived) risk and the least restrictive option available in the circumstances.
- BSMHFT staff need to be Trauma Informed. All staff should be aware of current or historical trauma whether personal or caused by the system to improve the impact of interventions delivered to service users. The Trust will work to ensure that processes and interventions do not reignite an individual’s past trauma experiences instead promoting safety and recovery.
- Any intervention should be trauma informed; staff need to be aware of the impact that restrictive interventions including physical holding can have on a service users recovery journey. This includes vicarious trauma when service users witness and incident involving another person.
- BSMHFT will promote care environments that promote safety and recovery through its physical environments and the culture and atmosphere within its services.
- **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 **Lone Working Policy Final Version.pdf**.
- 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 **Fundamental Training Policy.pdf**
- This policy acknowledges and pays due regard to the protected characteristics as defined in the Equality Act 2010. Staff are expected to take these elements into consideration when planning, implementing, undertaking, and reviewing restrictive practice interventions.
- 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 **Safe Use of force policy .pdf**

- **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: Restrictive Physical Intervention (restraint), Rapid Tranquilisation, Seclusion or Mechanical Restraint) is always considered a measure of last resort, must be proven to be reasonable under the presenting circumstances, utilised for the shortest of period of time possible and be necessary to minimise the risks to both the service user and staff.
- 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 care and management plan and/ or PBS plan or equivalent.
- The Trust extends this belief and continues to work towards, where possible, the avoidance of all use of restrictive intervention. This is in keeping with the CQC cross-sector policy position (2023) that identifies the need to ensure that interventions are person centred and trauma informed creating positive cultures that support recovery. **https://carequalitycomm.medium.com/restrictive-practice-a-failure-of-person-centred-care-planning-b9ab188296cf**

- Trauma whether historical or current and whether personal or caused by the health system is an issue that is acknowledged by the Trust and should be at the forefront of any decision making around the use of any form of restrictive practice.
- The Trust is committed to delivering care and interventions that are trauma informed and that all staff who work within services are aware and sensitive to the impact of actual, potential, or vicarious trauma for all service users and staff.
- 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, to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately to support this.
- 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 monitored on an on-going basis and be incorporated into RRP QI projects where appropriate. These projects will be regularly reviewed in the Reducing Restrictive Practice Steering Group (RRPSG)

2. **The policy** consisting of:

2.1 BSMHFT will engage in on-going work to reduce the use of restrictive practices and interventions within the organisation. The Reducing Restrictive Practice Steering Group (RRPSG) will oversee the development of RRP plans and will be the governance home for RRP workstreams.

2.2 The Trust will look to engage in workstreams that address both primary and secondary preventative strategies that include the environmental and cultural experience for individuals who use BSMHFT services.

2.3 The need for clinical staff and service users to plan strategies to prevent and manage incidents of aggression or violence. When looking to prevent and manage incidents, staff should apply the following process:

2.4 Staff should ensure that service users who are assessed as being liable to present with aggressive behaviour have a care or treatment plan which includes primary preventative strategies, secondary preventative strategies, and preferred tertiary interventions. In many services this may be referred to as a positive behavioural support plan (PBSP). These individualised care plans should be available in the care record and kept up to date' (DH, 2015, p. 284)

2.5 Wherever possible, service users who are admitted into services should have an LDA sensory assessment to identify any sensory needs. A copy of the assessment should be kept in the service users RiO record and be utilised when formulating care or management plans around the prevention and reduction of aggressive behaviours.

2.6 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

2.7 In acute services the principles of PBS (i.e. primary & secondary prevention, and tertiary interventions) will be applied to risk management plans relating to the therapeutic management of aggression.

2.8 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

3.1.1. 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

3.1.2. Care Environment

The Trust is committed to investing in environments that are conducive to care. However, when working in some of the older facilities and with service users who may present with agitation or behavioural disturbance, staff should consider 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:

- Access to preferred items and a range of therapeutic activities.
- A unit where excessive environmental stimulation/noise is managed.
- Staffing numbers and skill mix to ensure both safer staffing and to meet the needs of the inpatient population.

- Active avoidance of areas where there is a reliance on compliance and the adherence to blanket rules. Please see the Trust's **Blanket Restriction Policy .pdf** for further guidance.

If these elements have not been applied due to specific justifiable reasons, then such reasons should be clearly documented in the individual service user's 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.

When developing new care environments, services should aim to make the environments as homely and comfortable as safety will allow whilst considering relational security requirements associated with the service specification to include but not limited to décor, fixed furniture, and furnishings.

3.1.3. Engaging with individuals and their Families

The Trust has established policies and procedures that foster environments conducive with working with a service user's family 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, e-mail, and letter.

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

The care management plan should be reviewed weekly at the MDT.

Unless justifiable reasons exist (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) and treatment planning.

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

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

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.

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

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 **Advance Statements and Advance Decision policy .pdf**

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

3.2. Secondary Preventative Strategies

3.2.1. 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).

Staff should use the information gathered from the PBSP (or equivalent) as a basis for de-escalation. 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.

De-escalation should always be employed when managing potential behavioural disturbance. Staff should use the 'Talk Down' model of de-escalation endorsed through the safewards model as a template. **Talk Down (safewards.net)** is delivered on all AVERTS courses and reinforced within AVERTS e-learning packages.

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.

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. Enhanced Observations

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 **Supportive Observations and Therapeutic Engagement Policy.**

3.4 Reducing Restrictive Practice Steering Group (RRP)

3.4.1 The RRPSG is the Trusts governance group that drives the reduction of restrictive practices (RRP) agenda within the organisation. The group meets monthly. It is chaired by the Deputy Medical Director for Quality and Safety and is co-chaired by the AVERTS/ RRP lead.

3.4.2 The membership of the panel is multidisciplinary and organisation wide. Experts by Experience are integral to the group and are actively involved in the RRP workstreams.

3.4.3 The RRPSG utilises QI methodology to develop and disseminate learning. The panel is also responsible for delivery on the organisational pledge made to the Restraint Reduction Network. The pledge can be found **here**.

3.4.4 All workstreams relating to RRP must use the RRPSG as the governance home, this includes oversight of the ongoing RRP QI workstreams, PMO guided RRP projects, policy development around restrictive practices, the Trust wide monitoring of RRP incident data, presentation of RRP case studies and identification of areas of good practice and learning lessons for wider dissemination.

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

3.4.6 The RRPSG will review RRP related data monthly. This will include the monitoring of protected characteristics.

3.4.7 The Trust acknowledges that individuals from BAME communities are more likely to face enhanced levels of restriction and be subject to RPI interventions. This data will be actively monitored within the RRPSG and disseminated back to individual clinical areas. The data will inform workstreams to reduce health inequalities and RRP interventions in this population.

3.5. Reducing Restrictive Practice and Violence Reduction

Individual service areas within BSMHFT have developed their own RRP action plans which should include the continued use of safewards. Each area will identify key staff to assist with the on-going implementation of the RRP plan. These staff will support and guide staff in the application of the violence reduction strategies identified within the RRP action plans and those associated with the safewards model. This work will be supported by the RRP Lead nurse and the DMD for Quality and Safety with oversight from the Reducing Restrictive Practice Steering Group.

3.6. Tertiary Preventative Strategies

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

3.6.1 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.

3.6.2 On some occasions use of restrictive interventions may be needed to manage acute behavioural disturbances that pose significant risks to the person or others, or in emergency situations. 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 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)

3.6.3 Methods of restrictive interventions are:

- Physical Intervention
- Mechanical Restraint
- Seclusion
- Rapid Tranquilisation
- Blanket Restrictions
- Therapeutic Observations

3.6.4 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.

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

3.6.6 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 consider any adaptations required to meet the individual's personal needs (communication, frailty, physicality etc.).

3.6.7 The AVERTS consultants are a Trust resource to consult on restrictive physical intervention and can discuss individual care arrangements and assist in the formulation of management plans and ensure the least restrictive option is adhered to where required.

3.7. 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.

3.7.1 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:

3.7.2 The registered professional in charge on each shift must allocate a suitable staff member to respond to the response alarm. Ideally this member of staff will be RRI (AVERTS) trained.

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

3.7.4 TSS with limited clinical experience or new to the organisation should not be nominated without a localised induction and a full understanding of the roles and responsibilities.

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

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

3.7.7 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 clinical areas.

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

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

3.7.10 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.

3.7.11 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 restrictive physical intervention upon commencement of employment and annually thereafter. All staff who require this training are identified in the Trusts Training Needs Analysis (TNA) held by the Learning and Development Department.

3.7.12 All staff who employ physical interventions must receive mandatory resuscitation training as detailed in the Fundamental Training TNA.

3.7.13 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.

3.7.14 Staff must only use those physical intervention techniques as taught on RRI (AVERTS) training courses delivered by RRN accredited trainers. 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.

3.7.15 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. RRI (AVERTS) training recognises that the employment of skills will be based on a proportionate response and least restrictive practice.

3.7.16 There are dangers inherent with continuous physical interventions in any position (i.e. Positional Asphyxia). To avoid prolonged physical intervention alternative strategies, such as the use of the Safety Pod, rapid tranquilisation, relocation utilising the Soft Restraint System (SRS) and/or seclusion, where available, should be considered.

3.7.17 Following the use of restrictive physical interventions staff should complete a body map to identify any areas where unintended injury may have occurred because of the restrictive physical intervention.

3.7.18 All service users should undergo a period of enhanced physical and psychological monitoring for as long as is clinically necessary following the application of restrictive physical interventions. These should be recorded in the persons electronic care record.

3.8. Use of the Safety POD

3.8.1 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.

3.8.2 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.

3.8.3 No other type of device should be used in place of the safety pod.

3.8.4 The use of the Safety pod should reduce the use of prone restrictive physical interventions and can be used to assist in the administration of Rapid tranquilisation into the deltoid and for Naso gastric tube feeding.

3.8.5 For more detailed advice, guidance and usage please see **Appendix 4.**

3.9. Prone Restraint

3.9.1 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).

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

3.9.3 Unless there are cogent reasons for doing so 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.

3.9.4 ‘Cogent reasons for doing so’ should be discussed and agreed by the MDT and clearly documented in the service user’s care records. 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) or the safe ingress and egress for seclusion where other options are contra-indicated.

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

3.10. Prolonged Restraint

3.10.1 Where restrictive physical interventions have been used for longer than 10 minutes this would be considered a prolonged restraint. This will include interventions where multiple holding positions have been utilised.

3.10.2 If a restrictive physical intervention 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.

3.11. 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)

The Trust has a **Mechanical Restraint Policy .pdf**.

3.12. Seclusion and Longer-Term Segregation

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

3.13. Rapid Tranquilisation

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 Tranq Policy .pdf**

3.14. Training

The safety of staff working in the Trust is paramount. Members of staff require appropriate training around the reduction of restrictive interventions (RRI), how to identify unsafe situations and how to manage individuals that may become unsafe. The Trust has its own model of RRI training called AVERTS. Further details regarding the RRI (AVERTS) training can be found in the **Fundamental Training Policy.pdf**

3.15. Personal Protective Equipment (PPE)

There may be occasions when management of violence and aggression requires staff to utilize personal protective equipment to minimise infection control risks during the event. The Trust PPE equipment currently consists of cut resistant gloves, protective eyewear, and full-face visors. All PPE equipment is to be sourced by individual units, cut resistant gloves can be sourced from the AVERTS training team.

It is the responsibility of the ward manager to ensure that equipment is well maintained and procured in a timely manner and that TSS and transient staff are aware of where the equipment is stored.

3.16. Guidance for Families and Carers

3.16.1 The Trust has a team of Experts by Experience and a Participation and engagement team to ensure that service users and carers voice is heard in relation to the reduction of restrictive practice.

3.16.2 Service users, families and carers will have access to information related to the reduction of restrictive interventions via the information leaflet in **Appendix 2**.

3.17. 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 behind a barrier if it is safe to do so. Police should be contacted in such instances under the auspices of the **Police Interventions Policy .pdf**.

3.18. Withdrawal of services

The Trust has a duty to and is committed to the provision of a safe and secure environment for staff and service users whilst employing the least restrictive option. The Trust also has a duty to provide a safe and secure care environment for service users and staff. The Trust will not accept abusive, discriminatory, or antisocial behaviour by any person.

To achieve this, the Trust has developed and implemented frameworks and associated policies that support staff and service users, so they are equipped to deal with potential or actual situations that involve criminal and or unacceptable behaviours. Given the broad range of services provided by the organisation and the diverse nature of the individuals we engage with, every situation will be assessed on an individual basis to ensure the effective management and prevention of such unwanted behaviours.

Abusive, discriminatory, or antisocial behaviours may also constitute a criminal offence, so in addition to processes outlined within The Management of Unacceptable Behaviours Policy it may also be appropriate and necessary to report such incidents to the police in

accordance with the Police Interventions Policy for consideration of criminal investigation and prosecution where appropriate.
Specific guidance can be obtained from the following policies:
Management of Unacceptable Behaviours Policy.pdf
Police Interventions Policy .pdf

3.19. Reporting and Recording

3.19.1 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.pdf.** All entries must ensure that they are Use of Force compliant as per **Safe Use of force policy .pdf**. 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 5**.

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

3.20. Service User and Staff Support

3.20.1 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 **Incident Management Policy.pdf**.

3.20.2 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.

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

3.20.4 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 Participation and Experience worker or an advocacy worker who can assist with the complaints process as per **Complaints Policy.pdf**.

3.20.5 Staff should be afforded the same levels of support as service users post incident.

3.20.6 All staff should be offered the opportunity to talk through the incident, this should form a part of the post incident support and de-brief.

3.20.7 Depending upon individual need there are various responses available to staff, whilst the Trust continues to improve its post incident support strategy, there are options available to staff; staff can be referred to PAM, can access the Employee Assistance Programme **EAP** and, where appropriate, be referred for TRiM input.

3.21. Safeguarding

Incidents that identify safeguarding concerns will be escalated and managed with reference to the **Domestic Violence and Abuse Policy.pdf**, **Adult Safeguarding Policy .pdf**, **Safeguarding Children and Young People.pdf** or **Safeguarding Allegations Concerning People in a Position of Trust** 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 by traffic light and TNA. 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 reducing restrictive practices laid out in this policy are consistently applied. Respond to data accessible through the Restrictive interventions reporting suite and through governance facilitators paying attention to trends and monitoring protected characteristics. Utilise RRI/ AVERTS Consultants for their respective areas.	
Policy Lead	Ensure that the policy is disseminated, reviewed, and monitored accordingly.	
Nominated Reducing Restrictive Practice Executive Director	Report to Trust board via CGC on the progress of the overall violence reduction strategy. Oversee the Trust's Reducing Restrictive Practice workstream as part of the overall Quality and Safety strategy.	
LSMS	Support staff who have been victim of assault in a timely manner & give feedback regarding progress to the affected member of staff. Liaise with the police in terms of the co-working arrangements with the Trust	
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 and annual refresher. Ensure that incidents are accurately reported and recorded.	

5: Development and Consultation process:

Consultation summary

Date policy issued for consultation	15th March 2024
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	**Date(s)**
Reducing Restrictive Practice Steering Group	19th March 2024, 16th April 2024
AVERTS team	March 2024
Disseminated to H&S committee, A&UC, D&F, Specialities & SCOH CGC's	April 2024
Short task and Finish teams meetings	September & October 2023

Where received	Summary of feedback	Actions / Response
	No feedback received	

6: Reference documents

- Bowers, L. (2014) A model of de-escalation. Mental Health Practice. 17(9), pp. 36-37.
- Care Quality Commission (2023) Restrictive Practice- a failure of person centred care planning **https://carequalitycomm.medium.com/restrictive-practice-a-failure-of-person-centred-care-planning-b9ab188296cf**
- 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.

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.
- **Restrictive physical intervention**.
- **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:

The Reducing Restrictive Practice Steering Group will be responsible for reviewing policy effectiveness and will report into Quality Patient Experience and Safety Committee quarterly regarding the ongoing RRP workstreams. A formal report to Trust CGC/Trust Board will be produced annually.

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements
Number of incidents of violence and aggression	Medical Director	Incident Reporting	Monthly	Trust Board NHSE benchmarking Use of Force requirements
Number of restraints and causation including review of protected characteristics	Medical Director	Incident Reporting and deep dive	Quarterly	RRP Steering Group, Trust CGC & QPESC
Number and type of seclusion episodes	Medical director	Incident reporting and deep dive	Monthly	RRP Steering Group, Trust CGC & QPESC
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

10: Appendices

Appendix 1 Equality Analysis Screening Form
Appendix 2 Restrictive Physical Intervention Information Leaflet
Appendix 3 safewards Leaflet
Appendix 4 Safety Pod Guidance, Use and Maintenance
Appendix 5 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 Therapeutic Management of Aggression Policy		
Person Completing this proposal	Samantha Howes	**Role or title**	ANP AVERTS
Division	Corporate	**Service Area**	Learning & Development
Date Started	13/03/2024	**Date completed**	13/03/2024

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 to manage and reduce the use of restrictive physical interventions and restrictive practice within the organisation. Any intervention utilised for the management of behavioural disturbance 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.
The policy aims to ensure that staff work within a human rights framework and looks to employ the least restrictive option when managing violence, aggression and behavioural disturbance that is likely to cause harm to self or others; staff should work collaboratively with service users (and family/ carers) and should be pro-active in their planning and implementation of interventions. Service users should be involved in the development of management plans and subsequent interventions and where this is not possible a documented reason should be made in the clinical record. 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 at the time of the incident should be involved in post incident support. The PSIRF should be followed and implemented.
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 any form of restriction is required it should be 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 supplementary evidence that suggests there is also an overuse 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	[redacted]			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 and service user population with whom they are working. The RRI skills are adaptable across the age span with individualised assessments of risk determining which RRI skills should be employed. All service users should have a management plan that considers age. Any concerns can be raised with the units respective AVERTS/ RRI consultant.
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	[redacted]			AVERTS RRI Skills are principle based and therefore adaptable to individuals with different physical health needs including frailty, disability, pregnancy, etc. Staff need to be aware of their own responses and actions should they engage in practices that include removing aids and adaptations from individuals who normally require them due to risk and how this can present as a restrictive intervention. Where staff are unsure or unclear, they should contact their dedicated AVERTS/ RRI consultant for further advice and support. All service users should have an LDA

	[redacted]			assessment on admission to identify any sensory needs that can be built into any management plans that should also include reasonable adjustments where appropriate. Staff members may also need reasonable adjustments where necessary which should be discussed on an individual basis and the AVERTS team contacted for advice and support where necessary.
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	[redacted]			Staff should ensure that they are always practicing in a trauma informed way and should ensure that all service users have a documented management plan for how they wish to be managed at point of crisis. The gender mix of staff assisting in any planned intervention should consider the expressed preferences of the individual being managed wherever possible. In emergency situations, where possible, staff should swap over to ensure an appropriate gender mix is maintained.
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	[redacted]			The policy is applicable to all service users. There is no differentiation in the policy based upon the marital status of the person being managed.
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			[redacted]	Suitable adjustments are in policy to allow for pregnant and post-partum staff to maintain their AVERTS training status. There are specific skills and advice that the AVERTS team along with perinatal staff can 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. There is a specific role requirement for a member of staff

			■	to always observe the bump when physically engaging with a pregnant female. Specific advice can be sought from the perinatal service.
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 into pregnancy and maternity?				
Race or Ethnicity			■	The Trust acknowledges the over representation of BAME populations and restrictive practice, particularly black African and Caribbean individuals within mental health care services. The GI team will seek ways to monitor the protected characteristics, this is also being developed as part of the restrictive interventions reporting suite available to all Trust staff in Insight. Monthly monitoring via RRPSG in restrictive physical intervention, 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	■			Where restrictive interventions are employed, staff will need to be aware of the spiritual needs of the individual and what his may mean if they are being managed at point of crisis. All service users should have a Positive Behaviour Support Plan that identifies any specific spiritual needs. Unit managers will need to be aware of the spiritual and cultural needs of staff and put mitigation in place where possible to support their involvement in incidents based around the cultural or religious needs of staff.
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	■			The sexual orientation of staff should not have any bearing upon the management of individuals at point of crisis.
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			Any service users or staff should be managed in accordance with their expressed preference. This will be documented in the PBS plan (or equivalent). Unit managers will be aware of the needs of the individual staff and their specific needs. This shouldn't preclude the staff members involvement in incidents. Consideration needs to be given when responding as part of a gender appropriate team.
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?
Regular monitoring and reporting of restrictive interventions. All clinical areas to develop a RRP plan to reduce numbers of incidents within their respective clinical areas.
How will any impact or planned actions be monitored and reviewed?
Seclusion, restraint, assault are all monitored using monthly data available on the Restrictive Interventions Reporting Suite. The GI team provide monthly reports to the AVERTS RRI consultants who may, if required, complete a deep dive to get contextual narrative to support the data and give an account to RRPSG and QPESc regarding practice within the organisation. This can then inform CQC conversations.
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.
Share positive practice throughout the Trust via RRPSG and AVERTS team.
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.

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 staff who is the same gender as yourself
- One member of the team will be responsible for monitoring your physical and mental health and wellbeing during the process
- A member of staff should continue to talk to you in attempt to try to deescalate the situation
- Staff will document in your care record what has happened as soon as the situation allows

What should happen after an event where physical interventions 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 any 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 have any concerns, you can also discuss this with your named nurse, advocacy or our Customer Relations team.

Customer relations

Website: https://www.bsmhft.nhs.uk/service-users-and-carers/customer-relations/

Telephone: 0800 953 0045

Opening hours: Monday to Friday, 8am to 4pm (excluding bank holidays)

Text: 07985 883509

Email: bsmhft.customerrelations@nhs.net

Reducing Physical Interventions

Managing difficult behaviour

A guide for service users, carers, and families

Birmingham and Solihull Mental Health NHS Foundation Trust understands 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 difficult 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 witness an incident.

The information and terminology contained within this leaflet mirrors national 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.

The techniques will involve staff holding onto you for a short period of time so that you cannot hurt yourself or others around you. Before using the holds, staff should have tried alternative ways of deescalating the situation. If staff do use restrictive physical interventions, they should also continue to try to calm the situation by talking to you. Our 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 their techniques 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 staff receive training and yearly updates from the Trust.

None of the techniques taught should deliberately cause pain. If you think that this has happened to you, speak to staff, or get in touch with our Customer Relations team.

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 or something included in your care plan that covers how you would prefer to be managed, this should be followed wherever possible. If doing this would put yourself or others at even greater risk, then staff may need to take a different approach to keep you safe. 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.

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

Appendix 3

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 three times per week and should have four 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. For example, activities
- 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, this can help facilitate conversations and relationship building.

This module can be done with service users wherever possible, also compiling a fact sheet about themselves describing likes and interests.

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 sensory 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. If there has been a distressing event, every service user should be spoken to individually or in small groups. Staff should also 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 inpatient facility 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 messages so people can see who they are from. 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:

www.safewards.net

Main switchboard: 0121 301 0000

www.bsmhft.nhs.uk

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Safewards

A guide for service users, carers and families

Safewards is a national initiative designed to improve service user experience within inpatient mental health facilities.

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

Our Trust has committed to implement Safewards across its inpatient facilities as part of the reducing restrictive practice agenda. Restrictive practice is when limitations are put in place for service users to try and ensure a safe environment for all service users, staff and visitors.

compassionate inclusive committed

What is Safewards?

Keeping safe is a goal of our inpatient services.

The Safewards model, developed by Professor Len Bowers, is a set of interventions that have shown to contribute to a reduction in incidents on mental health inpatient facilities. Research has shown that the model demonstrates significant effectiveness in reducing incidents such as the use of restrictive physical interventions, seclusion and rapid tranquillisation in the UK.

Why can units be unsafe?

Inpatient facilities 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.

Inpatient facilities 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 inpatient facilities giving modules different names to those identified in this leaflet.

Below is a brief introduction to the 10 modules and their official Safewards titles.

1. Clear mutual expectations

Unfortunately, difficult and challenging behaviours are displayed because there is an uncertainty about how individuals (staff, service users, families and carers) are expected to behave and work together.

A set of mutually agreed expectations will allow for consistency and clarify relationships. These can be reviewed on a regular basis and should be displayed for all to see.

2. Soft words

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

Sometimes the language that we use can cause situations to escalate. 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. For example, trying to avoid saying no and offering explanations and alternatives.

3. Talk down

This is a model of de-escalation and is a three-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 be 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 'handover'. 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. Dealing with bad news (mitigation)

Research has shown that service users can impulsively leave services in anger following unwelcomed 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 4

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 de-escalation 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.
4. Any staff wishing to use the safety pod must have received appropriate information and instruction from the AVERTS team.
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 de-escalation, 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 provides the safety pods offer a refill service. Charges will apply to units to have the safety pod refilled.

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 because of the 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
Injury to Service User	ECLIPSE	AVERTS/ Health & Safety	Quarterly	RRP Steering Group
Injury to Staff	ECLIPSE	AVERTS/ Health & Safety	Quarterly	RRP Steering Group
Service user feedback	Post Incident Support (RiO)	Matron/ Participation and Engagement lead.	Quarterly	Local CGC and RRPSG
Staff Feedback	Post Incident Support (RiO)	Matron/ Participation and Engagement lead.	Quarterly	Local CGC and RRPSG

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.

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Safety Pod™ Manual of Guidance

Appendix 5
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 over-ride 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 in line 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.