PREVENTION AND MANAGEMENT OF VIOLENT AND AGGRESSIVE SITUATIONS & PSYCHIATRIC EMERGENCIES PROCEDURE

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Documents to read alongside this Procedure	NICE guidelines CG25 – The short-term management of disturbed / violent behaviour in psychiatric in-patient settings and emergency departments. (Feb 2005) Welsh Assembly Government – In Safe Hands. Implementing Adult Protection Procedures in Wales. (July 2000) Welsh Assembly Government – Framework for Restrictive Intervention Policy and Practice. (March 2005) The David 'Rocky' Bennett Inquiry Report (Dec 2003) The All Wales NHS Violence and Aggression Training Passport and Information Scheme.

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OUT OF DATE POLICY DOCUMENTS MUST NOT BE RELIED ON

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	21/02/2013	28/03/2013	Updated and Reviewed to UHB document supersedes previous internal Mental Health Document 2006

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1 INTRODUCTION

Background and Context

1.1 Within Mental Health services the potential for incidents of violence and aggression is an acknowledged factor. It is recognised that despite professional attitudes and relationships, good communication, high quality clinical practice and observation, incidents will still occur. Such incidents of aggression, potential violence or violent situations can take many forms and no protocol will be comprehensive enough to cover every situation. This document outlines good practice in the prevention and management of such events.

1.2 Violence directed to patients, staff or visitors is unacceptable. The Health Board will support staff fully when it comes to prosecution of perpetrators. Strong links with the police and criminal justice system will continually be developed and used to ensure that a diagnosis of mental illness (including those detained under the Mental Health Act), or simply being a "patient in care" does not absolve perpetrators from the legal consequences of their actions. The decision to prosecute will therefore be made on a case by case basis.

1.3 If a patient has any concerns or complaints regarding the management of a violent or aggressive situation, they have the opportunity to complain under the Board's Complaints Procedure.

1.4 Cardiff and Vale University Health Board mental health division has provided training for the therapeutic management of violence and aggression for a number of years and the models of training have evolved. The service group now uses its own model, namely **Strategies & Interventions for Managing Aggression (S.I.M.A.)**, a training model that is de-escalation based, pain-free, and avoids prone (face down) restraint in it's approach for the management of violent and aggressive incidents.

2 PROCEDURAL STATEMENT.

2.1 It is the policy of Cardiff and Vale University Health Board to ensure the likelihood of employees being exposed to aggression and violence whilst at work is reduced to a minimum. This is re-enforced in the Health Board's Personal Safety Violence and Aggression Policy.

All staff will uphold their duty to ensure that reasonable care is taken to avoid acts or omissions which could reasonably foresee causing harm to a person, physically, mentally and emotionally.

2.2 Cardiff and Vale UHB advocates a restraint free approach to care. Indeed, restraint/physical interventions should only be used as a last resort. In situations where it is assessed as being required, and considered by the multidisciplinary team as being in the best interests of the patient, minimal restraint may be used to protect the patient and/or others from significant harm, but alternative measures such as enhanced psycho-social care, de-escalation and nursing observation need to have been explored first.

2.3 In situations where restraint is deemed to be necessary, the intervention will be pain-free (NICE CG25 Feb 2005). The individual will not be held in a face down / prone position as there is some evidence to suggest that this places the service user at a greater risk of positional asphyxia.

2.4 The Health Board recognises that employees working within the Mental Health Service may be subject to additional risks due to the nature of their work. The Health Board will ensure that staff are not knowingly asked to deal with situations that are known to be a risk to their health and safety.

3 AIM

3.1 The aim of this procedure is to provide staff with a systematic approach to caring for patients that have the potential to become violent. The procedure emphasises recognition, prevention and de-escalation strategies as the first line in the management of violence, and that Restrictive Physical Interventions (RPI) / restraint should only be used as a last resort when all other interventions have failed. They are used with the best interests of the patient in mind, and everything possible must be done to prevent injury and maintain the patient' personal dignity.

4 OBJECTIVES

4.1 To ensure staff have an understanding of their rights, roles and responsibilities when managing potential or actual incidents of violence and aggression.

4.2 To ensure staff attend the appropriate training and work within the framework for their particular level of training.

4.3 To assist staff in developing therapeutic skills and confidence for the safe management of violence and aggression.

4.4 To minimise the risk to service users, staff and visitors when managing incidents of violence and aggression, ensuring that the wellbeing of all is central to managing difficult situations.

5 ASSOCIATED POLICIES, PROCEDURES & GUIDELINES

5.1 Violence and Aggression does not occur in isolation. Hence, staff should have an awareness and understanding of other policies, procedures and guidelines identified.

5.2 The following is not intended to be exhaustive but staff must be familiar with and adhere to the following policies, procedures and guidelines:

- Special Observation
- Handover of Care Protocol
- Care Programme Approach Policy
- Clinical Risk Assessment Policy
- Search Of Patients Policy and Procedures
- Alcohol, Drugs and Substance Misuse Policy
- Admission/discharge
- Management of Violence and Aggression (personal safety) Policy.

- Policy on the use of Restraint in the Care Management of Patients who lack Capacity to consent to Treatment and Care
- Exclusion of visitors
- Security
- Rapid Tranquillisation Protocol for Older People
- Rapid Tranquilisation Protocol for Adult Mental Health Services
- Incident Reporting
- What to do if a patient makes serious attempts to leave the ward out of hours

6 KEY PRINCIPLES

6.1 The following key principles of care are taken from relevant guidance and provide a framework for the use of restraint in situations of violence and aggression:

6.2 Duty of Care

The NMC Code of Professional Conduct (2008) emphasises a duty of care. The more dependent the patient, both physically and psychologically, the greater duty there is to provide care which enhances their independence and dignity.

6.3 Human Rights Act 1998

A number of ECHR Articles are pertinent to the use of restraint – e.g.

- Article 3 – right not to be tortured or subjected to treatment or punishment that is inhuman or degrading
- Article 5 – right to liberty and security of person

It is therefore important that any restraint used is appropriate, proportionate to the risk posed and lasts for the minimum amount of time necessary to contain the violent and/or aggressive incident.

6.4 Mental Capacity Act (2005).

A person must be assumed to have mental capacity unless it is established that he lacks capacity.
Restraining people who lack capacity to consent is governed by the Mental Capacity Act 2005 (MCA 2005). Staff using restraint are required by law to have regard to the Mental Capacity Act 2005 Code of Practice.

6.5 Least Restrictive Principal

As there is a requirement to act in a way that would interfere least with the patient's rights and freedom, clinicians and practitioners must consider whether there is a need to use restraint at all, or if the person's safety and that of others could be assured by any other means. If restraint is assessed as being required, it should be the minimum necessary to achieve effective risk reduction and be used for the minimum amount of time.

The Mental Capacity Act 2005 states that "Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action."

In making decisions regarding the use of restraint, due consideration must be given to the patient's mental capacity to consent to this aspect of planned care. A formal Test of Capacity may be required to inform decision-making and this is outlined in C&V UHBs **'Policy on the Use of Restraint in the Care Management of Patients who lack Mental Capacity to consent to Treatment and Care '**. If the vulnerable adult is assessed as having mental capacity to consent and refuses restraint, its undue use would be viewed as illegal and subject to an investigation under the 'South Wales Protection of Vulnerable Adults from Abuse and Inappropriate Care Policy'.

6.5 Best Interests:

"An act done, or decision made for or on behalf of a person who lacks capacity must be done, or made, in his best interests." (Mental Capacity Act, 2005)

In making decisions regarding the use of restraint, clinicians and practitioners must be especially mindful to act only in the best interests of patients and should consider the principles of:

- Beneficence: the intention to do the patient good
- Non-malificence: the intention to do the patient no harm
- Justice: to treat all patients equally and fairly
- Autonomy: to aid and respect the patient's right of self-determination.

The decision to use restraint in the patient's best interests must be based on reasonable grounds and objective reasons, following consideration of:

- The patient's feelings and wishes: His/her past and present wishes and feelings, as far as they are reasonably ascertainable; the beliefs and values that would be likely to influence their decision if they had capacity, and the other factors that he/she would be likely to consider if he/she were able to.
- The views of other people: The person making the decision must take into account, if it is practicable and appropriate to consult with them, the views of anyone named by the person as someone to be consulted with; anyone engaged in caring for the person or interested in his welfare; any donee of a Lasting Power of Attorney (a future role when the Mental Capacity Act is enacted which will address personal welfare and healthcare matters, as well as financial issues), and any deputy appointed for the person by the court.

6.6 Mental Health Act (1983).

If a patient is not subject to compulsory treatment, but care planning and risk assessment indicates that restraint in any form may be necessary during care, consideration should be given as to whether formal detention under the Act might be appropriate.

Restraint may be used to administer medication (or other forms of treatment) to an unwilling patient, where there is legal authority to treat the patient without consent. It should never be used unless there is such legal authority.

MHA Code of Practice for Wales 2008

6.7 Last Resort

"In the case of anything done or a decision made by a person other than the court it shall be sufficient if that person reasonably believes that what they do or decides is in the best interests of the person concerned." (Law Commission, 1997)
Anyone who applies any form of restraint must be prepared to justify his or her reason for doing so. Provided that the restraint could be shown to have been the only way of preventing harm to the individual or others, and is for as short a duration as is possible, the action is unlikely to be unlawful. The more restrictive the restraint, the higher level of justification will be required.

6.8 Legal Overview

The common law imposes a duty of care on healthcare and social care staff. If a person exhibits challenging behaviour, or is in the acute stages of illness, causing him/her to act in a way which may cause harm to others, staff may, under the common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else.

For further details, please refer to the following cases –

Black v. Forsey [1987] SLT 681 (detaining a person of "unsound mind" who is a danger to himself or others)

R (on the application of Laporte) v. Chief Constable of Gloucestershire Constabulary [2006] UKHL 55 (restraining a person in order to prevent a breach of the peace)

R (on the application of Munjaz) v. Mersey Care NHS Trust [2003] EWCA Civ 1036 (taking such steps as are reasonably necessary and proportionate to protect others from the immediate risk of significant harm)

6. 9 Restraint as Abuse

"Physical abuse is any physical contact which harms patients or is likely to cause them unnecessary and avoidable pain and distress… This includes unreasonable physical restraint." (NMC, 2002)
The use of pain as a means of gaining compliance should be restricted to the immediate rescue of staff, service users or others. (NICE CG25 Feb 2005)
'In Safe Hands', the Welsh Assembly Government (2000) guidance document concerning the protection of vulnerable adults, recognises 'undue restraint' as a form of physical abuse. If the restraint being applied is unjustifiable or is increasing the risk of significant harm rather than reducing it, then a referral under the 'South Wales Protection of Vulnerable Adults from Abuse and Inappropriate Care Policy' may be appropriate, and an investigation involving Social Services and Police partners should follow.

6.10 Significant Harm

"Significant harm is defined as ill treatment (including sexual abuse and forms of ill treatment that are not physical); the impairment of or an avoidable deterioration in physical or mental health; and the impairment of physical, emotional, social or behavioural development." (In Safe Hands, WAG 2000)

It has to be recognised that restraint in itself can cause harm sometimes even death (Please see The David 'Rocky' Bennett Inquiry Report (Dec 2003). Other examples include skin tears or bruising when delivering personal care to service users that lack mental capacity and are resistive.

6.11 Risk Assessment.

Following any incident that has required the use of Restrictive Physical Interventions (restraint) a detailed risk assessment must be undertaken / reviewed.

Use of Restrictive Physical Interventions (Restraint) should therefore, wherever practicable, only be used after a risk assessment is undertaken; the risk of using restraint is considered less than the risk it aims to reduce, and the effects of restraint are closely evaluated and it is reviewed on an ongoing basis. In making decisions, clinicians and practitioners are encouraged to accept a degree of risk taking and to explore alternatives to using restraint, as detailed in the following procedural guidelines.

7 PROCEDURE FOR THE USE OF PHYSICAL INTERVENTIONS.

Initial Engagement

7.1 Prevention is the first objective. Understanding that certain factors can precipitate aggressive or violent reactions and wherever possible taking steps to eliminate or reduce the effect of such factors, can go some way to preventing incidents occurring.

7.2 Recognition of these factors should begin at the start of the care process, from the moment the service user is received into the service. Therapeutic engagement and assessment will facilitate the gathering of data necessary for a care plan to be formulated. The care plan should identify the signs and triggers (identified by the service user and the assessing staff) which may be an early indication of aggressive or violent behaviour. The care plan should also include agreed (by the service user and the assessing staff) means of dealing with the aggressive behaviour at the earliest appropriate opportunity. As with all other areas of the care process, the agreed means of dealing with violent/aggressive behaviour will need to be reviewed as and when required, and as part of the ongoing review of care.

7.3 Observation

7.4 Observation is a core nursing skill. Nursing observation is arguably a primary intervention in the recognition, prevention and therapeutic management of violence.

7.5 The process, first and foremost, begins with meaningful engagement with the patient.

7.6 If the patient is informal, but requires an enhanced level of observation i.e. 1:1, then this should be agreed with the patient and form part of the consented care plan. In the event that the patient lacks mental capacity advice ought to be sought from the UHB Mental Capacity lead to ensure a Deprivation of Liberty is prevented.

7.7 This engagement process involves the nurse getting to know and understand the patient (and vice versa) and begins a process of building a trusting and therapeutic relationship. However, this is not a skill unique to nursing staff. Other staff within the multidisciplinary team also possess the necessary skills required.

7.7 Thereafter, risk assessment, risk management and a programme of supportive observation (augmented by multi-disciplinary planning) should follow. Observation should underpin all other strategies.

7.8 Initial Intervention

7.9 During any aggressive or violent incidents, the safety of patients, visitors and staff is paramount and should not be compromised.

7.10 All staff on duty will be made aware of the environmental controls within their particular area e.g. panic alarms, affray alarms/handsets etc. and how to summon assistance. EG via the shift co-ordinator. Or if urgent by phoning **2222** to declare a **'psychiatric emergency.'**

7.11 Whenever possible, de-escalation and distraction techniques should be utilised in the first instance, to defuse potentially violent situations in a positive manner.

7.12 In the event of an actual violent incident, staff should:

a) Continue to try to de-escalate the situation if it is safe to do so. **One** person should lead the process.

b) Summon assistance using the agreed appropriate means. E G by phoning **2222** to declare a **'psychiatric emergency.'** One member of staff should, if possible, meet emergency responders at the unit entrance and direct them to the area.

c) Staff must not tackle situations alone.

d) Move other patients, visitors and themselves if necessary to a safe environment.

7.13 Staff should also: -

A) Be aware of their tone of voice and should speak steadily and calmly, avoiding long sentences, complicated language and jargon.

b) Listen to the person. When someone is aggressive and angry, they are often trying to tell you something. Staff should try to understand what they are attempting to communicate.

c) Be aware of the effect of body language. The posture and stance adopted can communicate powerful messages. Avoid standing with hands on hips and arms folded. Adopt an 'open' posture.

d) Avoid prolonged eye contact.

e) Keep their distance. Staff should be aware of how invasion of 'personal space' can increase distress and potentially places them in a position of greater risk.

f) Be aware that their actions and reactions will have a powerful effect upon aggravating or diminishing the incident.

G) Due consideration must be given to patients who have sensory or physical impairment.

H) Socio-cultural conditions should determine whether the behaviour has any special meaning within the patient's religion, subculture and healing traditions.

7.14 Physical Interventions.

7.15 During any aggressive or violent incidents, the safety of patients, visitors and staff is paramount and should not be compromised.

7.16 Staff must, at all times, be aware of their own safety and always be in a position to summon help and/or able to leave the room/area.

7.17 If one patient attacks another patient or visitor, staff should summon help immediately and take the most reasonable, appropriate action to protect the victim.

7.18 Using diversionary tactics may help but any 'physical intervention' should be in line with these guidelines.

7.19 If a member of staff is attacked they should take the most reasonable, appropriate action to protect themselves and should attempt to 'break away' from their assailant using the minimum force necessary.

7.20 'Physical Intervention' skills must only be used as a last resort by staff that have completed the relevant training. When staff use physical intervention it must be used for the **absolute minimal** length of time possible (NICE CG25 Feb 2005). Staff must only use techniques specified in training and they must assess and identify the most appropriate method.

7.21 All wards/units need to identify an area(s) within the ward/unit where physical interventions can be safely undertaken. This should not be the patient's bedroom unless the patient is being cared for in older people's services or is an older person. There may be other instances where a bedroom may be considered preferable. E.g. Patients that have a low BMI, or other physical condition, that is of concern to the MDT. When a bedroom is utilised outside of MHSOP discussion must take place via the MDT to ascertain if this is in the patient's best interests.
Where a patient needs to be escorted to an area of the ward for de-escalation / reduced stimulus etc, the identified area should be utilised.

7.22 Should an incident occur where environmental constraints prevent the full deployment of the appropriate techniques, staff will be expected to use their own initiative to safely manage the incident. However, any practice must adhere to all current recommendations and guidelines.

7.23 If staff are unable to control the situation safely, the lead person (typically the person containing the head and monitoring the airway), must make a decision about whether to withdraw the team, they should also contact the Senior Nurse/shift co-ordinator on duty and the duty Medical Officer. Where physical intervention is utilised, the patient's physical wellbeing must be closely monitored.

7.24 Patients **must never** be restrained using a prone (face down) position. If such a situation occurs, the patient must be immediately turned to a supine (face-up) position, or released immediately and the situation reassessed.

7.25 When physical intervention (restraint) situations occur, the Shift Co-coordinator/Advanced Nurse Practitioner/Night Site Manager must be contacted as soon as possible and requested to visit the ward to assess the situation (David Bennett Inquiry Dec 2003 / NICE CG25 Feb 2005). **Additionally the duty SHO should be called either before and not later than 20 minutes of safe-holding and asked to attend.** If this is not possible the shift co-ordinator is to be advised and the incident management discussed.

7.26 Due consideration must be given to patients who have sensory or physical impairment, as well as when dealing with female patients who may be pregnant.

7.27 In summary, professional judgement should always be used in the assessment of all situations prior to and during the use of 'physical intervention'. There is no obligation on staff members to use 'physical interventions' if it is assessed as being unsafe to do so. EG In the presence of somebody armed with a weapon.

7.28 On some occasions, a registered medical practitioner may prescribe rapid tranquillisation for a patient. Staff must be familiar with and adhere to the Rapid Tranquillisation Protocols at all times. When considering rapid tranquilisation both the nursing and medical team will need to consider which Rapid tranquilisation protocol is more appropriate. i.e. the Rapid tranquilisation policy for Adult Mental Health or the Older Peoples Services protocol for rapid tranquilisation.

7.29 During and following the application of Physical interventions/Safe-holds and/or Rapid tranquilisation staff will need to consider/review the patients levels of observation and also monitor the patients vital signs and pulse oximetry (O2 saturation) (see Rapid tranquilisation policy). Staff should complete a body map especially if bruising/ injury is suspected / evident.(See Appendix 3)

7.30 A **'physical intervention / restraint recording chart'** must be completed (**Appendix 2**). This is a valuable tool and should provide an accurate time line of the incident.

7.31 Police assistance

Staff at times may think it is appropriate to call the Police.

Examples of incidents where the Police should or could be called include:

a) Persons other than patients causing nuisance and refusing to leave, or acting suspiciously.

b) Where a criminal act has been committed including abuse, assault and damage to UHB property.

c) Where control of situations involving patients has been lost. Staff must be aware that police management of situations may differ from that of UHB staff.

d) Where a weapon has been used or use of a weapon is threatened.

e) Where a patient has been assaulted by another patient.

f) When incidents occur in community settings. eg when staff are escorting patients and an incident occurs.

The decision to call the Police should fall to the most Senior Nurse on duty.

Community Settings: Use of Physical interventions when escorting in-patient service users.

The use of physical interventions in the community should not normally be required. However, the risk assessment and care plans of some service users that display certain risk behaviour may indicate the need for them to be escorted by one, two or more staff when outside the ward or hospital for medical treatment, therapeutic activities or for social reasons.

It is imperative that such individual's needs are discussed by the MDT and the risks identified and planned for on an individual basis. It may be that the team advise that the individual requires several escorting staff or perhaps that the trip should not take place due to the level of risk.

The care plan should reflect the actions staff should take or consider taking if the identified risks are presented during the planned escorted leave. This will help reduce the need for escorting staff to manage risk on a crisis basis.

Possible actions: (i) Use of a mobile phone for assistance (e.g. to call the police). (ii) Following service users that have become distressed or aggressive. (iii) Use of safe-holds in an emergency.

Staff will need to consider if using safe-holds will place themselves at greater risk (e.g. from passers by).

8. ACTIONS TO BE TAKEN FOLLOWING AGGRESSIVE OR VIOLENT SITUATIONS.

8.1 Assaults. Following any assault staff should consider contacting the police as the individual may wish to pursue criminal proceedings. Initial staff support will be provided by the individual line manager. An incident form will be submitted for each victim.

8.2 Additional **Staff** Support and legal advice is available via the Case Manager, Health & Safety, Denbigh House, **UHW. Tel 20746434**. This should be done within 48 hours.

8.3 Once reported, the police will contact the Responsible Clinician (RC) to ascertain if the patient had Mental Capacity. Based on this the Crown Prosecution Service (CPS) will decide if criminal proceedings should follow.

8.4 Where patients/others have been assaulted again the police should be contacted. The victim may also wish to seek legal advice regarding prosecution. Staff should ensure they are aware of this right.

8.5 If staff have sustained an injury they should be encouraged and supported to seek further medical advice as required. e.g. A&E or GP.

8.6 Staff have the right to seek counselling if they wish. This service can be provided by the Occupational Health Department or Employee Wellbeing Service. Managers may also request help from the department for individual members of groups of staff.

8.7 A post incident review of the patients care plan and Risk Assessment **MUST** be undertaken immediately following the incident.

8.8 Any adjustments to the patient's care plan **MUST** be communicated to all members of the ward team.

8.9 All incidents of aggression and/or violence must be reported by the completion of an Incident Report Form. The incident form should reflect the details of the incident and also indicate aspects such as the use of de-escalation, the types of hold utilised, by whom and for how long.

8.10 Following investigation of the incident, the senior nurse will provide feedback to the ward team including documenting that a debrief had taken place.

8.11 Post– incident analysis and debriefing must be held by the ward team as soon after the event as is practicably possible. The shift coordinator will ensure this has taken place liaising with staff as necessary.

8.12 Post – incident support must also be provided to the patient(s) involved, as well as other patients/visitors in the vicinity.

9 RESOURCES

9.1 A group of internal clinically based trainers will need to be maintained by the UHB. In addition to delivering training the trainers will be responsible for offering clinical advice before, during or following an incident and will ensure that best practice and developments in national strategy are upheld.

10 TRAINING

10.1 Cardiff & Vale UHB is committed to ensuring that the opportunity for staff to attend training is made available.

10.2 All staff involved in SIMA should receive relevant training, which should be updated at least annually.

10.3 A central record will be maintained of staff attending SIMA training.

10.4 The assessment of staff capability to undertake SIMA techniques in clinical incidents is the responsibility of line managers through performance review.

10.5 All staff members will be individually responsible for ensuring that they are applying up to date knowledge and skills in practice and must identify any training needs to line Managers.

10.6 Staff to be made aware of the Procedure through the University Health Board Communication systems. Additionally, Line Managers, Departmental Managers, Senior Nurses, Divisional Managers and Directors are responsible for ensuring that all staff are aware of and have access to this document.

10.2 Skills training: Clinical staff will attend annually for the training specific to their service group to update their skills in dealing with incidents.

11 IMPLEMENTATION

11.1 The UHB Quality and Safety Committee will monitor the implementation of this procedure. This will be reinforced within Divisions at ward and department level.

11.2 Ward Managers will ensure that all necessary training is given to staff to ensure the execution of this policy.

11.3 The training coordinator will monitor and record wards and individuals attendance at annual training.

12 AUDIT

12.1 All incidents to be recorded on Clinical Incident Reports DATIX.

12.2 An audit of compliance against this policy will be carried out periodically, or if there is any change in legislation.

13 DISTRIBUTION

13.1 This procedure will be circulated to the Divisional Heads of Nursing, Divisional Managers and Directors for further dissemination.
It will also be available on the UHB intranet.

Appendix 1

CONSIDERATIONS WHEN MANAGING SITUATIONS OF AGGRESSION OR VIOLENCE (MENTAL HEALTH).

As one would expect staff should endeavour to prevent situations developing and de-escalate them early on if possible. If de-escalation is successful and prevents an incidence of violence please document this on an incident form.

Situations of Aggression or Violence where safe-holding (restraint) is used.

Unit nurses should, wherever possible, lead the situation.
If assistance is called via the 2222 system or similar system, the attending Response team (bleep carriers or nurses called from other areas) are there to assist/support as necessary. Their attendance does not imply that the staff of the unit they are attending can now withdraw from the incident. At least one member of the unit' staff should be present. This person should be familiar with the patient and the current situation.

During incidents.

One member of staff **must** lead the process**.** This will normally be the person managing the head when the patient is being safe-held on the floor. Ideally this should be a qualified nurse but this is not always possible. The team should, ideally, consist of staff of the same gender. If this is not possible a member of staff of the same gender **must** be present at all times. The cultural needs of the patient should also be considered and respected where possible.

The lead/head person will:

- Ensure the safety/wellbeing of all involved. E.g. Is the patient's airway clear? Do they have good circulation? Is the patient injured? Are staff tired or injured in any way?
- Lead the process of safe-holding/restraint. Seek to continue the de-escalation process, speaking calmly and attempting to engage the patient in the process.
- Co-ordinate any changes of staff.
- Co-ordinate the safe administration of prescribed medication if appropriate. This may be oral or IM (if appropriate).
- Ask for the patients physical observations to be recorded if possible. (e.g. O2 sats, Pulse, Resps, BP and Temp).
- Ask for the ward or duty SHO to attend after 20 minutes or earlier if required.

On the incident form note:

EG:

- Details of why the incident occurred.

- Name of lead person. Names of staff (not initials) involved and their position e.g. left arm, right arm, etc.
- Was de-escalation effective? Was 2222 called? How long safe-holding / restraint lasted.
- Was medication given? Which site? By who?
- Was the duty SHO asked to review the patient? Was a body map completed? Were any injuries apparent?

NB If sufficient room is not available on the form for the information, a supplementary sheet can be attached or reference to PARIS notes made.

Following the incident:

A 'debrief' can be helpful in ensuring the wellbeing of the staff and patient. Ask staff if they feel the situation was handled sensitively and safely? Are they ok? Do they need support? Is the patient ok? When calm offer an explanation to the patient. Discuss and record their feelings or concerns.

Importantly please:

- Ensure a Care and Treatment plan (CTP) re: violence/aggression is in place.
- Review & update any existing care plan,
- Review and update the Risk Assessment and Management plan.
- Review the patient' levels of observation. Do they need to be changed?
- Physical obs. (Pulse, Resps, BP and O2 sat levels) should be recorded every 15 minutes initially or more often, perhaps every 5 minutes, especially if rapid tranquillisation has been used. Equally, if the patient refuses to co-operate this should be recorded.

(continued…)

- Complete a body map of the patient as bruises may be evident.
- Note also if and why it was not possible to record physical Observations, as this demonstrates that staff did in fact consider them.
- Ask the ward or duty SHO to review the patient.
- Advise the shift co-ordinator if there is likely to be a delay as another doctor may need to be asked to attend (especially out of normal hours).
- Check the patient, staff and other patients are ok. They may be fine initially due, in part, to adrenalin but later may be subdued or distressed.

Remember the intention of Rapid Tranquillisation is to calm the patient and not sedate him/her to the point that they cannot be roused.

Delivering personal care to resistive/aggressive patients.

If patients are resistive to; EG having their essential personal care needs attended to, staff must assess their Mental Capacity. If they are found to lack Mental Capacity, staff must then complete a best interest form to permit and justify their need to carry out that particular intervention. This safeguards the patients' rights and helps ensure staff interventions are in the patients' best interests. A care plan and record entry needs to reflect the need for the interventions. Risk assessments and management plans need to be updated etc.

Contact **MCA lead Julia Barrell Tel: 743652** if advice or training is required.

For **Mental Health Act** issues ring **Tel 20336471, 20336513, 20336317**

Assaults against Staff.

If staff have been assaulted and wish to take legal action against the perpetrator, they should contact the police giving details and ask for a crime/incident number. They should then contact the Health Boards **Case Manager Carl Ball at H&S on Tel No. 20746434**. The case manager will guide them through the process and can put them in touch with other support systems such as the **Wellbeing service**.

Please contact me on **20336321** if further assistance is required. Alternatively via email at: mike.lewis3@wales.nhs.uk

Mike Lewis - Management of Violence & Aggression Training.

Appendix 2

PHYSICAL INTERVENTION / RESTRAINT RECORDING CHART.

Patient's name: _____PARIS
ID:_____DOB_____

Ward/ Area_____

Points to Remember.

1. **Advise shift coordinator of situation.**
2. **Contact SHO before or at 20 minutes.**
3. **Monitor the patient during/following safe-holding/restraint & following the use of medication.**
4. **Review the patient and level of Observations following cessation of safe-holding.**
5. **Complete an incident form. (+ body map if injury evident or suspected).**

To be completed every 15 minutes (sooner if required).

Date	Staff Name	Signed	Time of restraint / entry	Time restraint stopped	Observation Notes: E.g.: patients' condition during restraint. Physical obs. BP, Pulse, Respirations and O2 levels. Interactions. Difficulties encountered.

Appendix 3.
Please use the section below to identify the position of any marks, bruising or other injury that are a result of use of safe-holds.