

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Therapeutic and Safe Intervention and de-escalation (TASID) the management of Violence and Aggression

The Therapeutic and Safe Interventions and De-escalation training model the Trust have adopted underpins all the principals of the Restraint Reduction Network (RRN) Training Standards 2019 where the focus is on prevention strategies. TASID adopts the world health organisation's approach to reducing violence and aggression Primary Secondary and Tertiary.

Use a restrictive intervention only if de-escalation and other preventive strategies, including p.r.n. medication, have failed and there is potential for harm to the service user or other people if no action is taken. Continue to attempt de-escalation throughout a restrictive intervention. Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance.

Ensure that the techniques and methods used to restrict a service user:

- Are proportionate to the risk and potential seriousness of harm.
- Are the least restrictive option to meet the need.
- Are used for no longer than necessary.
- Take account of the service user's preferences, if known and it is possible to do so.
- Take account of the service user's physical health, degree of frailty and developmental age.

1.0 Decision Making for the Use of Physical Intervention/Restraint Tertiary

- 1.1 Where risk assessments identify that physical intervention/restraint may be needed, their implementation should be planned in advance and recorded as tertiary strategies within the positive behaviour support plans (or equivalent).
- 1.2 On other occasions, behavioural disturbance may not have been predicted by risk assessments. In such cases emergency management of the situation and the use of physical intervention/restraint should be based on clinical judgement which takes account of relevant best practice guidance (such as those published by the National Institute for Health and Care Excellence (NG10)) and all available knowledge of the patient / resident's circumstances.
- 1.3 Restrictive interventions should be used in a way that minimises any risk to the patient / resident's health and safety and that causes the minimum interference to their autonomy, privacy and dignity, while being sufficient to protect the patient / resident and other people. The patient / resident's freedom should be contained or limited for no longer than is necessary. Unless there are cogent reasons for doing so, staff must not cause deliberate pain to a patient / resident in an attempt to force compliance with their instructions (for example, to mitigate an immediate risk to life).

- 1.4 The choice and nature of physical intervention/restraint will depend on various factors, but should be guided by:
- The patient / resident's wishes and feelings, if known (e.g. by an advance statement).
 - What it is necessary to meet the needs of the individual based on a current assessment and their history.
 - The patient / resident's age and any individual physical or emotional vulnerability that increase the risk of trauma arising from specific forms of restrictive intervention.
 - Whether a particular form of restrictive intervention would be likely to cause distress, humiliation or fear.
 - Obligations to others affected by the behavioural disturbance.
 - Responsibilities to protect other patient / residents, visitors and staff, and the availability of resources in the environment of care.
- 1.5 Any use of restrictive interventions must be compliant with the Human Rights Act 1998 (HRA), which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR).
- 1.6 Where an incident occurs, either spontaneously or as the result of a deterioration of a situation that has not responded to preventative strategies or de-escalation techniques and it is necessary to use advanced management interventions of Physical intervention / Rapid tranquilisation this is considered a Psychiatric Emergency and requires the presence of the following to ensure a safe conclusion of the incident:
- Alarm systems to summon other staff to assist in the management of the incident.
 - Grab bags must be available on all inpatient / resident wards / units containing Resuscitation Equipment, including Defibrillator, Bag Valve Mask, and Oxygen, suction, all of which must be contained in good working order
 - Attendance of a Doctor.
 - Site Co-ordinator upon arrival will be informed and updated on the situation.
- 1.7 For Nursing Homes where an incident occurs either spontaneously or as the result of a deterioration of a situation that has not responded to prevention strategies or de-escalation techniques and it is necessary to use advanced management interventions of Physical intervention / Rapid tranquilisation this is considered a Psychiatric Emergency and requires the presence of the following to ensure a safe conclusion of the incident:
- Alarm systems to summon other staff to assist in the management of the incident.
 - Grab bags must be available containing Resuscitation equipment including Defibrillator, Bag Valve Mask, and Oxygen, cannula, fluids, suction, all of which must be contained in good working order.
 - Nurse in Charge

- Contact Nursing Home Manager
- 1.8 Where a patient / resident is restrained unintentionally in a prone/face down position, staff should either release their holds or reposition into a safer alternative as soon as possible.
 - 1.9 In all circumstances where restraint is used one staff member must monitor the patient / residents head, airway and physical condition throughout the restraint to minimise the potential of harm or injury. Observations that include vital clinical indicators such as pulse, respiration and complexion (with special attention to pallor or discoloration) must be carried out and recorded. Staff must be trained to be competent to interpret these vital signs. If the person's physical condition and/or their expressions of distress give rise to concern, the restraint must stop immediately.
 - 1.10 Staff must continue to monitor the patient / resident for signs of emotional or physical distress for a significant period of time following the application of restraint.
 - 1.11 Staff must only use methods of restrictive intervention for which they have received and passed professional training. Training records must record precisely the techniques that a member of staff has been trained to use.
 - 1.12 A member of staff should take responsibility for communicating with the person throughout any period of physical intervention in order to continually attempt to de-escalate the situation.
 - 1.13 Staff must not cause deliberate pain to a person in an attempt to force compliance with their instruction. Where there is an immediate risk to life, in accordance with NICE guidelines, recognised techniques that cause pain as a stimulus may be used to mitigate that risk. These techniques must be used proportionately and only in the most exceptional circumstances and never for longer than is necessary to mitigate the risk to life. These techniques can only be used by trained staff having due regard for the safety and dignity of patient / residents.
 - 1.14 People must not be deliberately restrained in a way that impacts on the airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, ribcage and/or abdomen. There must be no planned or intentional physical intervention of a person in a prone/face down position on any surface, not just the floor. This will best be achieved through the adoption and sustained implementation of restrictive practice reduction programmes and the delivery of care pathways that incorporate Positive and Proactive Behaviour Support Plans or equivalent.
 - 1.15 Where unplanned or unintentional incidents of any restrictive practice occur there should always be recording and debrief to ensure learning and continuous safety improvements.

- 1.16 Staff must not deliberately use techniques where a person is allowed to fall, unsupported, other than where there is a need to escape from a life threatening situation.
- 1.17 Staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purposes of an immediate rescue in a life threatening situation.
- 1.18 Prone restraint should not form part of a planned intervention and must be viewed as an unplanned event. There may be exceptional circumstances where a patient / resident may request to be restrained in the prone position and these will need to be discussed as an MDT with the patient / resident to explore the reason for this request and appropriate plan recorded and circulated to all staff.

2.0 Using Physical Intervention/Restraints

- 2.1 When a decision to use physical intervention has been made the Nurse in charge should where ever practical carry out the following actions:-
- Assemble a physical intervention team.
 - Inform the team of what the patient / resident is likely to do.
 - State any possibility of infection and take appropriate precaution.
 - Direct other staff not involved in the physical intervention with tasks such as removal of obstacles, management of other service users etc.
 - Feeding in substitute members of staff where fatigue or injuries dictate.
 - Prepare Rapid tranquilisation medication when this decision is made.
 - Prepare the seclusion room (if appropriate) if this decision is made.
 - Ensure the attendance of a doctor / duty doctor.
 - Ensure Emergency resuscitation equipment is present at the incident.
- 2.2 The designated team if possible and time allows should determine team roles, especially the allocation of the lead for the physical intervention who will take on the responsibilities listed below. Be briefed on the situation and possible causes and determine a plan of management of the incident including expected outcome of the physical intervention.
- 2.3 One member of staff should assume control throughout the process. He or she is responsible for:-
- Liaison with the nurse in charge.
 - Maintaining de-escalation techniques with the patient / resident and creating a dialogue of communicating the actions the team will take with the patient / resident to achieve a quick and favourable outcome.
 - Setting out for the patient / resident the clear, positive instructions and expectations of behaviour that will end the use of physical intervention.
 - Respond to and reinforce all compliance by the patient / resident.

- Protecting and supporting the patient / residents head and neck, where required. (The protection of the head constitutes a duty of care owed to the patient / resident).
- Ensuring their airway and breathing are not compromised.
- Ensuring vital signs are monitored.
- Leading the team through the process by giving clear instructions and relevant information.

2.4 If a physical intervention ends up on the floor a head person must physically be in place or an identified member of the team accepts that responsibility. In exceptional circumstances if this is not practicable (possibly due to environmental factors) then another member of staff must take over the roles and responsibilities of the head person as outlined above.

Other considerations for the use of physical intervention must include.

- Strict avoidance of excess weight being placed on any area, but particularly the areas of fingers, head, neck, thorax, abdomen, back or pelvic area.
- Where possible the use of at least one same staff to patient / resident gender especially where female patient / resident physical intervention is concerned, if necessary substitute physical intervention staff as required and safe to do so.
- Determining the end of Physical intervention must be the decision of the physical intervention team leader. They should take into account where appropriate advice from other physical intervention team members the Doctor and Nurse in Charge and considered factors such as:-
- Has the patient / resident calmed sufficiently for physical intervention to be terminated. If so what follow up interventions are to follow? I.e. observation levels, movement to low stimulus environment etc.
- Has physical intervention been used for an excessive amount of time with no response from the patient / resident? Consider Rapid Tranquillisation and or Seclusion as alternatives to lengthy physical intervention with attendant risks.
- Maintain continual assessment of the patient / resident to enable early reintegration into the main ward environments.

2.5 When physical intervention has been used, staff must report the incident on Datix and include all the restraint details. Following any violent incident event in mental health and learning disability services, the priority is reconciliation. The continued development of the therapeutic relationship between staff patient / resident can be enhanced by the acknowledgement of any incident event. Ideally on the day following any incident where appropriate staff and the patient / resident should meet to discuss the event, the rationale for any procedures used, triggers and causes of the incident and plans regarding how future incidents may be avoided.

2.6 In Community Health Services a post incident review would be undertaken prior to any future service provision to the patient / resident.

3.0 Post Incident Management

- 3.1 Account for all patient / residents and staff ensuring their safety and wellbeing, (incidents have been used to distract staff to allow other patient / residents to self-harm or abscond etc.). Determine the safety of the environment for continued care of patient / residents.
- 3.2 A Doctor must examine the patient / residents for physical injuries especially where an injury has occurred or is suspected and or adverse symptoms are observed this might include breathlessness, fainting or potential head trauma. This examination must be recorded in the healthcare records. Any injuries or adverse symptoms of the patient / resident, staff or others must be reported.
- 3.3 Nursing staff must carry out basic vital signs observations as soon as possible after the event especially if physical intervention and rapid tranquilisation procedures have been used. This should be repeated up to every 4 hours (more frequent if necessary) and for up to a period of 24 hours minimum and recorded on a MEWS chart. After this period the Doctor and Nurse should decide if monitoring should continue on a regular basis if necessary.
- 3.4 In conjunction with the Doctor, make an assessment of the patient / resident potential to relapse consider all possibilities regarding safety, including observation status and staffing levels. Consideration must be given that includes transfer to more secure services such as a Psychiatric Intensive Care Unit (PICU).
- 3.5 If required inform senior management of the incident and the seriousness of the incident. Update frequently on actions taken.
- 3.6 Anyone present at the time of the incident will be offered immediate debrief support this includes staff, patients / residents and visitors who were involved or in the area.
- 3.7 If there are 5 incidents with 1 patient / resident in 1 week a review needs to be undertaken with someone not involved in the incident.
- 3.8 All incidents of prone restraint must be reviewed and lessons learnt.
- 3.9 Patients / residents should be given the opportunity to record and have filed within their healthcare records their view and account of their experience, including that of any intervention used.