NHS GREATER GLASGOW AND CLYDE

Guidance on the NHS GGC Restraint Policy (December 2014)

‘The reduction of restraint within healthcare.’

This document must be read in conjunction with the NHS GGC Restraint Policy 2014.

April 2016

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1. Introduction

Violent incidents are more likely to occur in inpatient settings, in particular acute admission wards and some other speciality areas. This is because patients are more acutely ill, and therefore more likely to misinterpret what is going on around them as well as being less able to control their impulses. It is also because these highly ill patients are in an environment in close proximity with each other, and because that environment is highly regulated. Finally, because some inpatients are admitted because they are known to be a risk to themselves and others when ill, and are detained against their will under the Mental Health Act 2003, they are already stressed and distressed. In combination, these factors can produce a tense atmosphere that provides many potential triggers to aggression.

While violence is a higher risk in inpatient areas, it is also the location with the most skilled staff in the highest numbers. These staff can act in ways that avert stressed or distressed behaviour from occurring through the avoidance of flashpoints, distraction, skilled communication and patient management. Speedy and effective medical treatment can also reduce symptoms and therefore risk of stressed or distressed behaviour. However, should such behaviour be imminent or actually occur, staff require the necessary skills to manage the patients so as to prevent harm to themselves, other patients and the staff, while maintaining the patient’s dignity and respect and minimising any coercion applied.

There are a number of stages of care management whereby a range of alternatives to restraint must be considered, before any form of restraint is considered.

This guidance document covers the hierarchy of management control measures which must be considered including a robust assessment of patient needs. It is however recognised that in certain situations the application of physical restraint is the only viable option available to staff charged with the prevention of harm to the patient or others. It is acknowledged that the application of physical restraint can present a high level of risk to the patient and to the staff participating, who may be required to justify that these risks are less than the risk of not applying restraint. Staff must ensure that the safe balancing of these risks is achieved through a robust process of informed assessment, topical education and the utilisation of a staff team who have been trained to an acceptable level of practical competency.

Over the past thirty years there have been more than fifteen restraint related deaths occurring in health and social care settings within the United Kingdom. This statistic indicates the inherent risks associated with restraint, and emphasises why the organisation must have an effective Policy and guidance in place, to minimise these risks.

2. Guidance Aims

This guidance document must be read in conjunction with the NHS GGC Restraint Policy. (December 2014).

The aim of this guidance is to provide clear direction for staff in relation to the appropriate and safe use of restraint. The guidance will explain the legal, ethical and professional issues which must influence any decision to restrain. Alternatives to restraint must always be initially considered.

While the provision of healthcare will be delivered in a manner which protects the rights of the patient, it is recognised that where legally and ethically justifiable, restraint will be used as a last resort to maintain patient or staff safety.

The guidance will assist in ensuring that staff will be informed and supported towards making the correct decisions regarding the application of restraint, or the consideration of other potential alternatives.
All incidents requiring any degree of patient restraint will be governed through the implementation of the Restraint Policy, this associated guidance and by competently trained staff.

3. Definitions of Restraint

The NHS GGC Restraint Policy uses the following definition:

‘Restraint is taking place when the planned or unplanned, conscious or unconscious actions of staff prevent a patient (or other) from doing what he or she wishes to do and as a result places limits on his or her freedom. Restraint is defined in relation to the degree of control, consent and intended purpose of the intervention.’

Rights Risks and Limit to Freedom – Mental Welfare Commission 2013

Further detail on the definition is provided in the GGC Restraint Policy.

4. The Responsibilities of the Employer

NHS GGC is responsible for:
• Providing a safe working environment in line with Health & Safety legislation.
• Providing healthcare in a safe and efficient manner.
• The full and effective implementation of the Policy and guidance.
• Ensuring that the risks associated with restraint are subject to a robust process of assessment and evaluation.
• Providing the resources required to train staff on all aspects relating to violence reduction and safe restraint.
• Ensure that incidents involving restraint are monitored and investigated as appropriate by senior management.
• Ensure that the Restraint Policy and associated guidance is reviewed every three years to maintain both efficacy and topicality.

5. The Responsibilities of the Employee:

Senior Managers are responsible for:
• Ensuring that all Service/Departmental Managers are aware of this guidance and of the requirements within it.
• Ensuring appropriate systems and processes are in place to support documentation of patient clinical risk assessment and management plans.
• Ensuring that strategies are in place to reduce and manage risks, and to monitor the ongoing effectiveness of these strategies.
• Providing the mandatory training for all staff that may be expected to undertake any element of restraint.
• Ensuring that all aspects of the guidance contained within the Incident Management Policy are being rigorously followed.
• Promoting the implementation of post incident support strategies for those individuals who may be adversely affected by restraint issues. (patients, visitors and staff)

Service/Departmental Managers are responsible for:
• Ensuring that all staff are aware of this guidance and the requirements within it.
• Ensuring the completion of documentation relating to individual patient care needs, risk assessments and appropriate management plans.
• Implementing the strategies that have been identified to reduce and manage risks, and that these strategies are regularly monitored and reviewed.
• Communicating the outcomes of risk assessments to ensure that staff and senior management are fully aware of the identified risks and the measures required to reduce and manage them safely.
• Ensure attendance of their staff to the level of mandatory training identified through risk assessment and training needs analysis.
• Ensuring that staff adhere to all aspects of the guidance contained within the Incident Management Policy are being rigorously followed.
• Accessing the specialist advice and support available from the Health and Safety Service and the Violence Reduction Service.
• Facilitating the implementation of post incident support strategies for those individuals who may be adversely affected by restraint issues

All staff are responsible for:
• Taking reasonable care of themselves and any others who may be affected by their actions or omissions.
• Adhering to all policies and procedures that have been designed to promote safe and effective working practices.
• Contributing to the risk assessment process and adhering to the methods of intervention identified within the patients care plan.
• Attending the designated level of mandatory training which includes the safe usage of restraint procedures.
• Reporting all incidents and near misses in accordance with the guidance contained within the Incident Management Policy.
• Reporting any concerns or dangers identified in relation to the implementation of restraint procedures.

6. Alternatives to Restraint and Management of Behaviour

6.1 Where possible, restraint should be a last option following a full consideration of all other reasonable alternatives. Where there is an emergency situation, and the time taken to consider other alternatives would leave the patient or others exposed to harm or danger, restraint must be applied immediately.

6.2 When a patient’s behaviour is presenting a recurring level of exposure to risk, staff should try to avoid focusing solely on managing the behaviour. A viable option in this instance may be for staff to focus their attention on the underlying factors which are causing the problem behaviour.

6.3 When restraint is being considered as a feature within a patient’s individualised care-plan, the following factors should be considered:

• Is there an aim to the patient’s behaviour?
• What is the patient’s emotional/psychological condition?
• Are there any underlying conditions present?
• Is there an environmental impact on the behaviour?
• What is the patient’s mental capacity?
• Are there any risks associated in restraining this patient?
• Are there any communication issues?
• Is the patient cognitively impaired?
• Is the patient detained under the Mental Health Act?
• Have relatives, carers, Named person been involved in developing the plan of care?
• Are there any issues of equality and diversity?
6.4 Where possible the issues identified should be addressed using a therapeutic approach designed to have a positive impact on the patient's behaviour, therefore reducing or removing the need to apply restraint. It is important to have a range of different therapeutic activities and opportunities for staff.

6.5 There are some patient groups which may require an adapted specialist approach within the hierarchy of restraint. These are identified in this list – which is not exhaustive:

- Older people with a sensory or cognitive impairment
- People with a cognitive impairment
- People with a learning disability
- People with major / acute mental health problems
- People for whom English is not a first language
- People with sensory impairments
- Children and young people
- People with a brain injury
- People with a learning disability
- Pregnant women

If advice is required in relation to the above patient group, staff should contact the Violence Reduction Service within Mental Health Services, or Health and Safety Services - Management of Violence and Aggression Service. Further guidance on the use of restraint within the Learning Disability Service, Children’s Specialist Services and the Older Peoples Service, can be obtained by contacting their respective clinical management team. Advice can also be sought via the Psychiatric Liaison Service and the Interpreting Service.

7. Types of Restraint?

Types of restraint are detailed in the Restraint Policy. An overview is as follows:

7.1 Physical Restraint (Safer Holding)

This involves one or more members of staff holding the patient, moving the patient, or blocking their intention to move away from an area.

7.2 Psychological Restraint

This can involve staff telling patients what they can and what they cannot do i.e. to stay in a chair, to go to bed, not to leave the ward. It may also include removing their possessions or denying them access to vital equipment i.e. withholding glasses, shoes or walking aids can effectively restrict patient movement. Procedures where staff directly and constantly observe the patient, or where the patient is placed under escort, can also be defined a psychological restraint.

7.3 Mechanical Restraint

This involves the direct or indirect use of equipment to restrict a patient from moving. Typical examples of this are locked doors, bedrails, chairs with a harness, or strategically placed pieces of furniture. This type of restraint is illegal and not permitted.

7.4 Technological Surveillance

This involves the use of electronic tagging, pressure pads, and door alarms to alert the staff that the patient is moving or trying to leave the area. Closed circuit television can also be employed to monitor patient movement or behaviour.
7.5 Chemical Restraint

This involves the administration of medication designed purely to control or moderate a patient’s movement or behaviour. It includes the use of covert methods of dispensing such as concealing medication within the patient’s food or drink. It also includes the administration of medication against the patient’s will. This type of restraint is illegal and not permitted.

For further information please refer to Rapid Tranquillisation Guideline. (available on StaffNet)

8. Is Restraint Legally and Ethically Justifiable?

8.1 Alternatives to restraint must always be initially considered.

8.2 Restraint is legally justifiable when the patient gives informed and voluntary consent as part of a planned programme of care. In other instances there may be a professional duty of care to restrain a client in order to protect them from a greater risk of harm, or to prevent any foreseeable harm to staff or others. Chemical and mechanical restraint would not be regarded as legally or ethically justifiable in this context.

8.3 Restraint is ethically justifiable when the staff are able to demonstrate that the risk of harm arising from the application of restraint is less than the risk of harm present without staff intervention. Staff must attempt to maintain a balance between their duty to provide care and the need to maintain the patient’s rights.

8.4 Whenever restraint is applied, staff must adhere to these universal principles:
- The patient’s behaviour must be causing or have the potential to cause harm to themselves, to others, or in certain circumstances, to property.
- All alternatives to restraint must be considered and where appropriate implemented (except in emergency situations, see section 12)
- Any form of restraint must be a necessary last option, and must be proportionate in relation to risk, degree and duration.
- Restraint must not be used for retaliation, retribution, or to make up for any shortfall in service provision.

Restraint may also be justifiable when:
- A patient requires treatment and/or the need to be maintained in a secure environment by a legal order i.e. under the Mental Health (Care and Treatment) (Scotland) Act 2003.
- Common Law – Self defence – ‘Any person may use such force as is reasonable in the circumstances in defence of themselves and others and in certain circumstances, property’.

It is therefore recognised at common law that there are occasions and circumstances where a person may use force on another without committing an offence. At Common Law force can therefore be used to:
- Prevent or ward off unlawful force (assault)
- Rescue another person from attack or prevent an attack
- Avoid or escape unlawful detention

In such circumstances the force used must be reasonable and no more than is necessary to repel any attack. It is also accepted that a person does not have to wait to be attacked. It may be lawful therefore for a person to act first in order to prevent an assault on themselves or another.
Force must be necessary, reasonable and proportionate.

Protecting property – Under common law we can also act to protect property. Use of force should only be used in the most serious of instances and the safety of staff and service users takes a high priority.

Saving life – At common law this power to use force to protect life also includes action to save life. This will include for instance surgical procedures to either promote recovery or prevent worsening of a life threatening condition. Force has also been used in order to protect the lives of individuals who have been self harming. The defence of necessity has been used in cases involving mental capacity and consent, where a decision to save or assist someone’s life without their consent has had to be made. The principle of best interest is the key to the doctrine of necessity; once necessity has been proven, the unlawful act is then justified.

9. Associated Legislation and Guidance

9.1 Human Rights Act (1998)

Ensures that the patient’s human rights are respected by all public authorities, making it unlawful to act against these rights. The articles of the act which are relevant to restraint are:

Article 2 – Right to life.
A person has the right to have their life protected by law. Staff may use restraint and force to stop and prevent imminent threat to life or serious harm being caused.

Article 3 – Prohibition from torture including inhumane or degrading treatment.
This right is referred to as an “absolute right” and should never be contravened. It is therefore unlawful for any person to use force with the intention of causing inhumane or degrading treatment and or punishment or for the purpose of torture.

Article 5 – Right to liberty and security.
This right is referred to as a limited right, which in some specific circumstances may be legitimately taken away i.e. if a person is arrested on a criminal charge. Under Common Law staff may have to remove a patient’s liberty in order to prevent them causing harm to themselves or to others.

9.2 Adults with Incapacity (Scotland) Act 2000

This Act provides a system for safeguarding the welfare and managing the finances and property of adults (age 16 or over) who lack the capacity to take some or all decisions for themselves because of mental disorder or inability to communicate by any means. It allows other people to make decisions on their behalf subject to attaining the following general principles:

- It must benefit the adult
- It must take into account the adult’s past and present wishes.
- It must restrict the adult’s freedom as little as desirably possible
- It must support the adult to maximise and develop their skills.
- It must consider the views of others with an interest in the adult’s welfare.
9.3 Mental Health (Care and Treatment) (Scotland) Act 2003

This law is based on a set of principles which must be taken into account by anyone involved in a person’s care and treatment. These principles can be summarised as:

- The patient’s past and present wishes. Information should be provided which supports the patient in taking part in decisions relating to their care.
- The views of their named person, carer, guardian or welfare attorney. Where appropriate others who can provide the patient with both support and guidance should be involved in the decision making process.
- The care and treatment that will be of most benefit. The nature of the treatment, including any strategies to manage behaviours should be identified within the patient’s care plan.
- The patient’s abilities and background. Important issues relating to equality and diversity must be taken into account by people providing care and treatment i.e. age, gender, racial origin, religion, sexual orientation, ethnicity.

9.4 Common Law

Common law allows direct physical intervention to be applied by staff in an emergency to safeguard patient’s who, due to a clinical presentation and behaviour, place themselves or others in a situation of imminent danger or harm. While common law may allow the application of restraint as a means of restricting movement or denying liberty, staff should as soon as appropriate seek official verification of any of their actions from within recognised legislation.

The application of common law must not be utilised as an alternative, or as a substitute for training staff to an appropriate level. Where there is a foreseeable requirement for the direct implementation of restraint, staff working within this area must receive the required skills and training to perform this intervention safely.

10. Duty of Care

10.1 All staff have an inherent duty of care to the patients who are receiving treatment. This means that they should always act in the “best interests” of the patient. In relation to a patient who may be in a situation of immediate risk, restraint may form part of this duty of care.

10.2 Within this duty of care there are four main principles:

- **Beneficence** – the intent to do good for the patient.
- **Justice** – to treat all patients fairly and equally.
- **Autonomy** – support/respect right to self determination.
- **Non-maleficence** – the intent to cause no harm.

10.3 There may be situations in which these principles seem to be in conflict with each other i.e. in order to do good for the patient (Beneficence) staff may have to compromise the right to self-determination by using restraint (Autonomy)

10.4 Duty of care is also set out in law to ensure that individuals who are owed a duty of care do not suffer any unreasonable harm or loss.

10.5 In addition, a duty of care will exist between colleagues. The application of restraint may then be required in order to safeguard the health and wellbeing of another member of staff.
11. Training for Physical Restraint (including Training Needs Analysis)

11.1 The identification of the training level required should be made through risk assessment and the completion of a training needs analysis form, which is part of the documentation for the management of violence and aggression policies and guidance.

11.2 In areas where the application of restraint is foreseeable, staff must attend mandatory training to ensure that they are able to perform physical restraint techniques in a safe and controlled manner. There is a collective responsibility present, between the management and the staff, which clearly directs that this training, in the interests of patient and staff safety, must be attended. Within Acute and Mental Health environments, training needs analysis must be undertaken to establish training requirements.

11.3 The provision of theory, whether delivered by e-learning or in a classroom, is designed to give staff the information required to prevent situations escalating to a critical point where restraint may be required. The focus of training for staff in the first instance is based on de-escalation and violence reduction. Such courses can be up to one day in duration in a classroom environment.

11.4 The provision of practical sessions is designed to equip the staff with the skills required to breakaway and physically disengage from an assault, or how to apply restraint techniques in a safer manner. Unless it is an emergency situation, staff should not participate in restraint until they have competently acquired these skills.

11.5 There are officially recognised levels which relate to the number of staff required to safely apply physical restraint:
   • Where a patient needs to be restrained in a standing or sitting position, two members of staff are required as a minimum number.
   • Where a patient needs to be restrained on the floor in a prone or supine position, in an emergency situation, three members of staff are seen as a minimum number (four is best practice).

NHS GGC advocates that, in situations which are other than an emergency, staff must not apply restraint in a one to one basis.

11.6 In situations where there is an insufficient number of competently trained staff available, alternative measures such as external support e.g. Police or security, or containing the issue in one location, should be considered – this may minimise risks to other patients, visitors and staff.

11.7 In exceptional circumstances staff may be required to use their individual judgement, skill and knowledge to intervene alone using reasonable force for the purpose of preventing harm to themselves or others.

11.8 Training needs analysis- This process is undertaken to formally evaluate the training development requirements of staff so that they can carry out their job effectively and efficiently, and also continue to grow and develop their careers. A range of approaches may be undertaken to complete TNAs. This can include a comprehensive analysis of all training and development needs across an organisation, and can also be used to describe a detailed analysis of one individual’s training requirements. When carried out effectively, TNAs will have beneficial effects for the organisation, services and individuals, as the training will be tailored to the requirements of the receiving staff, and therefore enable them to undertake their role more effectively. TNAs can be applied at specialty level to establish staff training requirements.
12. Restraint in an Emergency Situation

12.1 If there is a potential that a patient may require restraint in order to safeguard themselves or others, the nature of restraint required must be documented within the patient’s care plan. This clinical process must be transparent, and should be fully discussed with the patient (where appropriate), with any family or carers, and with all other multidisciplinary professionals who are involved in the provision of care.

12.2 In an emergency situation, as a last option implemented with the clear intent to preserve safety and prevent harm, staff may be required to apply restraint in the following manners:

- By appropriately communicating **verbal instruction** or withholding vital personal possessions i.e. shoes or outdoor clothing.
- By **mechanical restriction** or by utilising other technology as a means to prevent a patient from leaving a safe environment.
- By **direct physical intervention** when danger is imminent and there is insufficient time to identify an alternative.
- By the **administration of medication**, often dispensed in conjunction with a degree of physical restraint.

12.3 In an emergency situation, where physical intervention is unavoidable, staff may be required to employ a measure of reasonable force. Staff must ensure that the actions taken must be proportionate to the risks present, and to justify that restraint was necessary in order to prevent harm. Where a patient needs to be restrained on the floor in a prone or supine position, in an emergency situation, **three members of staff** are seen as a minimum number (four is best practice).

Considerations within Accident and Emergency departments are covered in Section 19.

13. The Risks Associated with Restraint

13.1 Clinical issues

During the application of physical restraint staff must be aware that they have a clear responsibility to constantly monitor the patient’s current state of health and wellbeing. Staff must be aware that there are a range of clinical issues which must be considered at all times during any restraint procedure:

**Positional asphyxia** – caused by an inappropriate and excessive application of force in a manner that applies pressure to the patient’s torso, restricting their ability to breathe normally. This condition can also be caused by compressing the body into a position which inhibits the natural process of respiration.

**Obesity** – patients who are obese or who are carrying an excess of abdominal weight are at increased risk when restrained in a prone (face down) position. The excessive weight can become displaced upwards into the diaphragm severely limiting lung capacity.

**Drugs and Alcohol** - drugs taken for medical or recreational purposes, and/or an excessive consumption of alcohol, may produce conditions which serve to impair cardiac and respiratory functioning.

**Medical conditions** ranging from the common cold, and diabetes, to chronic obstructive pulmonary disease may have an impact on the patient’s ability to breathe during restraint.
Mental illness i.e. delusional beliefs where the patient is experiencing extreme fear, producing a catecholamine stress on the heart.

Physical condition i.e. pregnancy, where a pregnant lady should not be restrained on the floor or in a position which may restrict the free flow of blood to the mother and the unborn child.

Excited or agitated delirium can result in death due to exhaustion from mental excitement i.e. occurring due to mania, psychosis or stimulant abuse. The altered pain perceptions of patients in this state, in combination with extreme levels of fear, serve to generate an intensive need to prolong resistance until a state of collapse or death occurs.

Prolonged or intense struggles can serve to increase the body’s demand for oxygen from what may be an already compromised respiratory state.

13.2 Risks with physical restraint (Safer Holding)

Healthcare organisations should ensure that physical restraint is undertaken by staff who work closely together as a team, understand each other’s roles and have a clearly defined lead. The priority should always be to restrain in a standing or seated position. When using physical restraint, avoid taking the service user to the floor, but if this becomes necessary:

- Use the supine (face up) position if possible or
- If the prone (face down) position is necessary, use it for as short a time as possible.
- Where a patient needs to be restrained on the floor in a prone or supine position, in an emergency situation, three members of staff are seen as a minimum number (four is best practice).

Do not use physical restraint in a way that interferes with the service user’s airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose.

Do not use physical restraint in a way that interferes with the service user’s ability to communicate, for example by obstructing the eyes, ears or mouth.

Undertake physical restraint with extra care if the service user is physically unwell, disabled, pregnant or obese.

Aim to preserve the service user’s dignity and safety as far as possible during physical restraint.

Do not routinely use physical restraint for more than 10 minutes.

If restraint is required for periods in excess of 10 minutes consider rapid tranquillisation or seclusion as alternatives to prolonged physical restraint.

Ensure that the level of force applied during physical restraint is justifiable, appropriate, reasonable, proportionate to the situation, and applied for the shortest time possible.

One staff member should lead throughout the use of physical restraint. This person should ensure that other staff members are:

- able to protect and support the service user’s head and neck, if needed
- able to check that the service user’s airway and breathing are not compromised
- able to monitor vital signs
- supported throughout the process.
Monitor the service user’s physical and psychological health for as long as clinically necessary after using physical restraint.

14. The Role of Security Staff within GGC (GRI & QEUH)

14.1 In order to ensure consistency and safety, the security staff should be given the same level and method of training as that given to frontline clinical staff.

14.2 In extreme emergency situations, and only when the clinical staff are unable to preserve safety, security staff may be asked to assist the clinical staff in the application of restraint.

14.3 Security staff will only assist in the restraint of patients when they are specifically directed to do so, by the clinical staff that hold the responsibility for the patient. Clinical staff must remain with the patient during any restraint.

14.4 Security staff must not be left alone to supervise or directly observe a patient’s behaviour.

14.5 Security staff at QEUH have additional responsibilities and so will prioritise response based on relevant circumstances.

15. Communication and Restraint

15.1 It is best practice to ensure that during the application of restraint, clear communication between the patient and the staff is maintained. In situations where the potential for restraint is foreseeable, it may be appropriate to discuss this with the patient and/or next of kin, beforehand.

15.2 During restraint, in order to avoid confusion, one member of staff using clear and simple language should take the lead role in communication. A prior agreement must be reached by staff with regard to the consistent delivery of appropriate verbal communication.

15.3 Where practical following the application of restraint, the patient should be de-briefed in order to explain what happened and why this action was taken.

15.4 Where there are communication issues present due to a sensory impairment or to a language barrier, staff should access support and advice from senior clinical managers.

16. Restraint as part of a Care Plan

16.1 Each clinical area which holds a foreseeable risk of using any form of restraint must complete a risk assessment which clearly directs how the restraint related risks are being managed within that service.

16.2 Where a patient’s behaviour presents a recurring need for physical restraint, this intervention must be incorporated as a safety feature within an individualised care plan.

16.3 Prior to this decision being made, consultation must occur between the clinicians, the patient, nominated family or carers, and other associated professionals involved in the delivery of care.
16.4 Once made, the decision must be fully documented and should include:
• A formal risk assessment which identifies the behaviour and the level of restraint required to
  safely manage it.
• Any degrees of risk associated with the identified method of restraint and the actions that
  must be taken to control these risks.
• Clear identification of the restraint techniques required; why they are required, when they
  will be applied and who will be responsible for applying them.
• Clear identification of when the assessment should be reviewed, and who should be
  involved in the review.
• A description of the alternatives to restraint that have been previously implemented, and the
  reasons why they were unsuccessful.

16.5 Restraint should be used for the minimum period of time required. **The maximum time is 10 minutes.** It is therefore essential that the risk assessment process should be subject to
constant review and that the control measures remain clear, in accordance with the identified clinical need. The incident review process must consider communication processes with patients, carers and staff.

17. **Post Restraint Actions**

17.1 In line with the guidance given within the NHS GGC Incident Management Policy, all incidents must be officially reported via the Datix incident management and recording system.

17.2 The application of restraint carries the potential to inflict significant emotional impact on both patient and staff. Following restraint, where appropriate, an incident review should be facilitated by management as a means of providing support to the staff involved, and as a vehicle for reflecting on practice with a view towards the future development of existing skills. A debrief should be considered for staff, visitors and other patients who may be involved and/or observe restraint.

18. **Restraint within Mental Health**

Refer to local procedures in accordance with the Violence Reduction Service within Mental Health Services.

During 2014/15 restraint was recorded as being used in 3553 incidents within Mental Health Services – 87% of all the restraints within NHS GGC.

19. **Restraint within Acute Services**

19.1 Managing Violence and Aggression within Accident and Emergency Departments

The use of restraint within Emergency Care Medical Services (ECMS) was recorded on 94 occasions during 2014/15, which is 2% of all restraints for NHS GGC over that period.

When considering Accident and Emergency Departments, consideration must also be given to related assessment units, e.g. IAU.

In 2011, the Design Council published the report ‘Reducing violence and aggression in A&E: Through a better experience’. This report identified 6 profile types that may contribute to the development of violence and aggression, accepting that many patients exhibit the traits of more than 1 profile. This, as the report suggests, clearly makes the management of service users whose behaviour is violent or aggressive more complex and difficult. The profiles identified are those who are **clinically confused, frustrated, intoxicated, antisocial/angry, distressed/frightened and socially isolated.**
Significantly the report states ‘Intoxication, in particular alcohol consumption, is believed by staff to be one of the most significant contributors to violence and aggression in A&E departments’. The report also refers to ‘environmental factors playing their part, including waiting times, lack of information and boredom to name but a few’.

For the purposes of this guidance, it is recognised that violence and aggression in emergency settings can come from a number of sources outside of patients experiencing mental health crises. There are, however, key indicators, so it is important to identify at the earliest opportunity patients who are potentially more disposed to violent and aggressive behaviour, gathering (within reason) all available information, to help inform staff when making decisions to firstly try to prevent an episode and, if that is not possible, to manage any violent and aggressive behaviour that occurs.

The guidance on physical restraint and rapid tranquillisation referred to in this document may be used in adult emergency departments. Emergency department staff may also be involved in immediate post-incident reviews. The following issues must also be considered with emergency departments:

Liaison mental health
Healthcare organisations should ensure that every emergency department has routine and urgent access to a multidisciplinary liaison team that includes consultant psychiatrists and registered psychiatric nurses who are able to work with children, young people, adults and older adults.

Healthcare provider organisations should ensure that a full mental health assessment is available within 1 hour of alert from the emergency department at all times.

Staff training
Healthcare provider organisations should train staff in emergency departments in methods and techniques to reduce the risk of violence and aggression, including anticipation, prevention and de-escalation.
Healthcare provider organisations should train staff in emergency departments in mental health triage.
Healthcare provider organisations should train staff in emergency departments to distinguish between excited delirium states (acute organic brain syndrome), acute brain injury and excited psychiatric states (such as mania and other psychoses).

Staffing
NHS Greater Glasgow and Clyde should ensure that, at all times, there are sufficient numbers of staff on duty in emergency departments who have training in the management of violence and aggression in line with this guideline.

Preventing violence and aggression
Undertake mental health triage for all service users on entry to emergency departments, alongside physical health triage.
Healthcare provider organisations should ensure that emergency departments have at least 1 designated interview room for mental health assessment that:
  • is close to or part of the main emergency department receiving area
  • is made available for mental health assessments as a priority
  • can comfortably seat 6 people
  • is fitted with an emergency call system, an outward opening door and a window for observation
  • contains soft furnishings and is well ventilated
  • contains no potential weapons.
Staff interviewing a person in the designated interview room should:
- inform a senior member of the emergency nursing staff before starting the interview
- make sure another staff member is present.

Managing violence and aggression
If a service user with a mental health problem becomes aggressive or violent, do not exclude them from the emergency department. Manage the violence or aggression in line with local guidance and do not use seclusion. Regard the situation as a psychiatric emergency and refer the service user to mental health services urgently for a psychiatric assessment within 1 hour.

20. Restraint involving children /young persons

20.1 Staff training – CAMHS

Child and adolescent mental health services (CAMHS) should ensure that staff are trained in the management of violence and aggression. Training programmes should include the use of psychosocial methods to avoid or minimise restrictive interventions whenever possible. Staff who might undertake restrictive interventions should be trained:

- in the use of these interventions in these age groups
- to adapt the physical restraint techniques for adults adjusting them according to the child or young person’s height, weight and physical strength
- in the use of resuscitation equipment in children and young people.

CAMHS should have a clear and consistently enforced policy about managing antisocial behaviour and ensure that staff are trained in psychosocial and behavioural techniques for managing the behaviour.

CAMHS staff should be familiar with the Children Act 1989 and 2004 and the Mental Health Act 1983, as well as the Mental Capacity Act 2005 and the Human Rights Act 1998. They should also be aware of the United Nations Convention on the Rights of the Child.

20.2 Managing violence and aggression

Manage violence and aggression in children and young people in line with the recommendations for adults, taking into account:
- the child or young person’s level of physical, intellectual, emotional and psychological maturity
- the recommendations for children and young people in this section
- that the Mental Capacity Act 2005 applies to young people aged 16 and over.

Collaborate with those who have parental responsibility when managing violence and aggression in children and young people.
Use safeguarding procedures to ensure the child or young person’s safety.
Involve the child or young person in making decisions about their care whenever possible.

20.3 Assessment and initial management

Assess and treat any underlying mental health problems in line with relevant NICE guidelines, including those on antisocial behaviour and conduct disorders in children and young people, attention deficit hyperactivity disorder, psychosis and schizophrenia in children and young people, autism diagnosis in children and young people and autism.
Identify any history of aggression or aggression trigger factors, including experience of abuse or trauma and previous response to management of violence or aggression. Identify cognitive, language, communication and cultural factors that may increase the risk of violence or aggression in a child or young person.

Consider offering children and young people with a history of violence or aggression psychological help to develop greater self-control and techniques for self-soothing. Offer support and age-appropriate interventions (including parent training programmes) in line with the NICE guideline on antisocial behaviour and conduct disorders in children and young people to parents of children and young people whose behaviour is violent or aggressive.

20.4 De-escalation

Use de-escalation techniques for adults, modified for children and young people, and:
- use calming techniques and distraction
- offer the child or young person the opportunity to move away from the situation in which the violence or aggression is occurring, for example to a quiet room or area
- aim to build emotional bridges and maintain a therapeutic relationship.

20.5 Restrictive interventions

Use restrictive interventions only if all attempts to defuse the situation have failed and the child or young person becomes aggressive or violent. When restrictive interventions are used, monitor the child or young person’s wellbeing closely and continuously, and ensure their physical and emotional comfort. Do not use punishments, such as removing contact with parents or carers or access to social interaction, withholding nutrition or fluids, or corporal punishment, to force compliance.

20.6 Physical restraint

If possible, allocate a staff member who is the same sex as the child or young person to carry out physical restraint.

20.7 Mechanical restraint

Do not use mechanical restraint on children. Healthcare provider organisations should ensure that, except when transferring young people between medium- and high-secure settings, mechanical restraint in young people is used only in high-secure settings (on those occasions when young people are being treated in adult high-secure settings), in accordance with the Mental Health Act 1983 and with support and agreement from a multidisciplinary team that includes a consultant psychiatrist in CAMHS.

Consider using mechanical restraint, such as handcuffs, when transferring young people who are at high risk of violence or aggression between medium- and high-secure settings, and remove the restraint at the earliest opportunity.

20.8 Rapid tranquillisation

Use intramuscular lorazepam for rapid tranquillisation in a child or young person and adjust the dose according to their age and weight.
20.9 Seclusion

Decisions about whether to seclude a child or young person should be approved by a senior doctor and reviewed by a multidisciplinary team at the earliest opportunity.

Report all uses of seclusion to the organisation's management team or equivalent governing body.

Do not seclude a child in a locked room, including their own bedroom.

End of section.
Appendix One - Unapproved and Unsafe Physical Restraint Techniques

NHS GGC is affiliated to the General Services Association (GSA) which is a membership organisation for organisations and tutors trained in GSA Physical Intervention Skills.

The techniques taught are based on the original training system which was introduced by the Scottish Prison Service in the early 1980s. Since then the techniques have been comprehensively adapted away from the initial pain based system towards a method of intervention which maintains compliance in a caring, supportive and controlled manner.

Over the past thirty years there have been more than fifteen restraint related deaths occurring in health and social care settings within the United Kingdom. These fatalities identified some unapproved forms of intervention:

- Wrongful application of dangerous techniques. ie. basket hold, neck hold, hog tying.
- Multiple staff (more than 4) participating and applying poor technique, causing severe pressure to the neck and to the back of the patient.
- Restraining a patient face down on top of a bed or a sofa.

These identified forms of intervention present an unacceptable level of risk to patient safety and must not be employed within NHS Greater Glasgow and Clyde. Examples of dangerous techniques and poor practice are:
Basket Hold

In this position the patient’s arms are crossed around the front of the abdomen and secured by a member of staff positioned behind. This can be done in a seated or standing position by one or two members of staff. The inward and upward pressure on the patient’s abdomen serves to restrict the ability to fully extend the diaphragm therefore reducing lung capacity. If this procedure is applied when the patient is bent over (either seated or standing) the lung capacity is further compromised.

Neck Hold

Pressure exerted on the windpipe and/or on the carotid arteries the patient can quickly induce unconsciousness or death.

Hog Tying

The patient's arms and legs are held behind the back with the wrists and ankles crossed and secured by a member of staff. This produces a hyper-expansion of the chest wall which makes breathing difficult. If the member of staff is exerting a level of downward pressure, or if the patient has an excessive amount of abdominal weight, respiration will be compromised.

Poor Practice in Prone position

In order to restrict movement when a patient is being restrained on the floor in a prone position the staff must apply pressure to the edge of the shoulder. Placing direct pressure against the patient’s back (as depicted) severely impairs the capacity to expand the diaphragm and breathe. The technique in the photograph must not be used.
Appendix Two – Emergency and Non Emergency Flow Charts

Managers Actions

A service risk assessment on the use of restraint must be completed.

A training needs analysis form must be completed in order to identify a relevant level of training.

Staff Actions

Staff must attend the level of training identified as relevant to the area.

Staff must gain a level of competency and maintain these skills by attending a mandatory training update.

<table>
<thead>
<tr>
<th><strong>Emergency Restraint</strong></th>
<th><strong>Non- Emergency Restraint</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify appropriately trained staff. Identify approved restraint technique.</td>
<td>Explore other alternatives and document within patient care plan and medical records before using any method of restraint.</td>
</tr>
<tr>
<td>Implement emergency restraint procedure. Maintain good levels of patient and staff communication.</td>
<td>Decide on method required and document within patient care plan. Before application discuss the process with the responsible doctor and with the patient’s family.</td>
</tr>
<tr>
<td>Ongoing monitoring of the patient’s health &amp; wellbeing. Ongoing monitoring of the staffs’ health &amp; wellbeing.</td>
<td>Identify the competently trained staff who will initiate the restraint process. Maintain good levels of patient and staff communication.</td>
</tr>
<tr>
<td>If required, access internal support (Clinical or Security). If required, access external support (Police).</td>
<td>Apply identified method of restraint. Observe closely and record both current and subsequent responses to restraint.</td>
</tr>
<tr>
<td>Document support within patient care plan. Officially report the incident and restraint used. Plan for future restraint requirement. Initiate post restraint procedures.</td>
<td>Regular review, frequency according to clinical situation, to ensure that the requirement for restraint remains, and if the current application of restraint has been beneficial to the patient and to the service.</td>
</tr>
</tbody>
</table>
Appendix Three - References and Further Reading

References:

Adults with Incapacity (Scotland) Act 2000

Human Rights Act 1998

Mental Health (Care & Treatment) (Scotland) Act 2003

Royal College of Nursing “Let’s Talk About Restraint” 2008


NHS GGC “Emergency Sedation Protocol” 2013

NHS GGC “Incident Management Policy” 2014

Further Reading:

Care Commission and Mental Welfare Commission “Remember I’m Still Me” 2009


Health & Safety Executive “Violence and Aggression to staff in health services - guidance on assessment and management. 2003


UKCC (now NMC 2001) "The Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care", UKCC, London
Appendix Four – Generic Risk Assessment documentation

Mental Health Services (currently under review)
Clinical Risk Screening and Management Tool

<table>
<thead>
<tr>
<th>Service Users Name</th>
<th>Chi &amp; Dob</th>
<th>PIMS No</th>
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</thead>
<tbody>
<tr>
<td>Keyworker:</td>
<td>Ward/Dept/CMHT:</td>
<td>Date:</td>
</tr>
</tbody>
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Legal Status:
- Informal [ ]
- Detained [ ]
- Community Order [ ]
Consultant Psychiatrist: [ ]

Context of Assessment:
- Inpatient Admission [ ]
- Initial Engagement with Service [ ]
- Engagement with Crisis Services [ ]
- MDT / C.P.A. review: [ ]
- Annual update: [ ]
- Significant change in presentation [ ]
- Transfer to other aspect of Service [ ]
- Other: [ ] specify

Sources of Information:
- Service User [ ]
- Carer [ ]
- Consultant [ ]
- Other Dr. [ ]
- Occupational therapy [ ]
- Named Nurse [ ]
- Social Work [ ]
- Psychology [ ]
- CPN [ ]
- Voluntary Agency Worker [ ]
- Pharmacy [ ]
- GP [ ]
- Support Worker [ ]
- Other [ ] specify

### Suicide/Self-Harm

<table>
<thead>
<tr>
<th>S1. Mental illness diagnosed or diagnosis uncertain</th>
<th>V1. Previous violent acts</th>
<th>O1. Vulnerable due to learning Disability, Cognitive impairment or mental illness</th>
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</thead>
<tbody>
<tr>
<td>S2. Use of violent methods</td>
<td>V2. Use of weapons</td>
<td>O2. History of stalking others</td>
</tr>
<tr>
<td>S3. Previous self-harm</td>
<td>V3. Previous Admission to secure units</td>
<td>O3. History of social, financial or sexual exploitation of others</td>
</tr>
<tr>
<td>S5. Past diagnosis of personality disorder</td>
<td>V5. Past diagnosis personality disorder or Psychopathy</td>
<td>O5. History of self neglect</td>
</tr>
<tr>
<td>S6. Major physical illness</td>
<td>V6. Alcohol or drug misuse</td>
<td>O6. Lacks basic housing amenities</td>
</tr>
<tr>
<td>S10. Impulsivity</td>
<td>V10. Impulsivity</td>
<td>O10. History of exploitation by others</td>
</tr>
</tbody>
</table>

Comments: (To include Reference No E.G. S3, details / context of Incidents etc.)

### Violence

|-----------------------|-----------------|--------------------------------------------------------------------------|

Comments: (To include Reference No E.G. S11, details / context of Incidents etc.)

### Other Risk Factors

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</thead>
<tbody>
<tr>
<td>S2. Use of violent methods</td>
<td>V2. Use of weapons</td>
<td>O2. History of stalking others</td>
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<tr>
<td>S3. Previous self-harm</td>
<td>V3. Previous Admission to secure units</td>
<td>O3. History of social, financial or sexual exploitation of others</td>
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<tr>
<td>S5. Past diagnosis of personality disorder</td>
<td>V5. Past diagnosis personality disorder or Psychopathy</td>
<td>O5. History of self neglect</td>
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<tr>
<td>S6. Major physical illness</td>
<td>V6. Alcohol or drug misuse</td>
<td>O6. Lacks basic housing amenities</td>
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<tr>
<td>S10. Impulsivity</td>
<td>V10. Impulsivity</td>
<td>O10. History of exploitation by others</td>
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Comments: (To include Reference No E.G. S3, details / context of Incidents etc.)
## PROTECTIVE FACTORS

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<td>S17.</td>
<td>Willing to respond to advice/careers</td>
<td>V17.</td>
</tr>
<tr>
<td>S18.</td>
<td>Has close relationship</td>
<td>V18.</td>
</tr>
<tr>
<td>S19.</td>
<td>Religious beliefs</td>
<td>O17.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>O18.</td>
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</table>

**Comments:** (To include Reference No E.G. S17, details / context of Incidents etc.)

---

### Outcome of screening/management plan discussed with

<table>
<thead>
<tr>
<th>Service User</th>
<th>Carer</th>
<th>Consultant</th>
<th>Other Dr.</th>
<th>CPN</th>
<th>Ward Nurse</th>
<th>Social Work</th>
<th>Occupational Therapy</th>
<th>Psychology</th>
<th>Pharmacy</th>
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</tbody>
</table>

### MANAGEMENT PLAN

- **Suicide/ Self harm**
- **Violence**
- **Other Risk Factors (specify)**

**Action By:**

---

### SCREEN COMPLETED BY:

(NURSING) (MEDICAL)

**PRINT NAME:**

**SIGNATURE:**

---

### Guidance

This screening form should be completed as fully as possible. It is a clinical judgement when this should take place however as a general guide this may be on admission to hospital or at the point of engagement with secondary mental health services. Thereafter it should be reviewed on a regular basis as pre-determined by the clinical team or as significant changes in circumstances or clinical presentation dictate. It is expected that reviews would routinely take place at multidisciplinary meetings, the point of transition from one aspect of service to another, as part of a planned annual review, at the point of CPA review, at the point of engagement with Crisis Services. In relation to admissions to hospital, the initial screening and formulation of risk should be reviewed at the next multi-disciplinary team meeting.

- Dependant on the information collected consideration should be given to carrying out a more detailed, specific risk assessment e.g. suicide risk assessment.
- This document should form an integral part of a comprehensive mental health assessment and care planning process, and the factors listed are not necessarily in any ranked order.
- This does not attempt to be an exhaustive list of safety issues or risk factors, merely an initial guide informing clinical management.
- The expectation that all safety risks can be predicted is unrealistic, and initial assessment may be based on incomplete information.
• If completed by one person (e.g. out of hours), this assessment should be discussed as soon as is practicable with the Consultant and multi-disciplinary team (including users and carers where appropriate).
• The assessment should include the service user and carer perspective of risk.
• The assessment must take account of parenting responsibilities and contact with children.
• Please refer to the Clinical Risk Screening & Management Policy for guidance.

End of document
SAFE AND SUPPORTIVE OBSERVATION CARE PLAN & SCREENING TOOL
INDIVIDUAL NEEDS AND INTERVENTIONS

NEED No. 

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>WARD/HOSPITAL</th>
<th>CHI No</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

NEED:
FOR OBSERVATION TO BE INDIVIDUALLY TAILORED TO REPRESENT THE LEAST RESTRICTIVE ALTERNATIVE
WHilst AFFORDING MAXIMUM THERAPEUTIC BENEFIT

RELATED TO I I

ENSURE INTERVENTIONS/ACTIONS ARE DISCUSSED WITH PATIENT AND/OR RELATIVES

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<thead>
<tr>
<th>DATE</th>
<th>INTERVENTIONS</th>
<th>REVIEW DATE &amp; SIGN</th>
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<tbody>
<tr>
<td>1)</td>
<td>THE MULTIDISCIPLINARY TEAM WILL, AS SOON AS IS PRACTICABLE, CLARIFY THE DEPTH OF OBSERVATION REQUIRED USING THE OBSERVATION SCREENING TOOL (ON REVERSE)</td>
<td></td>
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<tr>
<td>2)</td>
<td>THE NURSE IN CHARGE/NAMED NURSE WILL COMPLETE THE AFOREMENTIONED TOOL AS AN INTERIM MEASURE PENDING MDT REVIEW</td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td>ALL CLIENTS SUBJECT TO SPECIAL OR CONSTANT OBSERVATION WILL HAVE A DAILY PLANNER/WELL BEING RECOVERY ACTION PLAN INITIATED BY THE NAMED NURSE AND SHARED WITH THE CLINICAL TEAM AND THE CLIENT</td>
<td></td>
</tr>
<tr>
<td>4)</td>
<td>THE MDT WILL INFORM THE CLIENT OF THE LEVEL OF OBSERVATION THEY ARE SUBJECT TO AND REASONS FOR THIS</td>
<td></td>
</tr>
<tr>
<td>5)</td>
<td>THE NAMED NURSE SHALL GIVE THE CLIENT WRITTEN INFORMATION EXPLAINING THE PRESCRIBED LEVEL OF OBSERVATION AND A COPY OF THE OBSERVATION SCREENING TOOL</td>
<td></td>
</tr>
<tr>
<td>6)</td>
<td>THE NAMED NURSE SHALL GIVE THE NAMED PERSON/NEAREST RELATIVE A COPY OF THE INFORMATION ALLUDED TO IN POINT 5</td>
<td></td>
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<tr>
<td>7)</td>
<td>THE MULTIDISCIPLINARY TEAM WILL REVIEW OBSERVATION AS DEFINED WITHIN THE SAFE AND SUPPORTIVE OBSERVATION POLICY AND INFORM THE CLIENT OF THE OUTCOME OF THESE REVIEWS</td>
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</table>
# SAFE & SUPPORTIVE OBSERVATION SCREENING TOOL

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## Observation Level

<table>
<thead>
<tr>
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<th>DATE</th>
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<tbody>
<tr>
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</table>

- CONSTANT
- SPECIAL
- SIGHT

<table>
<thead>
<tr>
<th>NUMBER OF STAFF</th>
<th>GENDER</th>
<th>DAY / NIGHT</th>
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<tbody>
<tr>
<td></td>
<td>MALE / FEMALE</td>
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</tbody>
</table>

### Reason for Observation:

- **(1) Self Harm**
- **(2) Suicide**
- **(3) Medical Condition / Other**
- **(4) Aggression**
- **(5) Wandering**
- **(6) Unpredictable Behaviour**
- **(7) Sexual disinhibition**

### Activity

<table>
<thead>
<tr>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
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<tbody>
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### Constant Observation Proximity

- **(WS = Within Sight)**
- **(VP = Verbal Check & Prompt)**
- **(Circle as Appropriate)**

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<th>ACTIVITY</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Showers/Toilets</td>
<td>WS / VP</td>
<td>WS / VP</td>
<td>WS / VP</td>
</tr>
<tr>
<td>2) Sleeping</td>
<td>WS / VP</td>
<td>WS / VP</td>
<td>WS / VP</td>
</tr>
<tr>
<td>3) Own Time in Room</td>
<td>WS</td>
<td>WS</td>
<td>WS</td>
</tr>
<tr>
<td>4) Visiting</td>
<td>WS</td>
<td>WS</td>
<td>WS</td>
</tr>
<tr>
<td>5) When in Public Area</td>
<td>WS</td>
<td>WS</td>
<td>WS</td>
</tr>
<tr>
<td>6) Interview with Visiting Professional</td>
<td>WS</td>
<td>WS</td>
<td>WS</td>
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<tr>
<td>7) When Using Phone</td>
<td>WS</td>
<td>WS</td>
<td>WS</td>
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</tbody>
</table>

### Verbal Checks and Prompts

- **☐ 1) Showers/Toilets** 30 Seconds
- **☐ 2) Sleeping** 30 Minutes (Not for Self Harm/Suicide/Medical Condition, to be documented by Medical Staff)

### Access to Restricted Items

- **(I = Independent)**
- **(S = Supervised)**
- **(Circle as Appropriate)**

<table>
<thead>
<tr>
<th>ITEM</th>
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<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
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<td>NAIL CLIPPERS</td>
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<td>I / S</td>
<td>I / S</td>
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<td>HAIR STRAIGHTENERS</td>
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</tr>
<tr>
<td>REVIEW DATE(S)</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
**PILOT TEMPLATE**

**Patient specific risk assessment form for challenging behaviour**

<table>
<thead>
<tr>
<th>Name of Patient:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Present Behaviour *</th>
<th>Diagnosis **</th>
</tr>
</thead>
</table>

**Subject of Assessment:** E.g.: hazard, task, equipment, location, people

Verbal or physical aggression by patients with identified challenging behaviour which could result in physical or psychological injury to staff or other patients or visitors within ward environment

**Hazards** (Describe the harmful agent(s) and the adverse consequences they could cause)

Tick all that are relevant and add if other hazards not listed.

- Lack of or reduced level of understanding by patient due clinical condition.
- Acute psychotic episodes – patient disorientated, confused, afraid as a result of hallucinations (auditory and visual).
- Sense of perception severely altered due to medication, sedation or sleep deprivation resulting in absence of insight.
- Ataxia – standing/walking balance impaired resulting in an increased likelihood of falls.
- Fixtures in room – possible weapons e.g. drip stands.
- Permanent fixtures – possible weapon/self harm e.g. windows, sink, towel/glove dispensers.
- Triggers - ↑ noise, ↑ ward activity, over stimulation / reduced stimulation.
- Free movement being prevented, being physically helped/held at times when pt. is in immediate danger of falling or during nursing interventions.
- Other………………………………………………………………………………………………………..

**Description of Risk**

Describe the work that causes exposure to the hazard, and the relevant circumstances. Who is at risk? Highlight significant factors: what makes the risk more or less serious – e.g.: the time taken, how often the work is done, who does it, the work environment, anything else relevant.

Nursing interventions, personal hygiene of patient, etc. requires hands on contact between nurse and patient, which due to patient’s medical/clinical status this may introduce a level of misunderstanding of caring situation or activity.

Patient’s clinical condition increases risk of confusion, higher level of agitation, unpredictability.

Clinical activity may introduce or be perceived to introduce level of pain or discomfort to patient.

Preventing patient leaving ward / invading other patients’ space may increase agitation of patient.

* Trying to leave ward / Verbal aggression / Physical aggression / Self harm / Other – specify

** Alcohol withdrawal related issue / Drug intoxication / Dementia / Delirium / Head Injury / Pre existing Mental Illness / Other – specify
### Existing Precautions & Potential controls In place (add others not listed).

<table>
<thead>
<tr>
<th>Describe if these controls are in place or planned at time of assessment.</th>
<th>In place</th>
<th>Planned</th>
<th>Not planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>All staff have attended violence and aggression training and are taught de-escalation techniques and physical intervention skills.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice and support from Psychiatric Services has been given.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice and support from Brain injury specialists has been given.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice and support from Addictions specialists has been given.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice and support from Learning Disabilities specialists has been given.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice and support from ......................... specialists has been given.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment of any interventions, that may be antecedents to aggression in this individual patient e.g. assisting to mobilise, feeding, dressing and bathing, toileting or any therapeutic treatment that may result in discomfort or pain has been done and communicated to all staff.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff have been made aware to observe for early physical signs of aggression, which may include:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Increased motor agitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Verbal content such as aggressive language.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Change in voice tone or volume</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Posture and body language, such as fist clenching and thigh tapping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sudden cessation of activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An assessment has been made as to the ratio of staff to patient required for activities/interventions e.g. staff should work in two’s or three’s (where required.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See Guidelines for the Observation of patients with Acute Behavioural Disturbance in Acute Division Wards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff are compliant with the uniform policy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff have been reminded to remove all pens, badges and other items before entering a potentially violent situation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff have been reminded of local emergency procedure to call for assistance in a violent situation e.g. shouting or using any alarm system.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A behaviour monitoring or Antecedent/Behaviour/Consequences (ABC) chart has been commenced.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient in single room to reduce sensory load.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient close to nurses station to provide closer observation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unnecessary furniture removed from immediate vicinity.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A clinical review has been performed to eliminate possible exacerbating factors e.g. by doing an infection screen E.g. MSSU. If patient has delirium follow guidelines. Review environment to ensure patient is in most appropriate ward.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family kept informed of patient careplan and asked to sit with patient where appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relatives or carers have asked to be involved by identifying known triggers and calming/diversionary strategies. Completing ‘Getting to Know Me’ document.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider use of Standards of Behaviour Protocol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other..................................................................................................................</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Report all incidents or near miss situations on Datix.  
Ensure senior management are aware if violence is increasing or felt to be unmanageable.  
See ‘Escalation Process for Acute Inpatients Exhibiting Challenging Behaviour’

**Level of Risk** - Is the control of this risk adequate?  
Give more than one risk level if the assessment covers a range of circumstances. You can use the ‘matrix’ to show how ‘likelihood’ and ‘consequences’ combine to give a conclusion. Also, be critical of existing measures: if you can think how they might fail, or how they could be improved, these are indications of a red or orange risk.

**Risk Matrix**

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Negligible</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Certain</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>V High</td>
<td>V High</td>
</tr>
<tr>
<td>Likely</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>V High</td>
</tr>
<tr>
<td>Possible</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Unlikely</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>Rare</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
</tbody>
</table>

- **Very High**
- **High**
- **Medium**
- **Low**

**Current risk level**

Given the current precautions, and how effective and reliable they are, what is the current level of risk? **Green** is the target – you have thought it through critically and you have no serious worries. Devise ways of making the risk green wherever you can. **Yellow** is acceptable but with some reservations. You can achieve these levels by reducing the inherent risk and or by effective and reliable precautions.  
**High** (Orange) or Very High (Red) risks are unacceptable and must be acted on: use the Action Plan section to summarise and communicate the problems and actions required.

**Assessment of risk is Likelihood X Severity = Level**

**Action Plan** (if risk level is High (Orange) or Very High (Red))

Use this part of the form for risks that require action. Use it to communicate, with your Line Manager or H&S / Risk Coordinator or others if required. If using a copy of this form to notify others, they should reply on the form and return to you. Check that you do receive replies.

Describe the measures required to make the work safe. Review the controls list above for any that have still to be implemented. Include hardware – engineering controls, and procedures. Say what you intend to change. If proposed actions are out with your remit, identify them on the plan below but do not say who or by when; leave this to the manager with the authority to decide this and allocate the resources required.

**Proposed actions to control the problem**

<table>
<thead>
<tr>
<th>List the actions required. If action by others is required, you must send them a copy</th>
<th>By Whom</th>
<th>Start date</th>
<th>Action due date</th>
</tr>
</thead>
</table>
All staff who may come in contact with this patient should be aware and have access to this risk assessment to ensure they are familiar with the controls that should be in place.

The risk assessment must be updated on a regular basis to ensure any changes in actions completed or changing patient behaviour is taken into consideration.

Consider if you need to inform or require action / support by others e.g. H&S, V&A Coord, Line manager, specialist clinician, Addictions.

Please enter below who you have contacted and their response.

<table>
<thead>
<tr>
<th>Date contacted</th>
<th>Name</th>
<th>Position</th>
<th>Response</th>
</tr>
</thead>
</table>

**Reply**

*If you receive this form as a manager from someone in your department, you must decide how the risk is to be managed.*

If you receive this as an adviser or other specialist, reply to the sender and investigate further as required.

*Please add in the section below any further action taken from those who have received this form.*

<table>
<thead>
<tr>
<th>Action</th>
<th>Taken by</th>
<th>Date</th>
</tr>
</thead>
</table>

Ensure the action plan is updated and reply with a copy to others who need to know. If appropriate, you should escalate to senior management in the Sector /Directorate. See Escalation process for Acute Inpatients Exhibiting Challenging Behaviour in place.

<table>
<thead>
<tr>
<th>Assessment completed by:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of assessment:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Review date:</th>
</tr>
</thead>
</table>
Calming strategies & de-escalation checklist

Please ensure this list is shared with all staff who will be working with the patient as a reminder of how to behave to reduce the chance of conflict and to minimize it if it occurs.

- Make other staff aware of a potentially violent situation and that they should not enter it unobserved.
- Staff should if possible ask other patients to leave the area.
- Staff must not encroach upon the patient’s personal space. Keep at arms length.
- Staff to ensure that there is a clear exit from the situation and avoid cornering the patient. Do NOT block exit path for patient.
- All staff should observe the area around the patient for potential weapons, e.g. vase, cup, jug, bottles etc.
- Staff must try to appear confident, calm and relaxed. Do not fold arms, maintain an open posture.
- Move slowly, showing that you have nothing in your hands.
- Staff should talk quietly and clearly to the patient. Staff must not argue or become defensive.
- Staff should ask open questions and try to work at problem solving to reduce the patient’s frustration and carry out the actions decided upon with the patient.
- Staff should be aware of emergency protocol for their area (e.g. Use alarm system, call security and/or Police etc).
- Encourage patient to move to a quieter area of the ward, away from any source of irritation.
- Engage in distracting activities or conversation.
- Encourage patient to talk, listen to what is said and reassure patient.
- Continually assess patient’s body language, speech, level of distress or agitation.
- Do not restrict patient’s mobility unless a risk to self or others.
Risk Assessment Form

Use this form for any detailed risk assessment unless a specific form is provided. Refer to your Summary of Hazards/Risks and complete forms as required, including those that are adequately controlled but could be serious in the absence of active management. The Action Plan and reply section is to help you pursue those requiring action.

Name of Assessor: [ ]
Post Held: [ ]

Department: [ ]
Date: [ ]

Subject of Assessment: E.g.: hazard, task, equipment, location, people

Hazards (Describe the harmful agent(s) and the adverse consequences they could cause)

Description of Risk

Describe the work that causes exposure to the hazard, and the relevant circumstances. Who is at risk? Highlight significant factors: what makes the risk more or less serious – e.g.: the time taken, how often the work is done, who does it, the work environment, anything else relevant.

Existing Precautions

Summarise current controls in place
Describe how they might fail to prevent adverse outcomes.

Level of Risk - Is the control of this risk adequate?
Give more than one risk level if the assessment covers a range of circumstances. You can use the ‘matrix’ to show how ‘likelihood’ and ‘consequences’ combine to give a conclusion. Also, be critical of existing measures: if you can think how they might fail, or how they could be improved, these are indications of a red or orange risk.

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Action Plan (if risk level is High (Orange) or Very High (Red))

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<td>List the actions required. If action by others is required, you must send them a copy</td>
<td></td>
<td></td>
<td></td>
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</table>

Action by Others Required - Complete as appropriate: (please tick or enter YES, name and date where appropriate)

- Report up management chain for action
- Report to Estates for action
- Contact advisers/specialists
- Alert your staff to problem, new working practice, interim solutions, etc

Reply

**If you receive this form as a manager from someone in your department, you must decide how the risk is to be managed. Update the action plan and reply with a copy to others who need to know. If appropriate, you should note additions to the Directorate / Service Risk Register.**

If you receive this as an adviser or other specialist, reply to the sender and investigate further as required.

Assessment completed - date:  

Review date:  

End of document.