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Minister for Mental Health
Via email: mentalhealthlaw@gov.scot

Date: 10 May 2019

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Dear Clare,

Thank you for your letter dated 1 May 2019.

The number of incidents requiring restraint are very low, however, when the likelihood of restraint being required is identified there is clear guidance on escalation within our Management of Aggression Policy. In addition, where the patient exhibits a psychopathology which requires restraint and rapid tranquillisation this is subject to a MDT assessment led by the Consultant Psychiatrist or a member of the CMHT in consultation with a Consultant Psychiatrist colleague and other relevant clinical staff. The course of action is planned and implemented under clear control of a lead clinician and is subject to a post event debrief.

In response to the letter the Management of Aggression Policy will be reviewed to ensure that the guidance on the MDT and decision processes are explicit.

The CMHT Nurses have completed their management of aggression training however the control and restraint training has still to be completed. Other staff who may be involved in this type of incident are expected to comply with the requirement to complete management of aggression training and this is monitored closely.

Yours sincerely

Gerry O'Brien
Chief Executive

NHS Shetland restraint policy:

I am writing to you to provide a statement in respect of the patient safety and governance arrangements with have in place at NHS Shetland to ensure that we have appropriate crisis intervention and management plans in place to safety manage aggressive situations.

NHS Shetland approved a policy in 2018, which sets out the operational procedures for the management of restraint when that becomes the only option to ensure the safety of patients and/or other persons in the health setting. This policy promotes the use of physical intervention in a way that respects dignity, privacy, cultural values, race and any special needs of the patient which will be taken into account in so far as it is reasonably practical. The policy includes the requirements to support adults, children and pregnant women.

We also ensure that restraint is only be considered when all other practical means of managing the situation, such as de-escalation, verbal persuasion, voluntary 'time out', or gaining consent to taking medication, have failed or are judged likely to fail in the circumstances.

Staff have been trained in the use of MAPA® (Management of Actual or Potential Aggression) techniques. The MAPA® model follows good practice guidelines in relation to managing violence and aggression, underpinning values and a holistic approach to person centred care. The physical techniques equip staff to safely manage aggressive situations, both in a 'one to one' situation and as part of a team approach. We have provided this training to advanced level since 2016 and the policy sets out the procedure for calling in a team of staff with these skills to support a patient 1:1 as needed.

The policy also sets out the requirements for recording the use of MAPA techniques, the need for debrief discussions in order to identify lessons learnt and also the inclusion of the patient in that process and providing feedback on their experience.

As an Island Board that does not have inpatient mental health facilities, patients attend the Gilbert Bain Hospital as a place of safety. In order to ensure that we have the facilities to support a person where their behaviour is violent or aggressive, we have put in place a low stimulus room which is on the ground floor of the building and has been designed in line with the place of safety requirements at ward level e.g. able to provide close observation as needed, careful attention paid to reducing ligature access points etc

One of the challenges for us in our context is ensuring that we have the right skill mix to support someone when a crisis occurs and de-escalation is required (including advanced MAPA techniques if required) along with the timescales for transferring patients to specialist inpatient facilities. We have been working with NHS Grampian and SAS to ensure that the pathway for patients which involves air ambulance transfer is as streamlined as possible.

NHS
Shetland

PHYSICAL INTERVENTION POLICY

Version 1 created 11/04/2017

Version 2 created 10/11/2017

Version 3 created 28/11/2017

Version 4 created 18/07/2018

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1. Introduction

NHS Shetland Health Board will ensure that restraint will only be considered when all other practical means of managing the situation, such as de-escalation, verbal persuasion, voluntary ‘time out’, or gaining consent to taking medication, have failed or are judged likely to fail in the circumstances.

However, it is recognised that in certain situations the application of restraint is the only option available to staff responsible for the safety of patients, other persons in health settings and themselves.

This policy promotes the use of a physical intervention in a way that respects dignity, privacy, cultural values, race and any special needs of the patient will be taken into account in so far as is reasonably practicable.

The policy provides a framework to risk assessment systems and processes that are in place to record and review all incidents where restraint is used, to ensure that any restraint used is reasonable, proportionate and necessary.

NHS Shetland provides training in the use of MAPA® (Management of Actual or Potential Aggression) techniques. The MAPA® model follows good practice guidelines in relation to managing violence, underpinning values and a holistic approach to person centred care. The physical techniques equip staff to safely manage aggressive situations, both in a ‘one to one’ situation and as part of a team approach.

NHS Shetland will also ensure that professional and legal support is available, where necessary, to any member of staff acting lawfully and in good faith in situations where restraint has been used.

The policy only applies to NHS Shetland employees and settings that are part of the NHS Shetland estate.

2. National Context and Purpose of the Policy

The purpose of this policy is to detail NHS Shetland’s approach for managing potential or actual physical and non-physical aggression of patients through the use of restrictive physical interventions.

NHS Shetland recognises that person centred care is at the heart of all good practice and that all incidences of known or potential aggression must be dealt with on an individual basis in order to create a unique solution. The core aim is to promote a philosophy of proactive care and a reduction in the use of restrictive physical interventions.

The policy has been developed following guidance from several influential, national publications on the prevention and management of violence/ physical interventions as well as more general policy and includes:

- Equality Act (2010)
- Adults with Incapacity (Scotland) Act 2000
- Mental Health (Care & Treatment) (Scotland) Act 2003
- Human Rights Act 1998
- Criminal Procedures (Scotland) Act (1995)
- Royal College of Nursing “Let’s Talk About Restraint” (2008)
- Mental Welfare Commission “Rights. Risks & Limits to Freedom” (2006)

3. Objectives

The policy undertakes to provide support to staff on managing a violent and/or aggressive incident with the use of a physical intervention. This may include the management of a patient with significantly disturbed behaviour.

The overall objectives of this policy are to:

- Identify organisational and individual responsibilities for the management of violence and aggression and the use of physical interventions;
- Identify good practice principles on how to assess and reduce physical intervention risks;
- Ensure patients/employees are aware and provided with suitable support following a physical intervention;
- Recognise the importance of recording and monitoring physical interventions;
- Outline the standards/ key performance indicators associated with the policy

4. Roles and Responsibilities

The Chief Executive is accountable overall for ensuring that this policy is implemented on behalf of the Board, in line with its corporate objectives to provide high quality, safe and effective patient care and appropriate staff governance.

The Medical Director is responsible for ensuring that medical staff in all settings have the necessary competencies to provide appropriate assessment and management of patients presenting with an acute psychosocial, psychiatric or cognitive condition or learning disability and determining the appropriate parameters and thresholds of care e.g. when it is safe and appropriate to provide care locally versus transferring a patient to a specialist setting.

The Director of Community Health and Social Care is responsible for ensuring that the multi-disciplinary Adult Mental Health Team (NHS employed practitioners) has the necessary skills and resources to support patients presenting in crisis and can assist in the crisis intervention model as described in this policy.

The Director of Nursing and Acute Services is responsible for ensuring that the multi-disciplinary Child and Adolescent Mental Health Team (CAMHS) has the necessary skills and resources to support patients presenting in crisis and can assist in the crisis intervention model as described in the policy.

5. The MAPA® Model and Best Practice

NHS Shetland has an Approved Training Centre (ATC) agreement through the Crisis Prevention Institute (CPI) for the delivery of the MAPA® model. The physical interventions skills within the MAPA® model have been independently risk assessed and are compliant with the UK National Physical Interventions Accreditation Scheme (PIAS).

The MAPA® programme is a behaviour management system designed as a safe, non-harmful approach to assist staff in the management of a wide range of disruptive, challenging, aggressive, and violent behaviours, including the most acute behavioural disturbances and risk behaviour.

MAPA® Underpinning Values and Philosophy: Care, Welfare, Safety and Security℠

- Care - Demonstrating respect, dignity, and empathy; providing support in a non-judgemental and person-centred way;
- Welfare - Providing emotional and physical support; acting in the person's best interests in order to promote independence, choice, and well-being;
- Safety - Protecting rights, safeguarding vulnerable people, reducing or managing risk to minimise injury or harm;
- Security - Maintaining safe, effective, harmonious, and therapeutic relationships which rely on collaboration

The MAPA® model consists of the following physical interventions 'physical holding and disengagement/ emergency responses':

- MAPA® Physical Holding skills form a hierarchy of restriction (low, medium and high). This hierarchy ranges from the least restrictive intervention that allows staff intervening to prompt and guide the patient, to an intermediate restriction that allows movement whilst being held; to the most restrictive intervention whereby all movements are limited.
- MAPA® Disengagements/ Emergency Responses: The use of a physical intervention to gain a release from any holding situation whilst minimising pain or injury in situations in which the behaviour has been assessed as a low, medium, high or extreme risk to self and others.

Best Practice

A physical intervention should always be used as a last resort in the management of violence and aggression where primary and secondary strategies have not had the required effect.

Early intervention can be extremely effective in reducing risks and the incident escalating into a crisis phase. De-escalation techniques should be used before any other interventions are considered (where possible). If the situation continues to escalate and requires other interventions, then de-escalation must be used continuously throughout.

Positive and Proactive Care (2014) promotes the following key points to improve care:

- If a restrictive intervention is used it must not include the deliberate application of pain;
- If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need;
- People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support;
- Individualised support plans, incorporating behaviour support plans, must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions

Legal and Professional Issues

Scots law imposes on every individual a general duty not to cause unjustifiable harm to others. This duty is owed to all persons who could be harmed if the duty is not observed. The duty is imposed through the operation of statute or of common law, or a combination of both.

NHS Shetland is responsible for the provision of care, including physical interventions, which are in the patient's best interest while working within the 'legal framework'.

This policy promotes the use physical intervention in a way that respects dignity and protects human rights, and where possible respects the preferences of people who use services. It also requires that its use is always appropriate, reasonable, proportionate and justifiable to that individual.

Staff should be aware that the use of force can only be justified if it is reasonable to use it to prevent injury or serious damage to property. In all contexts staff should use the minimum force necessary to prevent injury and maintain safety that is consistent with the training they have received. In such circumstances staff retain their duty of care to the patient and as such any response they make must be:

- Proportionate to the circumstances
- With any force used being "reasonable"
- Commensurate with the achieving of appropriate outcomes

Staff should be confident that the possible adverse outcomes associated with the intervention (for example, injury or distress) would be less severe than the adverse consequences, which might have occurred without the use of physical intervention.

If a patient is not detained but physical interventions have been deemed necessary, whether as an emergency or as part of the patient's individualised care plan, consideration should be given to whether assessment for formal detention under the Mental Health (Scotland) Act 2015 is appropriate, especially if interventions have occurred on a repeated basis.

6. Managing a Physical Intervention

MAPA® Response Teams

In order to facilitate a proactive response to MAPA® alerts, a wide range of staff have been trained as MAPA® responders. Some staff are based at ward level in the hospital, others work across the Gilbert Bain and Montfield campus.

A rota of four MAPA® responders is in place at all times to ensure that if there is an alert, a MAPA® response team can be mustered.

The team can be contacted 24/07 via the main switchboard – response time will be up to 45 minutes during the 'out of hours' period. If the situation is such that urgent intervention is required then any MAPA® responder available in the immediate vicinity should be contacted to respond.

As a minimum there should be a Registered Mental Health Nurse (RMN) and a Registered General Nurse (RGN) who is ILS trained called as part of a MAPA response. Other members of the team will be made up of appropriately trained MAPA responders.

The flow chart in Appendix A sets out the call out procedure.

MAPA Team Leader/ Co-ordinator

The MAPA model promotes a Team Leader to manage a physical intervention; typically this will be a RMN trained nurse. The Team Leader may be involved in the intervention or someone who is independent to the intervention (depending on the number of MAPA trained staff available).

At the start of a physical intervention the staff member responsible for protecting the patient's head, neck and breathing will assume the role of the Team Co-ordinator. Ideally this will be the clinical nurse responding as the MAPA trained member of the team.

Emergency use of Physical Intervention

Emergency use of physical interventions may be required when a patient acts unexpectedly and presents unforeseen risks for which there are no risk management measures planned. Once an incident is made safe a record should be made about the incident, the level of risk it presented and the interventions employed to make the situation safe. An individualised care plan (see next section) should be created following an emergency physical intervention.

Restraint as part of a Care Plan

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

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

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.

The choice and nature of the restrictive intervention will depend on various factors, but should be guided by:

- 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.

If the patient is unable or unwilling to participate, they must be offered the opportunity to review and revise the plan as soon as they are able or willing.

A care plan template can be found in **Appendix B**.

To support the development of appropriate care plans, staff are encouraged to contact MAPA® Certified Instructors for advice and support.

A list of instructors is included in **Appendix A.**

Risks presented by Physical Interventions

Physical interventions pose a number of risks to the health, safety and well-being of people who implement them and those they are applied to because of the degree of force that is inherent in these techniques. Good practice requires services to assess and minimise the level of risk presented by the use and application of physical interventions to patients, staff and others.

Patients should not be deliberately restrained in a way that impacts on airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure to the neck region, rib cage and/or abdomen. Unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor. If this becomes necessary, use the supine position if possible or if the prone position is necessary, use it for as short a time as possible.

Physical interventions should be avoided if at all possible, not used for prolonged periods and should be brought to an end at the earliest opportunity. Manual restraints should not be routinely used for more than 10 minutes. If a manual

restraint exceeds this then consideration must be made to use rapid tranquillisation or seclusion as an alternative to a prolonged restraint.

Positional Asphyxia

Positional asphyxia, also known as postural asphyxia, is a form of asphyxia which occurs when someone's position prevents them from breathing adequately. Anybody position that obstructs the airway or that interferes with the muscular or mechanical components of respiration may result in positional asphyxia. For this reason MAPA® does not endorse pressure to the neck region, restriction of the chest wall and impairments of the diaphragm.

During physical interventions the patient must be observed and monitored to reduce the risks of positional asphyxia. If, at any time, concerns are raised regarding the patient's physical health, physical holds should cease and the situation dealt with as a medical emergency.

A resuscitation trolley should be positioned in the environment or within easy reach in order to manage any physical deterioration in the patient's health, including asphyxia.

Physical Care Monitoring

Any patient involved in a physical intervention should be physically/psychologically monitored during a restrictive intervention, immediately following the intervention and hourly post intervention until there are no further concerns about their physical health status.

The patient should have observations undertaken every 15 minutes in the following circumstances:

- If rapid tranquilisation has been administered and the BNF maximum dose has been exceeded;
- The patient appears to be asleep or sedated;
- The patient has taken (or it is suspected) illicit drugs or alcohol;
- The patient has a relevant pre-existing physical health problem;
- The patient has experienced harm as a result of the restrictive intervention.

During the intervention a nominated member of staff should monitor the individual's airway and physical condition to minimise the potential of harm or injury.

Observations, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/ discolouration), should be conducted and recorded.

All clinical observations undertaken during and following the restrictive intervention are to be reported on DATIX and a NEWS assessment form.

If consent and co-operation for these examinations and observations is withheld then this should be clearly documented and set out what alternative actions have been taken.

If a deterioration in the patients physical presentation is observed, staff are to cease the intervention and clearly state “Medical Emergency”.

If psychological distress is observed then this should be managed as indicated within the patients individual care plan.

Physical Intervention and Administering Treatment in Non-emergency Circumstances

The use of restraint to administer treatment in non-emergency circumstances should be avoided wherever possible; but may sometimes be necessary, especially if an emergency situation would be likely to occur if the treatment were not administered. The decision to use restraint should be collectively agreed by the clinical team and be endorsed by the Consultant responsible for the patient’s care.

The decision to use a physical intervention to support the administration of treatment in non emergency circumstances should also be taken in conjunction with the on call Consultant Psychiatrist or Speciality Doctor, providing hospital liaison.

The intervention should be properly documented and justified in the patient’s notes and detailed in the care plan.

Physical Intervention and Rapid Tranquillisation

In certain situations, the multidisciplinary team may agree the use of medication as the most appropriate method of managing extreme behaviour.

Rapid Tranquillisation procedures should be implemented in line the Psychiatric Emergency Plan (PEP). The decision to put in place a rapid tranquilisation plan should be taken in conjunction with the on call Consultant Psychiatrist or Speciality Doctor, providing hospital liaison.

Removal of Clothing

For the purpose of this policy, the removal of clothing would not be considered as appropriate, however, a patient may experience physiological signs of a possible physical collapse due to escalating temperature. This, and any other signs and symptoms of deterioration in physical health must be treated in a proportionate manner, i.e. adjusting patient’s position, reducing the level of restriction or even removing layers of clothing due to a physical emergency through the use of scissors.

Physical Intervention and Provision of 1:1 Care

If a low stimulus environment is necessary, then the patient should be transferred to the low stimulus room (LSR)[1].

The LSR is not an inpatient mental health bed or unit – it is a specific, place of safety in the hospital that is designed to provide a person centred, private and dignified environment in which care can be provided where other settings in the hospital are deemed not suitable.

A decision to transfer a patient to the low stimulus room needs to be taken as a multi-disciplinary decision and where provision has been made to provide safe staffing levels to enable the patient to be cared for in a secluded environment.

Patients should only be transferred to a low stimulus environment if it is certain that an alternative care setting can be identified within 6 hours of admission to this area. That could be transfer to specialist services e.g. Cornhill Hospital or other specialist psychiatric inpatient environment. In some instances it may be possible to make provision elsewhere in the hospital e.g. the place of safety or in the community, if adequately trained staff can be identified to manage the patient's needs out with a specialist off island facility.

Use of the LSR therefore needs to be made as a collective decision including the following individuals:

- The Consultant responsible for the patients care whilst in hospital;
- The Consultant Psychiatrist or Speciality Doctor, providing hospital liaison;
- The Chief Nurse (Acute and Specialist Services) – or if unavailable, the senior nurse on duty for the hospital or Hospital bleep holder;
- The Director of Nursing and Acute Services – or if unavailable, the senior manager on call

The following principles therefore must be applied if a patient is to be cared for in a LSR out with the usual 24/7 staffed clinical areas in the hospital:

- That there is clear justification that the LSR is the most appropriate therapeutic environment in which to provide patient care;

- That there is a clear plan in place which means that 1:1 care in the LSR will not be necessary for more than 6 hours e.g. transfer on to a specialist environment can be organised;

- That four MAPA® responders[2] can be made available (continuously) for six hours to enable constant observation of the patient and provide support to undertake a physical intervention if required whilst the patient is in the LSR;

[1] The LSR is located in the Relatives Room, opposite the Sanctuary.

[2] A MAPA® response team may be augmented with security operatives, so long as they can demonstrate that they are able to meet the same standards as staff employed directly by NHS Shetland. The minimum RMN and RGN input still apply.

- That nurses competent in ILS are available (continuously) to provide support if a medical emergency arises MAPA® responders may not necessarily be clinicians or healthcare staff with advanced resuscitation skills;

- That the Consultant Psychiatrist or Speciality Doctor, providing hospital liaison are available to provide ongoing clinical advice to the clinical team directly supporting the patient throughout the duration of the seclusion/low stimulus period

Interventions outside of Hospital sites/ Units

When patients are transferred to receive care or services out with the acute ward or the Gilbert Bain Hospital e.g. transfer to mainland services; then careful consideration needs to be afforded to the level of support available and needed to make the transfer safe. Staff may need to escort a patient due to anticipated aggressive behaviour and this must be reflected in an up to date risk assessment and individual care plan that can be shared with the Scottish Ambulance Service (SAS). It is essential that escorting staff have sufficient knowledge of the patient and are MAPA® trained[3].

It is important to note however, that all staff activities in relation to MAPA® must follow the same 'least restrictive', proportionate and reasonable principles as within inpatient settings.

Physical Interventions and Pregnancy

Special provision should be made for pregnant women in the event that a physical intervention has to be used. Physical Interventions should be adapted to avoid possible harm to the unborn child.

Individual care plans must be completed for the planning of any potential use of restraint with pregnant women. This must be written with the patient (where possible) and the Multidisciplinary Team. MAPA® Certified Instructors are available to assist with the development of an elective plan if necessary.

Best practice procedures should include:

- Proactive use of holding pregnant women in the seated position, semi recumbent;
- Staff letting go if the intervention moves to prone;
- Pregnant women being medically assessed at the earliest opportunity after a physical intervention. The medical assessment should be recorded in the patient's health record;
- **Pregnant women involved in a physical intervention should be physically/** psychologically monitored during a restrictive intervention, immediately following the intervention and hourly post intervention for a period of 24 hours). Signs and symptoms to observe should be discussed with the Multidisciplinary team and where advised the local midwifery services

[3] It may not be necessary for escorting staff to be trained to advanced level, but they should be familiar with de-escalation techniques.

Physical Interventions and Children

If a child is detained under the Mental Health (Scotland) Act 2015, the expectation is that the 'staff intervene positively' if that child attempts to leave without authority.

In other circumstances, staff should only intervene where immediate action is necessary to prevent a child from significantly injuring themselves or others or causing significant serious damage to property. Injury in this context is taken to mean ''significant injury'' and would include actual bodily harm or grievous bodily harm, physical abuse, risking the lives of, or injury of, or injury to self or to others by wilful or reckless behaviour. The law requires that force should only be used when every other approach has been tried and that all practical methods to de-escalate the situation have been employed.

Staff should be familiar with other relevant legislation such as the Children and Young People (Scotland) Act 2014.

Individual care plans must be completed for the planning of any potential use of restraint with children. This must be written with the child and/or parents (where possible) and the Multidisciplinary Team. MAPA® Certified Instructors are available to assist with the development of an elective plan if necessary.

7. Post Physical Intervention

Post Incident Support for Patients

Following a physical intervention it is important that the patient is monitored by the Multidisciplinary Team for assessment of any on-going physiological problems or psychological concerns as a result of a physical intervention. This may provide staff involved, this should include the patient, staff members and significant others with an opportunity to positively engage with the patient regarding their care plan and any possible changes or considerations. This may also include contact with the family.

Post incident support may explore the following:

- Circumstances that led to the physical intervention
- How they felt in the lead up to the physical intervention
- What they wanted to achieve and did it work?
- What they did to try and manage their distress and did it work?
- What support they need from others

Post Incident Support for Staff

Post-incident support is seen as a matter of good management practice to limit, wherever possible, the effects of exposure to distressing workplace events. Responding quickly to the needs of a member of staff who has been through a distressing experience is important. NHS Shetland will aim to make sure that everyone who has been involved in any sort of incident can feel supported and be given an opportunity to talk about and work through their experience. As a minimum all staff will be offered a meeting with their manager and referral to Occupational Health.

Staff Development can also be utilised to provide support through individual or team reflective practice sessions. Clinical supervision should also be used as a means of reflection.

The Chaplaincy/Spiritual Care Team also offers an informal listening and support service to staff of all faiths and beliefs.

Staff sustaining injuries or if the blood borne virus procedure is triggered must contact the Occupational Health Department for assessment and advice.

8. Reporting

It is important that all incidences of physical interventions are reported. Thorough record keeping not only ensures good governance but is also a key feature for planning service delivery to patients.

The Senior Charge Nurse (SCN) or other designated practitioner other must ensure the team members complete the required documentation. Records will help to inform clinical audit and further development of practise.

The documentation must include:

- DATIX
- Health record – i.e. clinical notes
- Statements (where necessary)

All documentation must be completed as quickly as practicable after the physical intervention and no later than 24 hours after the incident.

The records must be used for a number of different purposes including:

- Reviewing of individual care, support and treatment;
- Monitoring of compliance with statutory requirements in relation to physical interventions;
- Auditing and evaluating service delivery

Monitoring of incidents of restrictive interventions will be by type. If the same type occurs multiple times within one incident/episode, then this can be recorded as one

incident of that type. For example, if an incident of restraint lasts an hour, and at four points during that hour the patient was restrained in a prone position, this should be recorded as one incident of prone restraint. However, if the patient calmed and was released and then a further episode occurred shortly afterwards in which prone restraint was used again, this must be recorded as a second incident of prone restraint.

All records/record keeping should comply with the Board policies on Records and Record Keeping.

Post Incident Analysis

Post Incident Analysis (PIA) or debrief, is the reconstruction of an incident to assess the chain of events that took place, the methods used to control the incident and how the actions of staff contributed to the eventual outcome.

The main purpose of a Post Incident Analysis is to:

- Reinforce staff actions;
- Identify procedures that are effective;
- Identify lessons for improving patient care;
- Maintain therapeutic relationships between staff, patients and their carers

Where the service decides a PIA is required it should take place as soon as possible and with 5 working days of an incident ending.

The 10 day report process is most commonly used for 'moderate to high' risk rated adverse events but can also be used for any adverse events, feedback or patient concerns or near misses that require more details (for further information see Adverse Event Policy).

9. Staff Training

All staff that are employed by the Board and are identified as likely to use physical interventions require training in order to implement this policy safely and effectively. MAPA® training will equip staff with core knowledge, skills and values as required by the Board when using physical interventions.

The MAPA® Foundation programme is modular and provides four key learning objectives:

1. Identify behaviour that indicates an escalation toward the aggressive and violent, and take appropriate measures to avoid, decelerate and / or de-escalate crisis situations
2. Assess the level of risk associated with crisis behaviour and make appropriate decisions related to the management of such risks
3. Use suitable and acceptable physical interventions to reduce or manage risk behaviour

4. Identify the impact of crisis events and describe post-crisis responses that can be used for personal and organisational support and learning

The foundation programme can be undertaken by any NHS Shetland staff as a one day course which does not include holding skills but does include disengagement skills. It can also be undertaken as a two day programme for staff who may work with potentially vulnerable people or individuals who may exhibit behaviours that can challenge and includes low level holding skills. There is 3 day training which builds on the foundation programme with advanced holding skills which are suitable for staff working with individuals whose behaviour may be more unpredictable and higher risk. This training is suitable for staff as part of a MAPA response team.

In addition to the foundation programme, staff will be expected to complete MAPA® advanced skills and MAPA® emergency holding skills training before joining the crisis intervention team and on call rota.

To ensure continuing good practice staff are required to undertake yearly updates of physical intervention practices however in exceptional circumstances and with agreement from the MAPA® Approved Training Centre this can be extended to 15 months. Failure to update within this timescale will result in staff repeating an Initial MAPA® course.

Staff who exceed 18 months should not routinely support any planned physical interventions. If an emergency situation presents itself to an out of date/non MAPA® trained staff then it may be necessary for the staff to reasonably assist whilst MAPA® trained staff are responding to the incident.

A rolling programme of MAPA® foundation and advanced skills is available to staff and details of courses are included in the Staff Development Bulletin.

Health Declaration

MAPA® training does not rely upon physical strength but managing movement safely by maximising the use of body mechanics. Therefore the training is suitable for a wide range of staff in healthcare settings. Staff attending MAPA® training should expect that the fitness level and range of movement required is no more than required in a busy care environment.

Prior to each training event staff are to:

- Declare any injuries, medical or physical exclusions they may have to their line manager. This discussion should ascertain their appropriateness to attend a MAPA® training course. Individuals are to seek advice from their GP or Occupational Health Department if they have any concerns;

- On the day of MAPA® training participants must declare to the Certified MAPA® Instructors any injury, medical, physical or other condition, which may

prevent them from fully taking part in training. These exclusions will be reported back to line managers

10. Procedures Associated with this Policy

Procedures for protection against occupational infection with blood borne viruses
http://www.shb.scot.nhs.uk/board/policies/bbv-procedures.pdf

Policy on the Use of Restraint (Adults) – including bed rails
http://www.shb.scot.nhs.uk/board/policies/RestraintPolicy.pdf

Policy and Guidelines for the Prevention and Non-Physical Management of Aggression and Violence (PMAV) in the Workplace
http://www.shb.scot.nhs.uk/board/policies/AggressionAndViolence.pdf

Learning from Adverse Events through Reporting and Review Policy
http://www.shb.scot.nhs.uk/board/policies/AdverseEventPolicy-Nov2016.pdf

11. Glossary of Terms used in this Policy

Restraint is taking place when the planned or unplanned, conscious or unconscious actions of staff prevent a patient [or other person] 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

Physical Restraint/ Interventions - Any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person

Non-Physical Assault - Use of inappropriate words or behaviour causing distress and or constituting harassment

Physical Assault - Intentional application of force to the person or another, without lawful justification, resulting in physical or personal discomfort

Aggression - Non-physical assault (see definition above)

Violence - Physical Assault (see definition above)

12. References

NHS Shetland Crisis Intervention Team Call Out Plan

Required Action	Required Response
Nursing team identifies that the crisis response team is required (see policy)	Nurse calls Reception and asks them to contact the crisis response team
Reception staff use the on call rota for crisis intervention to identify the right staff to come in to support an intervention as needed	Reception staff call in staff (contact details are held at Reception and on the EMT shared drive)
Reception contacts Hospital Co-ordinator	Hospital Co-ordinator attends the department/ward to provide assistance as needed
Reception contacts Consultant Psychiatrist or Speciality Doctor for hospital liaison	Consultant Psychiatrist or Speciality Doctor for hospital liaison contacts the Consultant Physician to find out if additional support is needed from the Mental Health Team (if
Out of Hours (overnight & weekends) Reception contacts Senior Manager on Call	Senior Manager on Call contacts the Hospital Co-ordinator to find out if further assistance is required and additional management support needed

Reception phones the Department requesting assistance to let them know the crisis intervention team is en route and estimated ETA

1. Name(s) of the Patient(s)		**2. Date/Time of Incident:**
Location of incident:	**Names of witnesses (if applicable):**	**Names of staff supporting the Crisis Intervention:**
3. Events leading up to Restrictive Physical Intervention (including alternative strategies used):		
4. Account of actual incident (including details of actions, method of intervention, words used, witnesses etc.):		
5. Outcome or resolution of incident:		
6. Follow up actions (advice to family/carers, to staff and other patients involved):		
7. Risk Assessment and Restrictive Physical Intervention Protocol reviewed: Yes/No **Outcomes:**		
9. Record of any injury or property damage:		
10. Datix has been completed and OH referral made as appropriate Yes/No **Outcomes:**		
Print Name:	**Signature**	**Job Title**
Date:		

This form to be retained locally

Restrictive Physical Intervention Risk Assessment

Location_____

Patient Name		**Date of Birth**
Address		**Gender**
Reason for Admission		
Relevant Past Medical History/Conditions		

Assessment of Risk

History	
Physical size and strength	
Categories of people exposed	
How could exposure take place	
When and how often could exposure occur	
Possible consequences of exposure	
Benefits of not intervening	
Consequences of not intervening	
Views of patient/service user/family	
Other information	

Agreed Individual Anticipatory Care Plan

Antecedents		
Warning Signs **1. Tension** **2. Non Verbal** **3. Verbal**		
Critical Moments		
Likely Restrictive Physical Intervention & Procedure		
By whom and how often with this protocol be reviewed.	**Date of next review:**	
Print Name:	**Signed:**	**Date:**
Print Name:	**Signed:**	**Date:**
Print Name:	**Signed:**	**Date:**
Print Name:	**Signed:**	**Date:**

To be retained as part of the individual care plan/record.

Perth and Kinross Health and Social Care Partnership
Supporting healthy and independent lives

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PERTH
PH1 5PH

Enquiries to Gordon Paterson
Extension/Direct Line: [redacted]
Email [redacted]
Your Ref
Our Ref GP/CW
Date 20 May 2019

Ms Clare Haughey
Via email: mentalhealthlaw@gov.scot

Dear Ms Haughey,

I write in response to your letter dated the 1 May 2019 regarding the assurance process in place with NHS Board with regard to the use of restrictive interventions.

Mental Health Services in NHS Tayside have a clear focus on reducing restrictive interventions and this is led through a Multi-Disciplinary Least Restrictive Care (LRC) Steering Group chaired by the Quality Improvement Lead for Adult Mental Health. All wards have a LRC Lead who sit on the LRC steering group and jointly we have developed a revised driver diagram that sets out the aim of a 50% reduction of restraint by the end of December 2019.

As we examine, understand and improve current practices our system has an increasing appreciation that service development needs must be framed more widely than de-escalation / restrictive intervention and must encompass consideration of the practice model, the therapeutic milieu and rights based, trauma informed care.

We must also acknowledge the high-quality interventions, skilled and sophisticated interventions that are compassionate, and evidence based in their origin that staff deliver daily. There is no one thing, rather an interdependent set of processes that will contribute to a reduction and our teams are testing interventions across a broad range of said processes. This involves using the SPSP-Mental Health Safety Principles, as well as LRC steering group-developed initiatives which include an aim of a minimum of 17 hours per patient per week of structured therapeutic engagement. This is currently being tested across 2 inpatient wards and based on the Royal College of Psychiatry Forensic standards which we are adapting and working alongside service users and teams to formulate the best possible 'menu' of activities that will establish engagement and sustainable therapeutic activity programmes across all wards.

Further interventions that look at prevention, recognition and response include the use of self-soothing boxes as a patient-led early intervention in response to stress and distress. The contents of the boxes have been developed listening to patient feedback and are used frequently. A second example is the alternatives to self-harm interventions which support patients with safe alternatives to manage their risk behaviours. These interventions are again based on patient feedback and learning from lived experience.

We have commissioned a review of the infrastructure around the delivery of training and application of the Prevention and Management of Violence and Aggression across Mental Health and Learning Disability services. This commission will be a desktop review of the content of the current Prevention and Management of Violence and Aggression Policy, staff

training programme, a mapping exercise against Scottish, UK and international best practice guidance and recommendations for areas for improvement.

The outcome will be a detailed report indicating the changes required to ensure the programme complies, meets and exceeds current best practice, alongside fit-for-purpose guidance to reinforce the core values of the service and stress restrictive intervention reduction.

There is a clinical governance and performance review framework within Mental Health Services which reports to the NHS Tayside Board and the Perth and Kinross Integrated Joint Board through standing Board Groups and Committees.

Within Mental Health Services each ward is provided with locally developed Ward Dashboards which includes restraint data and a monthly summary of incidents reported through the Datix Adverse Event Reporting System. This is monitored through the In-Patient Governance Group which has oversight of Policy, Practice, and staff training. The Mental Health Performance Review examines and considers practice over time and seeks assurance from Ward Teams and Services regarding quality and performance.
The In-Patient Health and Safety Committee have a focus on the environmental and broader health and safety related matters that contribute to safe clinical care environment for patients and staff.

Mental Health Services in Tayside submit restraint data to Health Improvement Scotland as part of the Scottish Patient Safety Mental Health Programme National Reporting.
The development of Mental Health Services is a key priority for NHS Tayside and Perth and Kinross Integrated Joint Board and we have a collective focus on improving the care experience for patients and reducing the use of restrictive interventions within practice.

Yours sincerely

Gordon Paterson
Chief Officer/Director – Integrated Health & Social Care
Perth and Kinross Health & Social Care Partnership

Scottish Ambulance Service restraint policy:

Within Scottish Ambulance Service we provide a theoretical session as a component of Learning in Practice (LiP) on Conflict Resolution to all paramedic and ambulance technician staff. We are in the process of further developing and expanding this session to be delivered over one full day and to include clinical skills on de-escalation techniques. This will support our staff when working with patients who are distressed or anxious.

The State Hospital restraint policy:

As a high secure environment, the use of restraint is a necessary feature of care delivery from time to time. Our focus, however, is on a rights based approach to care, with the least restrictive option driving our practice approach. As such, prevention of violence and aggression and minimising the use of restraint is a priority.

All of our staff are trained in the prevention and management of violence and aggression (PMVA), with 2 yearly updates on this being a mandatory requirement. Compliance with training is monitored through our Health, Safety and Welfare Committee, as well as local managers receiving monthly reports on training compliance. Our Training and Professional Development Department also provide these reports to local line managers, as well as planning and co-ordinating the delivery of PMVA training.

For our patients, we deliver psychologically oriented programmes such as 'Life Minus Violence', to help address underlying causes of violence. We also make extensive use of clinical risk assessment to inform our approach to safely manage the risk of violence, and to subsequently minimise the likelihood of the requirement for the use of restraint as an intervention.

All of our PMVA practice is underpinned by an extensive suite of policies and procedures which is widely available to staff. Statistics relating to the use of PMVA are reported as a standing item through the Clinical Governance Committee of the Board. All PMVA incidents are recorded on the DATIX system and are subject to review. Where, exceptionally, a patient is seriously injured, this is subject to CAT 1 review and reported to the MWC.

The use of rapid tranquilisation is monitored through the Medicines Committee, which, in turn, reports to the Clinical Governance Committee.

Finally, in the event that a patient is restrained, we operate a system of post physical intervention review which occurs immediately post restraint, to help ensure the health and wellbeing of our patents and our staff.