PHYSICAL INTERVENTION POLICY

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NHS Shetland Document Development Coversheet*

Name of document	Physical Interventions Policy		
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Clinical Governance Committee		

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Examples of reasons for presenting to the group	Examples of outcomes following meeting
Professional input required re: content (PI)	Significant changes to content required – refer to Executive Lead for guidance (SC)
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Please record details of any changes made to the document in the table below

Date	Record of changes made to document
11/04/2017	New Document
10/11/2017	Revision of document content
28/11/2017	Revision of document content
18/07/2017	Revision of document content
22/01/2021	Removed reference to on call rota location and added escalation of insufficient staff should go through Acute Silver Command.
24 May 2025	Now shown as V6.0 as a refreshed document replacing the 2021 version. Review Policy and convert into new Corporate Template. Update Section 6 to reflect current arrangements. Update Section 9 to reflect current training framework. Include reference to “Use of Ligature Cutters Procedure”. Include Definitions of Restraint. Include Staff Responsibilities & expand Chief Executives Responsibilities under H&S legislation. Add feedback comments from Occupational Health Service Manager around staff support from OHS and TRiM.
18 June 2025	6.2 Page 11, Add - Any restraint should be least restrictive and for the shortest period of time considered safe for all involved. Page 13, Add - the supine position for restraint is strongly recommended and the safest form of physical restraint. If prone restraint is used (for the shortest period of time required), must be recorded, reported and reviewed by a senior and experienced professional with restraint experience. Add - Principles under the Mental Health and Adults with Incapacity Acts. 7.0 Page 7 – Add NICE guideline (2017) Violent and aggressive behaviours in people with mental health problems.

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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 Crisis Prevention Institute techniques (CPI). The CPI 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. This may also include locums who have been trained in the CPI model approach.

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 and the European Convention on Human Rights
- Criminal Procedures (Scotland) Act (1995)
- Royal College of Nursing "Let's Talk About Restraint" (2008)
- Mental Welfare Commission "Rights. Risks & Limits to Freedom" (2021)
- Health and Safety at Work Act 1974, and Management of Health and Safety at Work Regulations 1999
- NICE guideline [NG10] 2015 Violence and aggression: short-term management in mental health, health and community settings
- NICE guideline (2017) Violent and aggressive behaviours in people with mental health problems. https://www.nice.org.uk/guidance/qs154

3. Definitions of Restraint

The Crisis Prevention Institute (CPI) defines restraint as follows:

Category A - Physical Restraint

Physical Restraint is defined by the Department of Health (2014) as 'any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person'. Physical restraint can also be called manual restraint, physical intervention and restrictive physical intervention.

Clinical Holding is physical restraint used solely for the delivery of safe care and treatment to a person who lacks capacity to consent for such treatment. The British Society for Disability and Oral Health (2009) define clinical holding as 'the use of physical holds to assist or support a patient to receive clinical care and treatment'.

The Royal College of Nursing (2010) provide further clarification by including the use of clinical holds as 'a suitable method of helping children and adults, with their permission, to manage a painful procedure quickly or effectively'.

Category B - Environmental Restraint

Seclusion is a specific method of environmental restraint typically used in acute and secure mental health settings and is defined as 'the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving'.

Category C - Chemical Restraint

Although the use of antipsychotics and sedatives may constitute chemical restraint, especially for individuals who lack capacity to consent, Rapid Tranquillisation is a specific emergency form of chemical restraint and refers to 'the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to

reduce agitation and aggression. This may provide an important opportunity for a thorough psychiatric examination to take place'.

Category D - Mechanical Restraint

Mechanical restraint involves 'the use of a device (e.g. belt or cuff) to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control' (Care Quality Commission, 2015a). Although the use of belts or cuffs is typically associated with the police and prison service, some acute mental health and forensic settings permit mechanical restraint to contain extreme violence and/or when certain individuals are admitted or transferred to and from hospital to minimise the risk of absconding.

4. 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;
- Ensure care and treatment is delivered in such a way that patient's rights are not compromised and in situations in which this is unavoidable, restraint will be used within the context of what is legally and ethically justifiable.

5. Roles and Responsibilities

Chief Executive

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 Chief Executive has overall responsibility for the provision of a safe working environment in line with Health & Safety legislation.

Medical Director

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.

Director of Community Health and Social Care

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.

Director of Nursing and Acute Services (DNAS)

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. The DNAS is also responsible for ensuring that other NMAHPs working for the Acute & Specialist Services Directorate have the necessary training to support the safe delivery of care, in context with their role.

Staff Responsibilities

All staff are responsible for taking reasonable care of themselves, and any other people whom may be affected by their actions or omissions.
Following all policies and procedures designed to ensure safer ways of working and the delivery of safe and effective patient care
Contributing to the risk assessment process, following individual restraint risk assessments and care plans and completing mandatory training to the appropriate level.
Reporting all incidents and near misses that may affect the health and safety of themselves or others, using the NHS Shetland Adverse Reporting System in line with the incident management policy.
Reporting any dangers they identify or any concerns they might have in relation to implementation of restraint.

6. The CPI Model and Best Practice

NHS Shetland has an Approved Training Centre (ATC) agreement through the Crisis Prevention Institute (CPI) for the delivery of the Safety Intervention model. The physical interventions skills within the Safety Intervention model have been independently risk assessed. CPI are affiliated to the British Institute of Learning Disabilities (BILD) Association of Certified Training (Bild ACT) which has been set up to certify training services that include a restrictive physical intervention.

Bild ACT is licensed by the Restraint Reduction Network (RRN) to certify training providers and services as complying with the RRN Training Standards of England and Wales.

The Safety Intervention 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.

CPI 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 CPI model consists of the following: Verbal Interventions, Safety Intervention Foundation and Advanced and Emergency programmes.

- CPI 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.
- CPI 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

Scottish 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'.

Both the Mental Health Act and the Adults with Incapacity (Scotland) Act provides a set of guiding principles to help to set the tone of the Act and guide there interpretation. As a general rule, anyone who takes any action under these Acts has to take account of the principles. These are:

Mental Health Act Principles:

1. Non-discrimination - People with mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs.

2. Equality - All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national or ethnic or social origin.

3. Respect for diversity - Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

4. Reciprocity - Where society imposes an obligation on an individual to comply with a programme of treatment of care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

5. Informal care - Wherever possible, care, treatment and support should be provided to people with mental disorder without the use of compulsory powers.

6. Participation - Service users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all the

information and support necessary to enable them to participate fully. Information should be provided in a way which makes it most likely to be understood.

7. Respect for carers - Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.
8. Least restrictive alternative - Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.

9. Benefit - Any intervention under the Act should be likely to produce for the service user a benefit that cannot reasonably be achieved other than by the intervention.

10. Child welfare - The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

Adults with Incapacity Act Principles:

1: Benefit - Any action or decisions taken must benefit the adult and only be taken when that benefit cannot reasonably be achieved without it.

2: Least restrictive option - Any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option that restricts the person's freedom as little as possible.

3: Take account of the wishes of the adult - In deciding if an action or decision is to be made, and what that should be, account shall be taken of the present and past wishes and feelings of the adult as far as they can be ascertained. The adult should be offered appropriate assistance to communicate his or her views.

4: Consultation with relevant others - In deciding if an action or decision is to be made, and what that should be, account shall be taken of the views of the nearest relative and the primary carer of the adult, the adult's named person, any guardian or attorney with powers relating to the proposed intervention, and any person whom the Sheriff has directed should be consulted, in so far as it is reasonable and practicable to do so.

5: Encouraging the adult - Any guardian, attorney, or manager of an establishment exercising functions under this Act shall in so far as it is reasonable and practicable to do so, encourage the adult to exercise whatever skills he or she has concerning property, financial affairs or personal welfare as the case may be and to develop new such skills.

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. Any restraint should be least restrictive and for the shortest period of time considered safe for all involved.

Staff should be aware that the use of force can only be justified if it is reasonable to use it to prevent injury to a patient and/or staff 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 2003 is appropriate, especially if interventions have occurred on a repeated basis.

7. Managing a Physical Intervention

CPI Response

In order to facilitate a proactive response to CPI alerts, a wide range of staff have been trained. Some staff are based at ward level in the hospital, others work across the Gilbert Bain and Mental Health Department based in Lerwick Health Centre.

Any responses that involve the Mental Health (Care & Treatment) (Scotland) Act 2003, a Registered Mental Health Nurse (RMN) and a Registered General Nurse (RGN) who is ILS trained should be present.

The Psychiatric Emergency Plan should be referred to in an emergency situation and a trauma informed approach taken.

CPI Team Leader/ Co-ordinator

The CPI 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 CPI Advanced / Emergency Level trained staff available.

There are a number of staff trained to the CPI Advanced / Emergency Level who form part of a MAPA® response Team.

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.

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.

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. The supine position for restraint is strongly recommended and the safest form of physical restraint. If prone (laid on their front) restraint is used (for the shortest period of time required), must be recorded, reported and reviewed by a senior and experienced professional with restraint experience.
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.

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. Any position of the body that obstructs the airway or that interferes with the muscular or mechanical components of respiration may result in positional asphyxia. For this reason the CPI 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 should be recorded on 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 with 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).

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 the Silver (Acute) bleep holder;
- The Director of Nursing and Acute Services – or if unavailable, the Gold Command

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 be restricted to as short a time as possible, dependent upon availability of transportation to a specialist environment;

- That nurses competent in ILS are available (continuously) to provide support if a medical emergency arises.

- That the Consultant Psychiatrist or Speciality Doctor, providing hospital liaison are available for ongoing clinical advice to the clinical team directly supporting the patient throughout the duration of their stay in the Low Stimulus Room.

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 CPI trained[1]. Any responses involving the Mental Health (Care & Treatment) (Scotland) Act 2003 a Registered Mental Health Nurse (RMN) is required to escort.

It is important to note however, that all staff activities in relation to CPI 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. CPI 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

[1] 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 2003 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. CPI Certified Instructors are available to assist with the development of an elective plan if necessary.

8. 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 potential outcomes from this meeting may include a referral to a TRiM practitioner and/or Occupational Health for assessment, if this is felt appropriate.

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 should seek appropriate medical assessment at the very earliest practicable opportunity. Sharps injuries and all significant incidents involving blood and body fluids, should be managed in line with NHS Shetland's Procedures for protection against occupational infection with blood borne viruses.

9. 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 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:

- An Adverse Event Report
- Health record – i.e. clinical notes
- Statements (where necessary)

All documentation must be completed as quickly as practicable after the physical intervention, 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).

10. Staff Training

The Board will evaluate training requirements by undertaking a training needs analysis (TNA) based upon the risk assessment process within individual departments, as it relates to violence and aggression.

The Board will provide a range of training programmes for staff, dependent upon the level of risk in accordance with a risk assessment for their area of work. This training can range from, but not limited to, managing difficult telephone conversations, de-escalation techniques and high-risk emergency intervention training, dependent upon the needs of the service area.

NHS Shetland will follow the framework set out by the Crisis Prevention Institute (CPI). This framework for training used to be known as MAPA, but has now been superseded by the new CPI framework. The following levels of training provided by NHS Shetland for the prevention of violence and aggression are as follows:

Course Type	Content	Who	Revalidation
Verbal Interventions CPI Verbal Intervention™	Staff who have limited physical interaction with distressed patient groups, but would benefit from	Reception Staff. Speech Language Therapy.	2 Yearly

incorporates trauma-informed and person-centred approaches. The programme, which was formerly an element of MAPA®, trains staff to respond to crisis situations with a focus on prevention using verbal de-escalation skills and strategies where restraint is inappropriate.	verbal de-escalation skills	Occupational Therapy. Managers. Estates and Public Facing Office Staff.	
Safety Intervention Foundation CPI Safety Intervention™ training, formerly known as MAPA®, incorporates trauma-informed and person-centred approaches. The programme is the perfect solution for professionals working in health, social care and education who need to prevent and/or intervene in crisis situations. With a focus on prevention, it also teaches staff de-escalation skills as well as non-restrictive and restrictive interventions.	Staff who are at increased likelihood of dealing with patients exhibiting challenging behaviours and require skills in verbal de-escalation as well as disengagement and restrictive techniques. This level of training will also include the CPI Clinical Holding Skills Training, which covers bed and trolley restrictive holding techniques.	GPs Midwifery McMillan Nurses Physiotherapy. Child & Mental Health Services	2 Yearly
Safety Intervention Advanced / Emergency CPI Safety Intervention (Formerly known as MAPA®). Advanced or Advanced and Emergency programmes are designed for organisations that support individuals who are more likely to	Staff who are at heightened exposure to patients displaying aggressive behaviours and requires de-escalation, disengagement and restrictive holding skills on the floor.	Mental Health. A&E and Ward 3 Nurses.	Annual

demonstrate more complex or extreme risk behaviours. It provides effective tools and decision-making skills to help staff manage higher risk situations, offering a wider array of verbal and physical intervention options. Participants need to complete the Foundation programme before undertaking this programme. RRN certificated training curricula. Provides both Continuing Education Credits (CEC) and Continuing Professional Development (CPD) Credits.			

All training can be booked through TURAS (search CPI) or contact CPI instructor/trainer Graham Laing at Graham.Laing@nhs.scot.

11. 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

12. 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)

MAPA® - the Management of Actual or Potential Aggression.

13. References

NHS Shetland - Management of Ligature Risk Policy.
NHS Shetland - Use of Ligature Cutters Procedure.