Acacium Group Community

Restrictive Physical Intervention and Breakaway Technique Policy

Policy Reference | CLIN 60

Version | V3.1

Policy Name	Restrictive Physical Intervention and Breakaway Technique Policy
Purpose of Document	To provide a structure for the training, identification for the need of and the use of Restrictive Physical Intervention and Breakaway Techniques
Target Audience	All staff carrying out physical intervention techniques
Version	V3.1
Author	Ian Gentry, Regional Clinical Lead, Clare Metcalfe, Divisional Chief Nurse and Vicki Guiney, Clinical Specialist
Date of Approval	February 2022
Published Date	February 2022
Lead Director	Karen Matthews Shard
Review Frequency	Annual
Last Reviewed	April 2024
Next Review Date	April 2025
Risk And Resource Implications	All risks related to the use of Restrictive Physical Intervention and Breakaway techniques i.e. risk of harm to candidates and client/patient/service users. Training of Restrictive Physical Intervention and Breakaway Technique and annual training update
Associated Strategies and SOPs	CLIN 01 Clinical Risk Management Policy CLIN 08 Safeguarding and Protecting Children Policy (England, Wales and Northern Ireland) CLIN 09 Safeguarding Vulnerable Adults at Risk Policy ORG 03 Health and Safety Policy ORG 19 Managing Behaviours that Challenge Policy ORG 41 Mental Capacity Act 2005 (MCA) & Deprivation of Liberty Safeguarding Policy ORG 41-1 Mental Capacity Act (Northern Ireland) 2016 (MCA) Deprivation of Liberty Safeguarding Policy
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A
Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
Draft	Jan 2019	First draft	IG/CM
Draft 1.1	Dec 2020	Draft	CM
Draft 1.2	Dec 2020	Review	Clinical Advisory Group
V1	Feb2022	Merge of 2 policies	Clare Metcalfe
V1.1	Oct 2022	Added in section 8.11	Vicki Guiney
V2	Feb 2023	Reviewed and updated	Clinical Advisory Group
V3	Jan 2024	Rebrand	Clinical Advisory Group
V3.1	Apr 2024	Reviewed and updated	Clinical Advisory Group

Table of Contents

1. Introduction

1.1. Acacium Group provide last minute and commissioned support for individuals with learning disability, Autism and/or mental health needs in both community and hospital settings. Many of these individuals present with high level complex needs, many of whom can reasonably be predicted to present with behaviours that challenge. This may put them at harm of restrictive interventions to manage their behaviour and reduce the risk of harm to themselves and others.

1.2. Acacium Group will take a positive approach to induction, training and development whilst recognising that their healthcare professionals are a great asset in its delivery.

1.3. Acacium Group are committed to delivering a physical intervention-free service and reducing the use of physical intervention in Mental Health and Learning Disability services in line with Physical intervention Reduction Network best practice guidelines.

1.4. Acacium Group will put in place measures to ensure that staff working in such services are trained and up to date to enable the safe management of behaviours that may be presented.

1.5. This policy clarifies that restrictive interventions will only be used:

- As a last resort when all other positive behaviour and proactive strategies have been used
- By staff who have completed an initial full course and subsequent refreshers in a Restraint Reduction Network (RRN), British Institute of Learning Disabilities (BILD)accredited training in protection and management of aggression training course and so are deemed competent to use such strategies
- For the minimum time required to keep the client, public and staff safe
- In an emergency to prevent serious harm to others

1.6. Consideration must always be given to the wellbeing, dignity and safety of the client.

1.7. Individual risk assessment must have been performed and plans put in place to manage any level of behaviours that challenge.

1.8. Ensuring that prior to any restrictive intervention, Relevant court approved documentation is in place and a copy available. If a client is under a court order, relevant documentation must be added to the client files. This includes any deprivation of liberty (DOLs).

2. Purpose and Policy Statement

2.1 The overall aim of this policy is to ensure the safety and wellbeing of the client/patient/service users who access the service, the staff who provide that service and any other individuals a client/patient/service user's behaviours that challenge could impact upon i.e. family members or members of the public.

2.2 This policy will ensure that all staff are aware of the legislation and guidance that underpins this policy so that the service is delivered in an ethical, consistent, and reliable manner.

2.3 The policy will ensure all staff are able to work within the frameworks of DoH guidance in the use of Physical Intervention. This includes upholding the rights, independence, inclusion and choice of client/patient/service users.

2.4 The policy will identify how staff will receive training in the use and delivery of Positive Behaviour approaches, Restrictive Physical Intervention (RPI) and Breakaway Techniques (BT) that are suitable for their care delivery needs and that these skills will be maintained and revised as appropriate, dependent on individual client/patient/service user need.

2.5 The policy will shape the delivery of evidence based best practice and develop staff knowledge, attitudes and skills which in turn will ensure continuous service development.

2.6 This policy sets out the principles and legal requirements covering the use of Restrictive Physical Intervention (RPI) and Breakaway Techniques (BT) by all staff employed within Acacium Group.

2.7 The advice, guidance and instruction contained within this policy is based on legislation, national guidance and evidence based best practice.

2.8 This policy will identify how staff will be able to access the training, development and maintain the skills required to:

- Support client/patient/service users who can present with behaviours that challenge, self-harming behaviours, behaviours that cause damage to property that may lead to physical harm occurring that pose a significant risk to the safety of themselves and/or others.
- Prevent aggressive behaviour in combination with Positive Behaviour Support theory applied through the functional assessment and the development of a Positive Behavioural Support Plan that will include proactive, reactive, crisis response and post crisis support strategies where appropriate.
- Use techniques to reduce the risk of harm to service users, their families, Staff and the public. intervention to be used appropriately, only when necessary and be utilised by trained staff and in line with the law, core values and ethical principles." (DoH 2017)
- This policy applies to and is to be used by all staff who will be working with client/patient/service user who are at risk of presenting with behaviours that challenge.

2.9 The policy is designed to provide part of the framework of care for all client/patient/service users who may present with behaviours that challenge, damage to property that could lead to harm occurring or self-harming behaviour challenges.

2.10 The policy applies to any Restrictive Physical Intervention which involves "A deliberate act to restrict a person's movement, liberty and/ or freedom to act independently" (DoH 2017) when that person is presenting with behaviours that pose a risk of harm to themselves or others. It is important to note this also includes the restricting of a person's freedom of movement using seclusion and the use of mechanical physical interventions (e.g. arm splints, mittens, helmets).

2.11 Examples of when RPI and BT using recognised techniques and reasonable/ minimal/ proportional force may be used are:

- To breakaway from harmful or dangerous physical contact initiated by a client/service user
- To separate a client/patient/service user from a "trigger" (something that may increase the likelihood of the behaviour occurring) that is known to pose a risk of harm occurring - To protect a client/patient/service user from a dangerous situation
- Where there is actual or identified risk of significant harm to self
- Where there is actual or identified risk of harm to others
- Where there is an actual identified risk of damage to property that could lead to a greater harm to self or others occurring.
    - The health and safety of clients, and Acacium Group staff, is paramount when supporting people who present with behaviours that challenge.

- All staff must ensure that there is a risk assessment in place to guide them around how to proactively respond to the individual behaviours that challenges.
- All Acacium Group health professionals are expected to comply with this Policy at all times and work with statutory partners in order to fulfil the requirements of the Policy, while ensuring that the clients specific care plan is being met
- Acacium Group nurses and carers who are unsure at any time of what action to take should contact the Clinical Team immediately for advice.
- Where possible all staff should be using the same accredited training to assure consistency in the techniques being used.
- Acacium Group will only accept management of aggression training certificates from a training provider that is RRN and BILD accredited. These includes but is not exclusive to:

- B Inspired, PRICE, MAPA, NAPPI & PMVA

3. Scope of Policy

3.1 This policy applies to all staff working within learning disability, Autism and mental health settings within Acacium Group

4. Exclusions

4.1 The policy does not apply to non-restrictive physical interventions where “force” is not required to support a person’s presentation.

4.2 Examples of when non-restrictive interventions are used are:

- Manual guidance to assist a person walking
- Where there is no purposeful resistance either physically or verbally by the person and every means possible to gain their consent has been made prior to direct contact
- Situations around health and safety (for example, preventing a client/patient/service user from walking into the road) when there is no behavioural aggression exhibited and where less aversive techniques or increased environmental support mechanisms can be used.

5. Definitions

5.1 Definitions relating to services, interventions and therapeutic approaches covered by this policy are set out in table below.

Definition	Explanation
Policy	A high level, overall statement of intent embracing general principles and the steps which the organisation expects to be followed in order to achieve them. Policies are enforceable and failure to comply may result in disciplinary action.
Procedure	A formal set of steps to follow in order to achieve specific outcomes, which are specifically agreed for designated staff. Any deviation from the steps is acceptable if this can be justified and the rationale for doing so documented appropriately.
Competence	Competence should be acquired through general professional training, attending educational workshops, observation and supervised practice in the clinical setting. Competence can be examined by questioning knowledge, observing practice and reflective practice journal.

Challenging Behaviour/behaviours that challenge	Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion Ref - Royal College of Psychiatrists (2007), "*British psychological society, & Royal college of speech and language therapists*", Challenging Behaviour: A Unified Approach, Royal College of Psychiatrists, London.
Restrictive Physical Intervention (RPI)	'Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: • Take immediate control of a dangerous situation where there is real possibility of harm to the person or others if no action is undertaken • End or reduce significantly the danger to the person or others • Contain or limit the person's freedom for no longer than is necessary' DoH (2014) • Physical interventions should only be used when the risks of not employing and emergency intervention are outweighed by the risks of using one • They will not become a standard way of dealing with situations or be used as a substitute for staff training in person centred care skills • Over time the term physical intervention has acquired a number of negative connotations and is a term closely linked with a particular kind of approach to the management of aggressive and violent behaviour 'control and physical intervention' For this reason this document uses the more neutral term 'physical intervention' to indicate a continuum between touching, holding and physical intervention, and the link with all other approaches of de-escalation to be used in conjunction with physical interventions at all times • Physical intervention involves direct contact between staff and a service user/client and would consist of seated, standing, or supine floor hold. This is used to prevent the person doing something i.e. preventing them from running in front of traffic • Segregation or seclusion- involves restricting a person's freedom of movement and isolating them from other people in a separate room or by blocking their view • Chemical intervention- involves the use of PRN (as and when) medicines (individually prescribed) to control risky behaviours, calm or sedate people • mechanical intervention- involves the use of belts, cuffs or physical barriers to restrict a person's movement. This includes using a harness in the car and using child gates to prevent access
Breakaway Techniques (BT)	"A set of physical skills to help separate or breakaway from an aggressor in a safe manner. They do not involve the use of physical intervention" NICE (2005a)
Supine Physical intervention	Supine physical intervention means the person is restrained in a face up position on the Clients back on the floor or other surface.
Prone physical intervention	A physical restraint in a chest down position, regardless of whether the person's face is down or to the side. This is not to be used unless exceptional circumstances. If used then the client/service user needs to be placed in supine holds as soon as possible.
Positive Behaviour Support (PBS)	A multicomponent framework for

	• Developing an understanding of challenging behaviour displayed by an individual, based on the assessment of the social and physical environment and broader context within which it occurs • With the inclusion of commissioner/family perspectives and involvement • Using this understanding to develop, implement and evaluate the effectiveness of a personalised and enduring system of support • And that enhances the quality-of-life outcomes for the client and other commissioner/family.
Restraint reduction Network	The Physical intervention Reduction Network Training Standards aim to facilitate culture change, not just technical competence. The Standards focus on the human rights, physical intervention reduction, prevention, de-escalation, safe use, and recovery. They focus on the fundamental principles that apply to all populations and settings (2019)

6. Roles & Responsibilities

6.1 **Organisational Staff**

6.1.1 Training and continuing professional development: Acacium Group will where required enable staff to participate in training that supports staff to deliver safe and effective care. This training will also help staff to understand their responsibilities in relation to restrictive practice, decision making, and the consequences should this policy and individual risk assessments not be followed

6.1.2 Where stipulated regular refresher training will be provided to support organisational objectives, client safety and care that are relevant to the individual needs of the client. The training will be proportionate, and relevant to the roles and responsibilities of each staff member.

6.2 **Supervision and support**

6.2.1 Acacium Group recognises the importance of providing supervision and support to staff. This may come in the form of a clinical supervision, debrief following an incident or wellbeing calls should this be required. The use of physical intervention can be traumatising for not only the client but the staff utilising this so we need to ensure that staff are at the forefront of any post incident support required.

6.3 **Robust complaints procedures**

6.3.1 Acacium Group has in place robust complaints and whistleblowing procedures, Acacium Group guarantees that staff and anyone using these procedures appropriately will not prejudice their own position, and prospects.

Job Title	Responsibilities
Trainers	Responsible for delivering safe protection and physical intervention training and keeping up to date with practice. Assessing staff level of competence to ensure safety for the clients being supported.
Global Clinical Director/Group Chief Nurses	Responsible for ensuring that all policies, standard operating procedures (SOPs), protocols, training, and competencies, are in place to support workers or care in the safe delivery of safe and effective care provision.
Operations Board	Ensure that the Directors have management, and accountability, structures that deliver safe and effective services

Team leaders and senior nurses/managers	Ensure that a thorough risk assessment of the behaviours is completed to ensure staff have proactive plans around the use of verbal de-escalation • Ensure that the environment that staff are working in is fit for purpose and has adequate space to manage behaviours that challenge should they be presented • Ensure any staff that are working in environments where there is a risk of behaviours that challenge are trained to the expected levels • Demonstrate leadership, be informed about and take responsibility for the actions of their staff • Lead on working with partners, and agencies, locally in order to provide timely and seamless care • Ensure that care is routinely planned and re-assessed with the appropriate use of resources • Maintain confidentiality • Ensure that staff are clear about their professional roles and responsibilities • Ensure their staff make comprehensive and accurate healthcare records • Ensure their staff work effectively with professionals from other relevant organisations • Facilitate and/or undertake regular audit of practices and restrictive practices • Ensures that physical intervention reduction practices is being built into the support • Ensures that there is legal documentation in place where there is risk physical intervention being utilised • At all times a person-centred approach will be used to support individual clients • Every individual has the right to be treated fairly, with respect, and to be fully involved in their own care • All care provision should be in the best interests of the individual • Restrictive Physical Intervention tools in place should ensure safety and should at no time be used to exert power over, or force compliance on, any individual • Emergency use of physical intervention in a non-planned situation must always be followed up by a full process of risk analysis, planning and staff training to ensure reduced risk in the event the behaviour of concern is presented again.
Individual staff members:	• Provide a consistently high standard of care that promotes quality of life for all • Utilised a positive approach to behaviours and utilise verbal de-escalation where this is possible • Promote client safety, dignity, equality, and individuality • Ensures that the client regularly takes their medication • Ensures that the service is predictable, consistent and structured to maintain a low level of anxiety whilst incorporating meaningful activities into the daily routine • Be aware of, and comply with, Acacium group policies, procedures, and guidance • Promote confidentiality, sharing information with partners on a need-to-know basis

	• Report any new behaviours or physical intervention required that is not identified within the clients care plan • Take part in training, including attending updates so that they maintain their skills and are familiar with procedures • All practitioners, registered and non-registered, should access regular supervision and support in line with local procedures • All staff should maintain accurate, comprehensive and legible records, with records being stored securely in line with local guidance • Report to the clinical team any new behaviours so that these can be assessment and supported effectively • All parties involved, for example, the client/patient/service user and staff members, should be fully supported through incidents where physical intervention is used as this is potentially a difficult and traumatic experience. This must be recognised prior to, during, and after an incident where physical intervention has been required • Physical Intervention should only ever be used when the risk of not doing so out-weighs the risk of doing so i.e. preventing a greater harm from occurring. Behaviour plans will reflect proactive strategies to reduce the need for physical Intervention, positive approaches to teach an individual the required skills to meet their needs appropriately (where possible) should always be considered as the last option to bring rapid, safe control over a situation • Physical Intervention will only be used by appropriately trained staff • All physical intervention strategies are to be pre-planned and agreed by relevant stake holders involved in providing care and support to an individual client/patient/service user and, where possible, include the client/patient/service user in the process • The use of physical intervention will aim to be gender, health and culturally sensitive • All interventions will be carried out with the underlying premise of minimal force, least restriction, least intrusion, shortest duration and proportional to the risk being presented.

7. Assessment Risk

7.1 Assessment of risk and planning are integral to the effective management of care provision and Acacium Group workers will be expected to contribute to these processes.

7.2 A documented risk assessment around behaviours that can be presented and strategies to manage these will be in the home.

7.3 The risk assessment must identify the levels of restrictive practice and physical intervention that is likely to the client being supported. Ways in which physical intervention will be likely to take place should be included i.e. level of holds, harness in the vehicle.

8. Determining ratio of staffing in last minute nursing community packages

8.1 If the client has a history of requiring physical interventions that require emergency holding to the floor either in supine or prone position a minimum of 3 staff must be placed to allow safe

management of the head and observation of the airway. 4 staff should be placed if the clients' legs are required to be placed in a restrictive position.

8.2 If a client has a history of requiring seated or standing physical interventions, then a minimum of 2 staff should be placed. If the client has a history of attempting to headbang/ bite or drive themselves forward onto the floor, then a 3rd person should be placed to restrict the head movements and minimise risk.

8.3 1 member of staff cannot use physical interventions on their own.

8.4 If a client is required to go out in a car, then they should always be placed in the back seat with a member of staff beside them. The driver should not be included in the ratios unless in exceptional circumstances.

9. Consent

9.1 Clients have a fundamental legal and ethical entitlement to determine what happens to their bodies. Valid consent to treatment is central to all forms of healthcare. Consent is a client agreement for a health professional to provide care.

9.2 This may be indicated nonverbally, orally, or in writing.

9.3 For consent to be valid the client must be competent to take that decision, be fully informed of the action and its consequences, and not be under duress. Consent should be sought verbally for the purposes of undertaking observations.

9.4 If a client declines care recommended by the Acacium Group health care professional, this should be documented in accordance with the Consent Policy.

9.5 Acacium Group staff should be aware of consent. If the client/service user is an adult, then no adult can consent for another adult and therefore legal documentation needs to be in place highlighting rights as part of best interest process. In certain situations, staff may be able to act if they are able to demonstrate that any actions are in the best interest of the client/service user. If the client/service user is a child, then parental consent can be accepted unless the child is a child in need or in care.

9.6 There may be a representative legally appointed to provide consent on the client's behalf.

9.7 Please read the Acacium Group Consent Policy for full details.

10. Client and Family Involvement

10.1 It is advisable, where possible to involve the client and their family in the organisation and delivery of the use of physical intervention. Where possible and in line with any legal requirements, full consideration of their views and practical support should be taken on board as they maybe the best ones to recognise care needs:

- Where appropriate, meet with the family at the assessment stage to review behaviours that challenge and the current interventions in place
- Where appropriate, discuss with the client and the family the best way that they would want behaviours to be managed
- Where appropriate, explain to the client and families the process around managing behaviours that challenge so that they are fully updated around the care plans in place

- Where appropriate, devise and review plans alongside the client and family

11. Recording and reporting

11.1 Staff should report and record any incidents where physical interventions were used.

11.2 This will enable accurate analysis and reflection of the use of physical interventions by managers and external services and staff receive the support they require to keep people safe from harm.

11.3 A record of the incident should be made by the person leading the physical intervention stating which alternative strategies were used or rejected and justification for using the restrictive intervention.

11.4 Staff recording the incident should clearly state what part of the individuals person they were holding e.g. head, legs right arm, left arm.

11.5 Staff should also state the level of restriction used e.g high level, low level etc.

11.6 Staff must report any Breaches in Policy.

11.7 All incidents require a thorough and careful investigation at a local level, taking full account of the context, circumstances and the position of the practitioner involved. Such incidents require sensitive management and a comprehensive assessment of all the circumstances before a professional, and managerial, decision is reached on the appropriate way to proceed.

12. Justification

12.1 Staff should always judge whether restrictive interventions are acceptable and legitimate based on all presenting circumstances.

12.2 Justification (as a legal defence) for using physical interventions needs to address these questions:

- Are staff clear about how the intervention helps the client's concern?
- Is the intervention being used for the benefit of staff, the person or other people, for example in times of staff shortages or unskilled staff on shift?
- Has there been accurate recording and analysis of incidents when interventions were used?

13. Key principles for reducing potential risks

13.1 Unplanned use of Physical Intervention in an unforeseen emergency must be reported to the Clinical Manager for that area so that a debrief/analysis can be conducted. The information gathered will inform any changes that may need to be made to a client/patient/service user's care plan and risk assessment.

13.2 In the event that a staff member is involved in an incident where unplanned Physical Intervention may be required, they need to be confident that the possible outcome from the unplanned intervention is less severe than the outcome that could occur were they not to employ interventions.

13.3 Local reporting procedures should be followed to record any use of physical intervention and reported and escalated as appropriate in line with Acacium Group ORG 04 Incident Reporting Policy.

13.4 Reasonable, proportional, and minimal force must always be used when utilising physical Intervention.

13.5 All accredited techniques used in a planned manner by the service will never involve the use of pain compliance to facilitate effective restraint and/ or dis-engagement from aggressive behaviour, and this concept must be strictly adhered to.

13.6 Physical Intervention to only be utilised in the least intrusive way possible and for the minimum period required by the service user's needs.

13.7 Clients who have required the use of Physical Intervention need to be assessed for any signs of injury or distress during and after an incident. Staff will be trained to identify the specific physiological signs associated with the major risks of using physical intervention strategies. They will also be trained in Basic Life Support skills and will take all appropriate actions required, if necessary, i.e. emotional support, first aid or contacting emergency services.

13.8 Staff working with clients where physical intervention has occurred will ensure that physical observations such as pulse and blood pressure will be carried out and documented using the NEWS and PEWS recording chart to ensure observations are within normal range for that person. If a staff member is concerned around a client's deterioration of health then they must escalate depending on the seriousness of the concern i.e. escalate to clinical lead, 111 or 999 if life threatening.

13.9 Any injuries or negative emotional responses resultant from Physical Intervention use to be documented in clinical notes and incident reporting. If felt necessary, staff will escalate to their manager and RPI/ BTs instructors for further support.

13.10 No form of seclusion (where a client/patient/service user is forced to spend time alone against their will) will be used in a person's care unless the seclusion prevents a greater harm occurring, and the seclusion is utilised only for the minimum duration required to negate a greater harm occurring. Where possible, if brief seclusion is identified as a positive response which reduces the risk of harm to the client/patient/service user and their carers, this will be documented within the Behaviour Support Plan and will follow the process of best interest ratification described above.

13.11 Acacium group recognise the risks associated with prone restraint and therefore this should never be care planned as a method of use. Should a client need to be placed in prone restraint due to the situation then staff are to turn the client over to supine as soon as possible or safely release the client from holds. All staff who are physical intervention trained will be taught how to turn a client over safely.

14. Associated Policies / SOPs

Policies

CLIN 01 Clinical Risk Management Policy
CLIN 08 Safeguarding and Protecting Children Policy (England, Wales and Northern Ireland)
CLIN 09 Safeguarding Vulnerable Adults at Risk Policy
ORG 03 Health and Safety Policy
ORG 19 Managing Behaviours that Challenge Policy
ORG 41 Mental Capacity Act 2005 (MCA) & Depravation of Liberty Safeguarding Policy

15. References

- Reducing the Need for Physical intervention and Restrictive Intervention: Children and Young People with Learning Disabilities, Autistic Spectrum Disorder and Mental Health Difficulties (2017) Department of Health, Department of Education
- Learning disabilities and behaviour that challenges: service design and delivery, NG93. (2018) National Institute for Health and Care Excellence
- Code of Practice for the use and reduction of restrictive physical interventions. 3rd edition (2010) BILD
- Positive and Proactive Care: reducing the need for restrictive interventions (2014) Department of Health
- Emerson E, Bromley J. The form and function of challenging behaviours. Journal of Intellectual Disability Research. 1995;39:388–98.
- The Clinical Practice Guidelines for Violence: The short-term management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments. (2005a) National Institute for Health and Care Excellence
- Gore et al. Definition and scope for positive behavioural support. International Journal of Positive Behavioural Support Volume 3 Number 2 Autumn 2013
- Department of Health (2002) Guidance for Restrictive Physical Interventions: How to provide safe services for people with a learning disability, London HMSO
- Nursing and Midwifery Council. (2015). The Code: Professional standards of practice and behaviour for nurses and midwives. London, NMC
- Human Rights Act 1998. Available at: https://www.legislation.gov.uk/ukpga/1998/42/schedule/1 (Accessed 2nd October18)
- United Nations Convention on the Rights of the Child 1989. Available at: https://www.unicef.org.uk/what-we-do/un-convention-child-rights/ (Accessed on 2nd October 2018)
- Code of practice: Mental Health Act (Updated October 2017). Available at: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983 (Accessed 15th October 2018)

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

pulse Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group

Appendix B: Legislation

1. The following is a list of the national policies, guidance and legislation that supports the need for the development of this policy:

Legislation/Guidance	Description
Autism Act 2009	The Autism Act 2009 is an Act of the Parliament of the United Kingdom. The Act makes provision about the needs of adults who have autistic spectrum disorders including autism and Asperger syndrome
Care Act 2014	An Act to make provision to reform the law relating to care and support for adults and the law relating to support for carers; to make provision about safeguarding adults from abuse or neglect; to make provision about care standards; to establish and make provision about Health Education England; to establish and make provision about the Health Research Authority; to make provision about integrating care and support with health services; and for connected purposes.
Human Rights Act 1998	This Act incorporates the majority of rights set out in the European Convention on Human Rights into UK law. In order to meet their obligations under the Act, healthcare professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention.
Deprivation of Liberty Safeguard (DoLs)	DoLS ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. ... Arrangements are assessed to check they are necessary and in the person's best interests.
Mental Capacity Act 2005	Provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes it clear who can take decisions, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity. A client who does not have the necessary mental capacity to take a treatment decision must receive treatment that is in his/her best interest.
Equality Act 2010	The Act makes it unlawful to discriminate against someone on the grounds of any of these characteristics: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion/belief, sex (gender) and sexual orientation. These are often referred to as protected characteristics
Health and Safety at Work Act 1974	Defines the fundamental structure and authority for the encouragement, regulation and enforcement of workplace health, safety and welfare within the UK.

Mental Health Act 1983, updated 2015	The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.
United Nations Conventions on The Rights of The Child (1989),	Article 19 and The Human Rights Act (1989) Article 5, focus on the states responsibilities to prevent harm to a child and also a person's freedom of movement. Consideration must also be given to the NICE Guidelines NG11, NG93 and NG54 as well as the Clinical Guidance CG170.
Adults with Incapacity (Scotland) Act 2000	Provides a framework for safeguarding the welfare and managing the finances of adults (people aged 16 or over) who lack capacity due to mental illness, learning disability, dementia or a related condition, or an inability to communicate
The Mental Health (Care and Treatment) Scotland Act 2005	An act to increase the rights and protections of people with mental disorders, which is a term that encompasses mental illness and learning disability
Mental Health Scotland Act 2005 (This is for HOSPITALS ONLY – not related to community so you may want to leave this one out of the ICS community policies	This act requires Ministers to carry out a review of the arrangements for investigating the death of patients in hospital for treatment for a mental disorder
The Mental Capacity Act (NI) 2016	This is currently only partially commenced and provided the new statutory framework in relation to deprivation of liberty
Violent and aggressive behaviours in people with mental health problems	This quality standard covers short-term prevention and management of violent and physically threatening behaviour among adults, children and young people with a mental health problem. It applies to settings where mental health, health and social care services are provided. This includes community settings and care received at home.
NICE - Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges NICE guideline [NG11]Published: 29 May 2015	This guideline covers interventions and support for children, young people and adults with a learning disability and behaviour that challenges. It highlights the importance of understanding the cause of behaviour that challenges, and performing thorough assessments so that steps can be taken to help people change their behaviour and improve their quality of life
Control of Substances Hazardous to Health (COSHH) Regulations 2002	Latex is classed as a hazardous substance which is covered by the Health and Safety Executive's Control of Substances Hazardous to Health (COSHH) Regulations 2002. Under the regulations, organisations have a duty to assess the risk, eliminate, substitute,

	and limit and control exposure to latex, unless there is a need to use it.
RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995	There is a requirement to report diagnosed cases of Occupational dermatitis (schedule 3) to RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995.

2. Equality and diversity

Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.

Appendix C: Example Positive Behaviour Plan Template

Behavioural Support Plan (BSP)

Appendix C Safe Holding and Incident Monitoring Tool
Safe Handling Use and Incident Recording Pack
Client Name:
In the event behaviours that challenge are being presented that require Staff to use Safe Handling Techniques, this pack of forms will need to be completed.

In the event that behaviours that challenge take place over a period of time whereby the staff need to apply a technique, reduce the level of the technique on stop the application and then re-apply the techniques, this will not be considered as multiple applications requiring multiple packs to be completed, but as 1 incident. However, all techniques and the staff involved in supporting the behaviour presented needs to be documented.

This enables us to monitor behavioural presentation, track are use of Safe Holding Techniques, identify areas for further assessment/ intervention development as well as demonstrate World Class levels of Service Delivery and transparency to all relevant parties.
This form can be used to record incidents that do not involve Safe Handling Techniques, but this must be stated on the form.

Safe Handling Technique Use Monitoring Tool
This form is to be completed whenever ARC Model Safe Handling Techniques are required to support a person in TCS care. This form needs to be read alongside the following TCS documentation that is also completed whenever an incident requiring safe handling use occurs:

- Clinical Notes
- Antecedent Behaviour Consequence chart
- Body Map (if required following incident)
- Post incident staff debrief
- DATIX (electronic incident reporting). Ensure the incident is called into the TCS office and the RCL is notified so an electronic incident form (DATIX) is also raised.

Each incident requiring the use of Safe Handling is to be allocated a number, this will be the client code (at the top of this document) and what number incident this is. This number must be quoted on each piece of documentation used to record that specific incident (the documents listed above). i.e. if this was the 4th incident involving Dave Smith, the code would be SMID04.

Date and Location:	Incident code:	Incident Start time (start of behavioural challenge):	Incident finish time:	Duration of Safe Holding Use during incident:
Technique Used: Refer to PBSP for names of techniques	Person on left arm	Person on right arm	Person/ people on leg support	Person on Head support

Client injury sustained due to behavioural presentation or Safe Holding Technique: is first aid required, A+E or ambulance (to be recorded on Body Map, clinical notes and debrief)				
Staff injury due to behavioural presentation or Safe Holding Technique: is first aid required, A+E or ambulance, is staff member able to continue shift (to be recorded in clinical notes and in debrief document)				

Airway/ Breathing Monitoring (Staff responsible for monitoring during incident, any concerns related to breathing during incident i.e. cyanosis, altered breathing rate or difficulties	Post incident observations if required (pulse, blood pressure, O2 sats, respiratory rate) and time recorded.

Post Safe Holding checklist

- All documentation completed Y/N
- Office and RCL/ On Call RCL notified Y/N
- Post incident debrief completed Date & Time: Y/N

Form completed by:
Print Name, designation and staff number: Date & Time:

Signature:

Appendix D: Example Post incident debrief conducted by (and date and time)

ABC CHART
FOR RECORDING & OBSERVATION

Client:	
Date of Birth:	
Setting:	

Date /Time	Staff initials	Antecedent *(What happened before)*
	Behaviour	
Consequence/Outcome (What happened after) Comments		

Body Map for Safe Handling Incident No:_____
Name of Client: Date of birth:

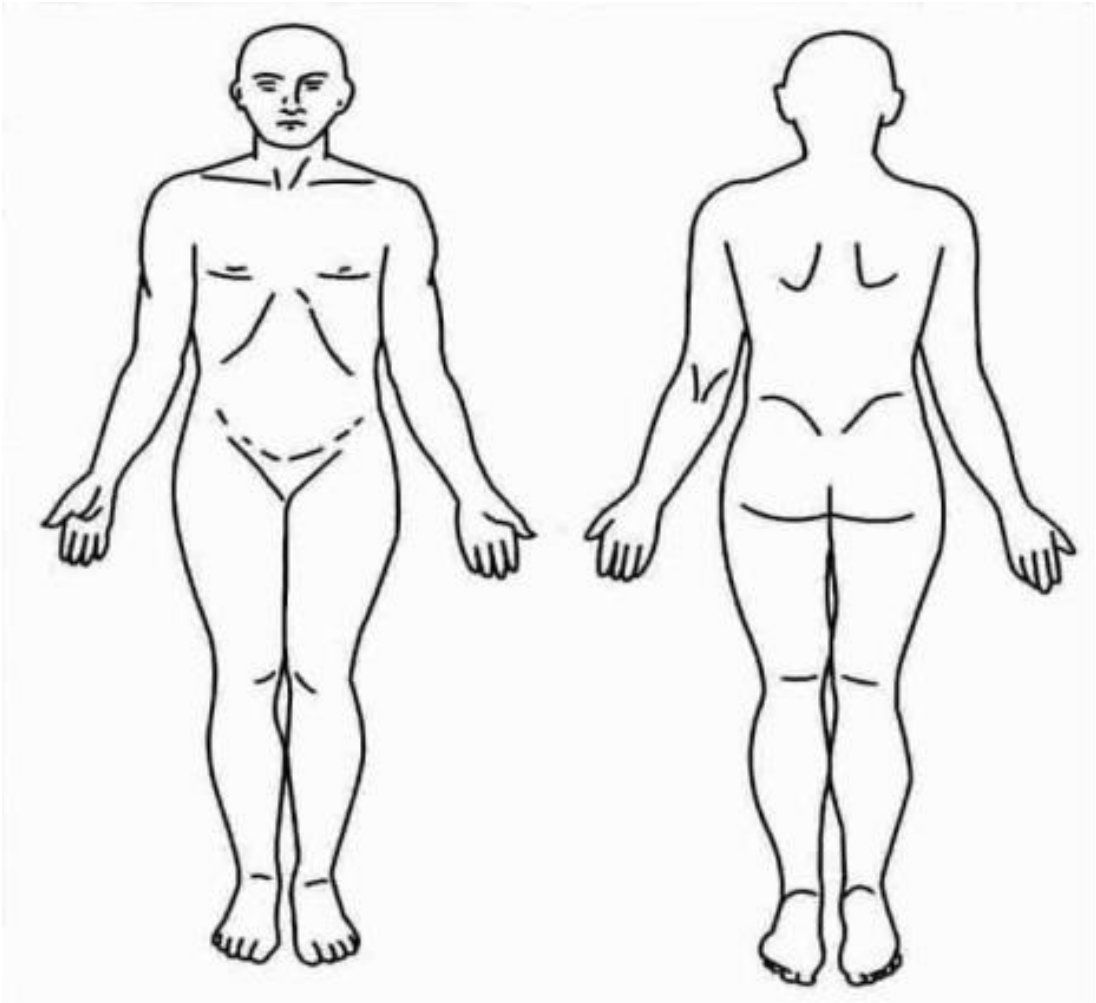
Support Worker Completing Assessment: - _____

Date of Assessment: - _____ Time of Assessment:- _____

Please draw on the body map in black ink, using the following key to indicate the different types of injury (alphabetic code), and provide brief details for each injury, e.g. wound, colour of bruise, etc

A – ulcers B - bruising C - cuts, wounds D - excoriation, red areas (not broken down) E- scalds, burns

F- Pressure Area Broken skin



Front Back

Right	Left	Left	Right

Please list the areas of concern below:

1. ……

2. ……

3. ……

4. ……

Action Taken:

Clinical Sign Off_____ Date _____

Post-incident debrief form - staff

Thornbury Community Services

This form can either be completed on site by the Nurse Lead on shift/ attending RCL or conducted by telephone between the care staff and the RCL

Staff member name:			
Client name:			
Daily activity log sheet no:		Date:	

Name of staff completing this form:			
Staff signature:		Date:	

Description of events leading up to the incident

What happened after the incident?

Staff carrying out debrief signature:		Date:	

Staff member signature:		Date:	