jrhsupport

PHYSICAL INTERVENTIONS POLICY

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1.0 Introduction

This policy and procedure has been produced as guide for all staff.

This policy has been prepared in 2 parts:

Part I Primary and Secondary Preventative Strategies
Part II Restrictive Physical Interventions

The use of force is associated with increased risks regarding the safety of service users and staff and inevitably affects personal freedom and choice.

For those reasons this guidance is specifically concerned with the use of restrictive physical interventions.

Part 1

Primary and Secondary Preventative Strategies

2.0 Definitions

2.1 Different forms of physical intervention are summarised in the table below, taken from the Dept of Health document Guidance on restrictive physical interventions, 2002.

	Bodily Contact	Mechanical	Environmental Change
Non-Restrictive	Manual Guidance to assist a person walking	Use of a protective helmet to prevent self-injury	Removal of the cause of distress, e.g. adjusting temperature, light or background noise
Restrictive	Holding a person's hands to prevent them hitting someone	Use of arm cuffs or splints to prevent self injury	Forcible seclusion or the use of locked doors

2.2 This table shows the differences between restrictive forms of intervention; which are designed to prevent movement or mobility or to disengage from dangerous or harmful physical contact; and non-restrictive methods. Restrictive physical interventions involve the use of force to control a person's behaviour and can be employed using bodily contact, mechanical devices or changes to the person's environment.

3.0 Primary and Secondary Preventative Strategies

The use of restrictive physical interventions should be minimised by the adoption of primary and secondary preventative strategies.

3.1 Primary prevention is achieved by:

- Ensuring that the number of staff deployed and their level of competence corresponds to the needs of the service users and the likelihood that physical intervention will be needed. Staff should not be left in vulnerable positions

- Helping service users to avoid situations which are known to provoke violent or aggressive behaviour, e.g., settings where there are few options for individualised activities

- Support plans which are responsive to individual needs and include current information on risk assessment

- Creating opportunities for service users to engage in meaningful activities which include opportunities for choice and a sense of achievement

- Developing staff expertise in working with service users who present challenging behaviours

- Talking to service users, their families, and advocates about the way in which they prefer to be managed when they pose a significant risk to themselves or others. Some service users prefer withdrawal to a quiet area, to an intervention which involves bodily contact.

3.2 Secondary prevention involves recognising the early stages of a behavioural sequence that is likely to develop into violence or aggression and employing diffusion techniques to avert any further escalation.

3.3 Where there is clear documented evidence that particular sequences of behaviour rapidly escalate into serious violence, the use of a restrictive physical intervention at an early stage in the sequence may, potentially, be justified if it is clear that:

- Primary prevention has not been effective

- The risks associated with not using a restrictive physical intervention are greater than the risks of using a restrictive physical intervention; and

- Other appropriate methods, which do not involve restrictive physical interventions, have been tried without success.

3.4 All prevention strategies should be carefully selected and reviewed to ensure that they do not constrain opportunities or have an adverse effect on the welfare or the quality of life of the service users (including those in close proximity to the incident) unnecessarily. In some situations it may be necessary to make a judgment about the relative risks and potential benefits arising from activities which might provoke challenging behaviours compared with the impact on the person's overall quality of life if such activities are proscribed. This is likely to require a detailed risk assessment.

3.5 Devices which are required for a therapeutic purpose, such as buggies, wheelchairs and standing frames (including any supporting harness) may also restrict movement. Such devices should never be provided for the purpose of preventing problem behaviour, although, in extreme circumstances, they might be used to manage risks. A decision to use therapeutic devices to prevent problem behaviour (for example strapping someone into a wheelchair) must be agreed by a multi-disciplinary team in consultation with service users, their families and advocates, and recorded within an individual's support plan.

3.6 Devices that are designed specifically to prevent problem behaviours should be considered a form of restrictive physical intervention, even if the service users does not resist the use of such devices. E.g., arm splints or protective garments might be used to prevent self-injury. They should only be introduced after a multi-disciplinary assessment which includes consultation with service users, their families and advocates. If used, they should be selected carefully to impose the least restriction of movement required to prevent harm while attempts should continue to be made to achieve the desired outcomes with less restrictive interventions. Such devices should only be used by carers who have received specific training in their usage. The rationale for using any devices and the circumstances in which they may be used must be clearly recorded within an individual's support plan.

Part 2

Restrictive Physical Interventions

4.0 If they are to be used, restrictive physical interventions can be employed to achieve a number of different outcomes:

- To break away or disengage from dangerous or harmful physical contact initiated by a service user.

- To separate the person from a trigger, for example, removing one person who responds to another with physical aggression;

- To protect a person from a dangerous situation – for example, the hazards of a busy road.

4.1 It is helpful to distinguish between:

- *Planned intervention*, in which staff employ, where necessary, pre-arranged strategies and methods which are based upon a risk assessment and recorded in support plans;

- *Emergency or unplanned* use of force which occurs in response to unforeseen events.

4.2 The scale and nature of any physical intervention must be **proportionate** to both the behaviour of the individual to be controlled, and the nature of the harm they might cause. These judgements have to be made at the time, taking due account of all the circumstances, including any known history of other events involving the individual to be controlled. The minimum necessary force should be used, and the techniques deployed should be those with which the staff involved are familiar and able to use safely and are described in the service-user's support plan. Where possible, there should be careful planning

of responses to individual adults known to be at risk of self-harm or of harming others.

4.3 The use of force is likely to be legally defensible when it is required to prevent:

- Self-harming
- Injury to other service-users or staff
- Damage to property
- An offence being committed

4.4 The use of force to restrict movement or mobility, or to break away from dangerous or harmful physical contact initiated by a service user, will involve different levels of risk. Good practice must always be concerned with assessing and minimising risk to service users, staff and others and pre-planning responses where possible.

Examples of physical intervention that might generally be considered low risk include:

- Members of staff taking reasonable measures to hold a service user to prevent him/her from hitting someone

- A specially designed arm cuff to prevent someone self-injuring

- Accompanying a person who dislikes physical contact to a separate room where they can be alone for a few minutes while being continuously observed and supported.

Elevated levels of risk are associated with:

- The use of clothing or belts to restrict movement

- Holding someone who is lying on the floor or forcing them onto the floor

- Any procedure which restricts breathing or impedes the airways

- Seclusion, where an adult is forced to spend time alone in a room against their will

- Extending or flexing the joints or putting pressure on the joints

- Pressure on the neck, chest, abdomen or groin areas

4.5 Planned physical intervention strategies should be:

- Agreed in advance by a multidisciplinary team working in consultation with the service user and his or her carers or advocates.

- Described in writing and incorporated into other documentation which sets out a broader strategy for addressing the service users behavioural difficulties;

- Implemented under the supervision of an identified member of staff who has undertaken appropriate training provided by an appropriate organisation. Specific techniques should be closely matched to the characteristics of individual service users and there should be a record of which staff are permitted to use different techniques. It is not appropriate for staff to modify the techniques they have been taught.

- Recorded in writing so that the method of physical intervention and the circumstances when it was employed can be monitored and, if necessary, investigated.

Where planned physical intervention strategies are in place, they should be one component of a broader approach to behaviour management, treatment or therapy.

4.6 Unplanned or emergency intervention may be necessary when a service user behaves in an unexpected way. In such circumstances, members of staff retain their duty of care to the service users and any response must be proportionate to the circumstances. Staff should use the minimum force necessary to prevent injury and maintain safety.

4.7 To the extent that *seclusion* involves restricting a person's freedom of movement, it should be considered a form of physical intervention. The use of seclusion for people detained under the Mental Health Act, 1983, is set out in the code of practice published in 1999.

The right to liberty and personal freedom is enshrined in Article 5 of the Human Rights Act 1998 and is protected by the criminal and civil law. For these reasons the use of seclusion outside the Mental Health Act should only be considered in exceptional circumstances and should always be proportional to the risk presented by the service user.

5.0 Environmental Change

5.1 DoH guidance distinguishes between

- *seclusion* where a person is forced to spend time alone against his/her will
- *time out* which involves restricting the person's access to all positive reinforcements as part of the behavioural programme
- *withdrawal* which involves removing the person from a situation which causes anxiety or distress to a location where they can be continuously observed and supported until they are ready to resume their usual activities.

5.2 Mechanical Restraint

- The definition of mechanical restraint incorporates all methods of restricting a person's movement through the use of objects or equipment.

- Mechanical restraint should always be used for the therapeutic value to the individual. Mechanical restraint should only be used when the risk involved where the method of restraint is not deployed reaches an unacceptable level. They should not be used as the first and simplest means of controlling behaviour. They should, however, be deployed before resorting to restraint by physical means, wherever possible.

- Some such mechanical restraint methods may be covered by Risk Assessments. This may include the need to keep fire doors shut, or the location of certain items of furniture in a room.

- Should it be identified that an individual would benefit from a form of mechanical restraint, such as medical aids or wheelchair accessories, the issue should be discussed at a full multi-disciplinary review. The review should involve all appropriate professionals, which may include physiotherapists, occupational therapists, and advocates, as well as the individual. From the review, a Support Plan should be compiled which reflects the views of all present. The Support Plan should identify the precise method of mechanical restraint, how it should be applied and when, for how long and when the next review should be. Any risks involved in the method should be recorded on a service user's Risk Assessment form, which should be reviewed at least three-monthly.

- It is important that staff should seek informed consent from the individual, their carer or advocate. If consent is not given to a proposed method of mechanical restraint, then a risk assessment must be completed and reviewed at least three-monthly by all those listed above.

- It is important to keep all professionals and relevant people up to date in the development of Support Plans and Risk Assessments to do with mechanical restraint. This may include keeping the individual's GP informed.

5.3 Restraint by Physical Means

5.3.1 If a member of staff is attacked they must use the most appropriate means available to defend themselves. This is a matter for personal judgment. If it is possible for the staff member to remove themselves from the vicinity without leaving themselves or any other member of staff or service user in danger, then they should do so with appropriate haste.

5.3.2 When using a physical prompt to encourage the person to move away from an area where there is greatest risk of violence, the prompt should be used

only until the area is an acceptable distance away, or that a mechanical object such as a door or furniture has been passed, or until the risk of violence has lessened to an acceptable level, whichever comes first.

5.3.3 Where injury is caused to a service user during restraint, the staff member(s) involved may be called upon to justify their actions.

5.3.4 Judgment by staff will always be required in this area. The Manager should be kept informed of all service users who resort, or are likely to resort, to violence.

5.3.9 The emphasis of these guidelines is on preventing violence rather than dealing with it after it has arisen.

5.4 Medication

In certain situations, the use of medication may be indicated as a method of managing extreme behaviour. Medication must only be administered upon medical advice and must only be used as a routine method of managing difficult behaviour where it is included within an individual's support plan and agreed by a qualified medical practitioner.
The use of medication should comply with regulations or national minimum standards issued under the Care Standards Act. Under their duty of care, staff should not give tranquillisers to service users who have contra-indications and any contra-indications should always be recorded in their support plan. Except in an emergency, where there is a significant risk of personal injury or a serious risk of an offence being committed, rapid tranquillisation should not be used as a method of gaining control over adults who display violent or aggressive behaviour. Even in an emergency, if force is required to administer a tranquilliser, the degree of force, must be reasonable.

6.0 Protection of Vulnerable Adults

It is important that good practice in the use of physical interventions is properly co-ordinated with other procedures designed to protect vulnerable people. These will include:

- Local multi-agency management committees set up to audit policies, procedures and practices for the protection of vulnerable adults;
- The Mental Health Act Commission when physical interventions are employed with anyone who is detained under the Mental Health Act;