PREVENTION AND MANAGEMENT OF VIOLENCE AND AGGRESSION (PMVA) POLICY JULY 2015

This policy supersedes all previous policies for The Therapeutic Management of Violence and Aggression
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<td>RM01</td>
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<tr>
<th>Document history</th>
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<th>Version</th>
<th>Summary of amendments</th>
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<tr>
<td>May 2011</td>
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<td></td>
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<td>Nov 2013</td>
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<td>Amendments to the criteria for involving the police, reporting following an assault and sanctions available</td>
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- Divisional Managers
- Learning and Development
- Local Security Management Specialist
- Matrons
- Operational Managers
- Professional Leads
- Risk Management Team
- Service User Representatives
- Team/Ward Managers
- Workforce Partnership Group
1. Introduction
The safety and welfare of staff, service users, families, carers, contractors and visitors who are in contact with Trust services is of paramount importance. This policy promotes safe practice, particularly focusing on reducing the risks associated with challenging behaviour in the form of violence, aggression and harassment.

2. Aims and objectives
The policy aims to ensure that staff and service users are provided with an environment that is safe and secure. It has been developed in line with the requirements of the NHS Security Management Service (NHS SMS), health and safety legislation and follows the template of the Health and Safety Executive (HSE) HSG65. It takes account of the Department of Health guidance ‘Positive and Proactive Care: Reducing the Use of Restrictive Interventions’ (Department of Health, 2014).

The ‘Positive and proactive...’ guidance follows six key principles:

1. Complying with the European Convention on Human Rights;
2. Understanding people’s behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced;
3. Involving people, their families, carers and advocates in decisions about their care wherever practicable and subject to the person’s wishes and confidentiality obligations;
4. Treating people with compassion, dignity and kindness;
5. Supporting people to balance safety from harm and freedom of choice;
6. Protecting and preserving positive relationships between the people who deliver services and the people they support.

This policy aims to ensure that violence and aggression is managed in line with the Trust’s values and best practice guidelines and that any restrictive practices are employed in a transparent, lawful and ethical manner on a ‘last resort’ basis.
3. **Scope of the policy**
This is a Trust wide policy. It covers violence and aggression which may relate to incidents:

A. Between service users and staff;
B. Between service users and service users;
C. Between visitors/carers and service users;
D. Between visitors/carers and staff;
E. Between visitors/carers and visitors/carers.

4.0 **Definitions**

4.1 **Violence**
Violence may be defined as: *an incident where an individual is abused, threatened or assaulted in circumstances related to their involvement with the organisation, which includes an explicit or implicit challenge to their safety, wellbeing or health* (adapted from DH 2000)

Examples of behaviour which could be viewed as violent or abusive are listed below:

<table>
<thead>
<tr>
<th>PHYSICAL VIOLENCE</th>
<th>NON-PHYSICAL VIOLENCE</th>
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<tbody>
<tr>
<td>· Assault causing death</td>
<td>· Verbal Abuse</td>
</tr>
<tr>
<td>· Assault causing serious injury</td>
<td>· Racial or sexual abuse</td>
</tr>
<tr>
<td>· Minor injuries</td>
<td>· Threats – with or without weapons</td>
</tr>
<tr>
<td>· Kicking</td>
<td>· Physical posturing</td>
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<tr>
<td>· Bitting</td>
<td>· Threatening gestures</td>
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<tr>
<td>· Punching</td>
<td>· Abusive phone calls</td>
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<tr>
<td>· Use of weapons</td>
<td>· Threatening use of dogs</td>
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<tr>
<td>· Use of missiles</td>
<td>· Swearing</td>
</tr>
<tr>
<td>· Spitting</td>
<td>· Shouting</td>
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<tr>
<td>· Scratching</td>
<td>· Name-calling</td>
</tr>
<tr>
<td>· Sexual Assault</td>
<td>· Bullying</td>
</tr>
<tr>
<td>· Deliberate self-harm</td>
<td>· Insults</td>
</tr>
<tr>
<td></td>
<td>· Innuendo</td>
</tr>
<tr>
<td></td>
<td>· Deliberate silence</td>
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4.2 Assault
NHS Protect (formerly the NHS Security Management Service) provides two clear legally based definitions of assault for the NHS:

1. Physical assault – *the intentional application of force to the person of another without lawful justification, resulting in physical injury or personal discomfort*;
2. Non-physical assault – *the use of inappropriate words or behaviour causing distress and/or constituting harassment*¹.

4.3 Restrictive Practices
The Department of Health (England) defines restrictive practices as: *‘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:*

1. *Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and*
2. *End or reduce significantly the danger to the person or others; and*
3. *Contain or limit the person’s freedom for no longer than is necessary*².

4.4 Physical Restraint
The Department of Health (England) defines physical restraint as: *‘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’*³.

4.5 Chemical Restraint
The Department of Health (England) defines chemical restraint as: *‘the use of medication which is prescribed and administered for the purpose of controlling or*

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² Department of Health (2014) *'Positive and Proactive Care: Reducing the Need for Restrictive Interventions*.
³ Department of Health (2014) *'Positive and Proactive Care: Reducing the Need for Restrictive Interventions*.
subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness."\(^4\)

**5.0 Preventing Violence and Aggression: safe working practices**

This policy should be followed in conjunction with the Trust's Clinical Risk Assessment and Management Policy (December 2014), which addresses the assessment and management of risk factors for individual clients. All staff should be aware of the impact of staffing, staff personal safety and the work environment on the prevention and management of violence and aggression.

**5.1 Staffing**

The Trust has a legal obligation to ensure that there is adequate staffing available to deal with potential and actual violence.\(^5\) Staffing levels should be based on anticipated future events, therapeutic staff/patient ratios and any recent adverse events. A consistent approach within a team improves communication and confidence in managing difficult situations. The following factors need to be taken into account, and are not an exhaustive list:

1. An agreed skill, gender and ethnic mix of staff and flexibility to meet ward/unit needs;
2. Adequate staff cover for night, weekend duty and shift change over;
3. Staff should not be left for long periods on their own, particularly junior or inexperienced staff;
4. The multi-disciplinary consensus on patient(s) clinical care needs;
5. The clinical presentation of patient(s) on the ward;
6. Staff training and development, with annual PMVA updates;
7. Violent incidents including verbal abuse must be reported;
8. The ward/team manager must all record injuries, sickness and absences arrangements related to violent incidents through Datix;
9. All staff need to be aware of the association between substance misuse and violence, and consider this in their risk management strategies.

In the event of staffing levels falling below agreed levels, or of previously agreed levels being insufficient to maintain the safety of patients or staff due to a combination of the clinical or situational factors detailed above, staff must

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\(^4\) Department of Health (2014)'Positive and Proactive Care: Reducing the Need for Restrictive Interventions

\(^5\) Health and Safety at Work Act 1974, section 2
complete an incident report detailing this using Datix, the Trust’s incident reporting system.

5.2 Staff personal safety
Every member of staff in every area of the Trust has a responsibility to preserve his/her own safety, that of others and providing assistance to others as necessary. All Trust staff should work in accordance with the Lone Working Policy. The aim of the policy is to provide guidance for Trust staff when they are working alone, either on trust premises, in the homes of service users, or in other settings. Below is a summary of the guidance;

1. All staff have a responsibility to work to uphold the Trust values and to support service users, carers, and their colleagues
2. Good communication underpins all aspects of enhancing safety. All staff must familiarise themselves with local communication systems
3. No member of staff, finding themselves alone faced with a potentially violent incident should attempt any physical interventions before adequate assistance has been obtained. The exception would be a situation where such inaction would endanger themselves or others and there is no opportunity to remove themselves from the situation
4. In inpatient areas, staff should use the personal alarm system to summon assistance.
5. Staff must weigh the impact of removing themselves from the immediate vicinity of an aggressor with their duty to care for and therefore protect patients
6. Additional assistance should be sought as soon as possible in an emergency situation. Staff should not wait to report the incident to the person in charge before calling for assistance
7. Staff must inform other members of the team of their whereabouts at all times
8. Collaborative clinical risk assessments must be completed for all patients.

5.3 Environment
It is every staff member’s responsibility to provide a safe environment and to take all practicable steps to ensure that this occurs. This includes creating a clean and welcoming environment. Below are the responsibilities of staff:

1. Safety measures - the weight, size and construction of movable objects must be considered. All staff must be aware of the emergency alarm
systems, using them consistently. There must be an awareness of everyone entering the ward and a request for identification from those who are unknown

2. Six monthly independent Health & Safety inspections of all buildings must be carried out. Staff should report all building issues or repairs as soon as they occur. Water, electricity and fire systems should be checked monthly to ensure standards of safety are maintained. All refurbishments and new builds meet NHS Technical Memorandum and NHS Building Codes

3. Both the Trust’s inpatient sites use the ‘Pin point’ alarm system, which is activated by pulling of the personal pit alarm that all staff must wear at all times when working on an inpatient unit

4. At all handovers, shift coordinators should conduct a safety check of the ward environment of each inpatient ward. The outcome of this safety check should be documented on the ‘general observations’ form found at appendix 2 of CL04 Observation and Engagement Policy (July 2013)

5. Environmental audits should be conducted on a weekly basis on inpatient wards by ward managers or a nominated individual

6. All community team bases must undertake a Health & Safety assessment to establish the ability of the Trust to provide a safe working environment for each base as well as review each team’s lone working practice. This is the responsibility of the team manager.

6.0 Preventing Violence and Aggression: Positive Behavioural Support (PBS)

6.1 Understanding Positive Behavioural Support
Positive behavioural support (PBS) is an approach promoted by the Department of Health. ⁶ It requires care providers to understand the context and meaning of behaviour and to use person-centred, values-based approaches to the care of people with potentially challenging behaviour. This involves getting to know the patient as an individual through assisting them to develop personal relationships, improve their health, become more active in their community and to develop personally.

PBS acknowledges that people may engage in behaviours that are challenging due to a combination of unmet needs, poor quality of life, and exposure to challenging environments. Skilled assessment is required in order to understand

⁶DH. (2014) Positive and proactive care: reducing the need for restrictive interventions
the probable reasons for behaviours of concern; what predicts their occurrence and what factors maintain those behaviours.

Skilled assessment and planning depends upon the consideration of a range of contextual factors. Factors likely to increase the risk of challenging behaviours are detailed in the table below. Please note that this is by no means an exhaustive list.⁷

<table>
<thead>
<tr>
<th>Historical</th>
<th>Current presentation</th>
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<tbody>
<tr>
<td>History of aggressive/ violent behaviour</td>
<td>Persecutory delusions</td>
</tr>
<tr>
<td>Relevant forensic history</td>
<td>Command/ distressing hallucinations</td>
</tr>
<tr>
<td>History of intent to harm others</td>
<td>Certain diagnoses</td>
</tr>
<tr>
<td>History of abuse/ trauma</td>
<td>Cognitive impairment or difficulties</td>
</tr>
<tr>
<td>Past experience of being 'rewarded' for violent behaviour</td>
<td>Psychological/ emotional distress</td>
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<tr>
<td></td>
<td>Physical health factors (e.g. Chronic pain)</td>
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<td></td>
<td>Illicit substance/ alcohol use</td>
</tr>
<tr>
<td>Environmental</td>
<td>Situational</td>
</tr>
<tr>
<td>Lack of meaningful activity</td>
<td>Inability to communicate effectively or feel understood</td>
</tr>
<tr>
<td>Lack of personal space, possessions and/or places to store possessions securely</td>
<td>Feeling threatened</td>
</tr>
<tr>
<td>Inability to hold private telephone conversations/ visits</td>
<td>Not feeling respected</td>
</tr>
<tr>
<td>An institutional rather than a homely environment</td>
<td>Not feeling in control of one’s situation</td>
</tr>
<tr>
<td>Restrictions on freedom</td>
<td>Experiencing perceived negative attitudes</td>
</tr>
<tr>
<td>Temperature (usually too hot)</td>
<td>from staff</td>
</tr>
<tr>
<td>Overcrowding and a lack of privacy</td>
<td>Inconsistency from staff</td>
</tr>
<tr>
<td>Noise levels</td>
<td>Dynamics on the ward (e.g. tension between service users)</td>
</tr>
<tr>
<td>Air quality</td>
<td>Unmet needs</td>
</tr>
<tr>
<td>Inadequate nutrition</td>
<td>Misinterpreting communication</td>
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<tr>
<td></td>
<td>Feeling staff are inaccessible</td>
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<tr>
<td></td>
<td>Being told 'no' consistently</td>
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<tr>
<td></td>
<td>Too little/too much stimulation</td>
</tr>
</tbody>
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6.2 Implementing PBS through Behavioural Support Plans
Any person who is at risk of being exposed to restrictive interventions must have an individualised behaviour support plan. This includes any service user with a

⁷ NHS Protect. (2014). Meeting Needs and Reducing Distress
known history or current presentation of violent, aggressive or challenging behaviour. This must take the form of a person centred care plan explicitly addressing this risk of violence and aggression. The care plan should detail primary, secondary, and tertiary interventions to prevent and manage challenging behaviour. It should include clear evidence of health and social needs assessment, and be created with involvement from the person, their carers, relatives or advocates. Behavioural support plans should be developed and maintained across the care pathway and should not be seen as solely the concern of inpatient services.

Behavioural support plans should identify:

A. The context within which behaviours of concern occur

B. **Primary preventative strategies** including proactive actions to manage identified environmental and situational factors, promoting autonomy through enabling decision making around alternative ways to express distress

C. **Secondary preventative strategies** including details of the techniques to be used by carers/staff when a person starts to become anxious, aroused or distressed. These strategies should aim to promote relaxation and avert any further escalation to a crisis

D. **Tertiary strategies** for how staff should react when a person’s agitation further escalates to a crisis where they place either themselves or others at significant risk of harm. This may include the use of restrictive interventions

In some instances patient histories and health and social care needs may not be known or well understood, for example if a patient is admitted without much information on their background history. In these instances judgements must be made on the clinical and actuarial evidence available, the gaps in information acknowledged, and the management plan should include attempts to elicit this information when possible.

Behavioural support plans should:

A. Be formulated in direct collaboration with the service user and family/carers where appropriate

B. Evidence attempts to involve family and carers, particularly when a service user lacks the capacity to be involved in the care planning process. The best means of doing this is through a multidisciplinary meeting.
C. Detail reasons for previous violence and aggression so that staff may take steps to reduce exposure to destabilising factors
D. Outline any psychological/physical factors which may heighten the risk of adverse effects of physical intervention
E. Be reviewed following any incident of violence/aggression
F. Reflect the service user’s advance decisions around preferred treatments

Wherever restrictive practices are included in a Behaviour Support Plan, it must be clear that:

A. There must be a necessity to act in order to avoid harm to the person
B. The nature of restrictive practices must be proportionate to the potential harm to the person
C. The practice must be the least restrictive option that will meet the need
D. Any restriction should be imposed for no longer than absolutely necessary
E. What is done, why and with what consequences must be recorded in an open and transparent manner

Examples of primary and secondary preventative strategies can be extracted from materials found at www.safewards.net.

7.0 Managing Violence and Aggression: a Violent Incident
On rare occasions Trust staff may have to respond to a violent incident or potentially violent incident. When confronted with acute behavioural disturbance, the choice of restrictive intervention must always be the least restrictive option to meet the immediate need. It should always be informed by the person’s preference (if known) and should address any risks associated with their general health, and an appraisal of the immediate environment. Individual risk factors that may suggest a person is at increased risk of physical and/or emotional trauma must be taken into account when applying restrictive interventions.

Staff faced with potential or actual violence must consider and take into account any physical, sensory or communication deficit the person is experiencing, and any gender or cultural considerations which may affect the patient.

7.1 Principles:
1. Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering, intimidation or humiliation
2. There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken
3. The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm
4. Any action taken to restrict a person’s freedom of movement must be the least restrictive option that will meet the need
5. Any restriction should be imposed for no longer than absolutely necessary
6. What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent
7. Restrictive interventions should only ever be used as a last resort
   • People who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions

7.2 Restrictive Interventions
For the purpose of this policy restrictive interventions refer to the areas the Department of Health outlined as follows:
   1. Physical restraint
   2. Mechanical restraint
   3. Chemical restraint
   4. Seclusion
   5. Long-term segregation

The Trust’s policy PHA03 Rapid Tranquilization Policy sets out expected practice in relation to ‘chemical restraint’. The Trust policy CL12 Seclusion Policy sets out expected practice in relation to ‘seclusion’. Mechanical restraint and long term segregation are not strategies used to manage violent and aggressive behaviour within the Trust.

7.3 Reasons for Restrictive Interventions in Inpatient Areas
Restrictive intervention should occur only as a last resort at the end of an unsuccessful hierarchy of primary and secondary interventions, and in one of the following circumstances:
   1. Significant threat of, or actual physical attack
2. Significant threat of, or actual attempt at self-injury
3. Serious damage to property, where injury may occur
4. Prolonged and serious verbal violence causing psychological distress to others
5. Prolonged over-activity and risk of exhaustion
6. Attempt to abscond when detained under section

If restrictive interventions are necessary it may also be necessary to summon assistance from neighbouring clinical areas not only to ensure the safety of the individual, but to maintain the safety of the ward as a whole. All inpatient wards have alarm systems as noted in section 4.5

7.4 Breakaway Techniques
All staff working in a clinical setting should undertake training that incorporates breakaway techniques. The level of force used to escape from a threatening situation must be necessary and proportionate to the perceived threat. Disengagement techniques taught in training cannot cover every eventuality and may not always be successful. Section 3 of the Criminal Law Act (1967) gives staff the right to use force that is reasonable to protect themselves or others from harm. Because community teams cannot safely operate physical and restrictive techniques personnel in these teams must be proficient in the use of breakaway techniques and be competent in lone working practice.

7.5 Weapons and Police Involvement
In extreme circumstances, staff must consider the scope of their training and skills. Police must be called to safely manage some circumstances. For example:

1. Weapons
2. Hostage taking
3. Barricading
4. Or any other situation deemed unmanageable by available resources.

In any circumstance where threats are made with weapons no attempt should be made to disarm the individual. If confronted with a weapon the priority should be to remove oneself from the situation immediately. Staff present should attempt to keep the situation contained and call the police for assistance. Staff should evacuate patients, visitors and staff to a safe area and dial 9-999 for the police informing them that 'Weapons police assistance is required'.
Information regarding the location of the incident, the weapon involved and a description of the assailant and the risks they present will assist the police risk assessment process and allow a prompt response. 999 calls receive a graded response and clear information is required. Reception staff should be advised of the call so the police can be directed to the area on arrival.

In community settings the Lone Worker Policy (2013) should be used to assess risks posed in all client contacts. If during this risk assessment process it is felt that a community patient poses a risk of violence, threatening behaviour or is believed to be carrying weapons, staff should contact the Trust security management specialist for support in developing appropriate management strategies, which may include police involvement.

The criteria/threshold required to request Police to assist in managing an ongoing incident of violence and aggression is quite separate from making a report to the Police that a crime has been committed. The circumstances when criminal acts should be reported to the Police are explained later.

8 Physical Restraint

Methods of physical restraint are taught to relevant staff through a contracted educational provider. Training addresses theory and practice requirements outlined in the NICE (2005) Clinical Guideline 25 for the short-term management of acutely disturbed violent behaviour/violence.

As outlined in their training, staff must ensure that the level of intervention utilised is proportionate to the risk presented. Staff must consider the psychological, emotional and physical impact of all levels of physical intervention prior to (where possible), during and after utilisation. During any level of physical restraint the person leading the restraint should be continuously attempting to verbally de-escalate the service user.

Three levels of physical intervention are taught as part of the PMVA syllabus commissioned by the Trust:

Level 1 Restraint: involves 2-3 staff members using supportive holds up to a secure straight arm hold. The patient may be stood, sitting or kneeling

Level 2 Restraint: involves 2-3 staff members using restrictive bent arm holds. The patient may be stood, sitting or kneeling

Level 3 Restraint: involves 3-4 staff members, including restraint of the patient’s legs. The patient is lying on the floor or a bed
Staff performing the use of arm holds should be aware of relevant restraint related risks, and who may be vulnerable to them, including but not limited to; bruises, breakages, compartment syndrome etc.

All staff must also be fully aware of the risks associated with positional asphyxia, particularly risks posed by level 3 restraints, or a seated position where the head is lowered. Staff must seek to minimise these risks by only using approved techniques taught during their training, and by complying with the monitoring arrangements set out in this policy.

Level 3 restraint must only be used in exceptional circumstances where it is deemed absolutely necessary in order to minimise the immediate risk to the service user or others and where less restrictive interventions are deemed unsafe.

**Staff must only use the methods taught on these courses during the practice of restraint.**

### 8.1 Preparing for Physical Restraint

Physical restraint may be planned or unplanned. The following aspects must be applied to all planned restraints, and all practicable aspects should be carried out when employing an unplanned physical intervention.

When a decision to physically restrain is made staff must adhere to the following guidance:

1. On admission, patients should undergo a basic physical examination which will provide clinical information that may influence the use of rapid tranquilisation. The examination should assess their physical condition and needs with particular attention to conditions that may affect cardio-pulmonary function, muscle or joint impairment (e.g. asthma, heart disease, obesity), use of illicit drugs and/or alcohol, and, in the case of women, pregnancy

2. A risk assessment considering the impact of restraint on the patient’s physical and mental health must be conducted, informed by the risks identified in this policy, including those identified in appendix 4

3. Any condition that may increase the risk of collapse or injury to the patient during restraint should be clearly documented in the records and communicated to all multidisciplinary team members

4. Adequate assistance should be arranged where possible before attempting any restrictive intervention. The number of staff involved in the management of a violent incident should be a proportional response,
ensuring a reasonable number necessary to restrain the individual whilst 
minimising the risk of injury to all parties. Where a member of staff has 
been assaulted by a service user, they should be replaced as soon as 
possible and play no further active role in managing the incident.

5. Staff who are to be involved in the intervention must remove from their 
person any items that have the potential to cause injury to themselves, 
their colleagues or the service user such as ID badges, pens and watches.

6. Allocation of roles should be clearly communicated by the person leading 
the restraint to each member of the team prior to the intervention.

7. To maintain dignity and reduce potential psychological distress, staff 
allocated should be appropriate to the size, age and gender of the service 
user. There must be at least one female staff involved in any restraint of a 
female patient.

8. Staff should consider therapeutic relationships with the service user when 
allocating roles. It may be that a member of the team has a particularly 
good therapeutic rapport with the service user and therefore may be more 
appropriate as the person leading the restraint (‘head person’).

9. Consideration should be given to other people on the ward, other patients, 
visitors, and students. The area should be cleared discretely and someone 
allocated to stay with the other patients to reassure them and to prevent 
them from intervening in the situation.

10. In addition to the staff physically involved in a restraint, there must be a 
designated ‘restraint controller’, who will be the primary support to the 
person leading the restraint (the ‘head person’), and will be responsible for 
managing the environment around the restraint, and arranging relief where 
needed.

11. An appropriately skilled member of staff must also be allocated by the 
restraint controller to monitor the persons breathing and physical condition 
throughout the restraint.

12. Other staff will remain on hand (and preferably out of sight of the patient) 
in case extra assistance or relief of team members is required.

13. All nursing and non-professionally registered support staff working on 
inpatient wards must be trained in PMVA techniques, and must work with 
their manager to ensure their competence and annual updates are
maintained. Members of staff unable to perform these duties due to health concerns must inform their manager immediately, and seek support from Occupational Health

14. The Highgate Mental Health Centre or St Pancras duty nurse on call should be informed and their assistance requested

15. A medical officer should be available within half an hour at all times and must always attend in the use of Level 3 or a prolonged restraint

16. Particular consideration should be given to any physical needs that may influence the patient’s safety during a restraint or rapid tranquillisation using the flowchart found in appendix 3 and information on risks associated with positional asphyxia found in appendix 4. This should include, but not be limited to, obesity, pregnancy, pre-existing cardiovascular conditions or muscular-skeletal conditions, learning disabilities or patients with epilepsy

17. Consideration should also be given to those who may be at risk of experiencing heightened levels of psychological/emotional distress during a physical intervention, such as those with autism, or a history of sexual or physical abuse

18. If other wards request assistance, then wherever possible, permanent staff and not bank/agency staff should be sent. This will promote effective teamwork and communication

19. In a planned restraint intending to administer intramuscular medication, in order to ensure the least restrictive approach is used it may be appropriate to offer the patient a final opportunity to take oral medication, or to receive the injection without the need for restraint

8.2 During Physical Restraint
The essence of restraint is the containment or limitation of another person’s freedom. The degree of force used should be necessary and proportionate in degree, duration and nature to the actual danger or resistance presented by the violent individual and may include use of other restrictive practices such as rapid tranquillisation or seclusion to reduce the duration or frequency of physical restraint. Staff attending a violent incident will have to make a decision as to what level of restraint is required, and this will always be underpinned by using a
therapeutic not punitive response (see Appendix 3; Flow Diagram of Risk Assessment and Management in Restraint).

8.2.1 Staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purpose of an immediate rescue in a life-threatening situation, in accordance with NICE Guideline 25 (2005). These techniques must be used proportionately and only in the most exceptional circumstances and never for longer than is necessary to mitigate that immediate risk to life. All staff are responsible for ensuring they do not inflict pain on the patient.

8.2.2 Staff must not deliberately use techniques where a person is allowed to fall, unsupported, other than where there is a need to escape from a life-threatening situation.

8.2.3 Any restraint must only be used for the shortest time necessary to ensure the immediate safety of the patient or others.

8.2.4 Continuous risk assessment is essential and the designated ‘Restraint Controller’ must continually ensure the level of intervention applied is proportionate to the presenting risk.

8.2.5 In line with training syllabus, the ‘head person’ should be the sole person responsible for communicating with the service user during the restraint, and has overall responsibility for directing the colleagues during the restraint.

8.2.6 The ‘head person’ is responsible for protecting the patient’s head and airway during restraint and any change in position, and ensuring that absolutely no pressure may be applied to the neck area at any time.

8.2.7 Where descent is necessary, this must be controlled by the ‘head person’ in accordance with the training syllabus, to protect the service user against the risk of injury.

8.2.8 The ‘head person’ should be continually communicating with the patient, explaining what is happening and using de-escalation skills throughout the intervention.

8.2.9 Patients must not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose must never be covered and patients must not be subject to pressure to the neck region, rib cage and/or abdomen during restraint.

8.2.10 There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.
8.2.11 If exceptionally a person is restrained unintentionally in a prone/face down position, staff should either release their holds or reposition into a safer alternative as soon as possible.

8.2.12 Any use of prone restraint, the circumstances of its occurrence, and the time spent in prone position must be recorded in the report of this incident. Any use of prone restraint will be investigated according to the Trust Management of Serious Incidents (May 2014) policy.

8.2.13 Dignity must be maintained including management of the presence of other persons in the vicinity, clear and respectful communication, and where possible, control of the location of restraint and/or administration of medication(s).

8.2.14 Once the risk of violence or aggression is deemed minimised and/or IM medication has been administered, the aim of the restraint team must be to safely withdraw from restraint, or modify the holds to a less restrictive intervention (e.g. seated de-escalation).

8.3 Monitoring the service user’s physical state during restraint
Due to the risk of positional asphyxia, the use of physical restraint on the floor must only be used when it is absolutely necessary to effectively gain quick control of an aggressive and agitated individual. This will usually involve the service user being held on the floor, or on a bed for a brief period of time to manage the initial struggle, and possibly to administer rapid tranquillisation via intra-muscular (IM) injection.

For all level 2 and level 3 restraints an appropriately skilled member of staff not physically involved in the restraint should provide additional monitoring of the patients airway and physical condition.

As soon as is safe to do so they must immediately begin to undertake observations that include pulse, respiration and complexion (with special attention to pallor or discolouration), and this should continue throughout the restraint. These observations should be recorded on the Emergency Physical Monitoring Under Restraint Checklist found in appendix 5.

Attention should be paid to observing the patient for:

A. Body position restricting the respiration process
B. Wheezing / Gurgling / Gasing sounds
C. Active person i.e. violent / aggressive suddenly turns passive and tranquil
D. Panic
E. Complaints of difficulty in breathing  
F. Cyanosed mucus membranes or hands and feet  
G. Fits/seizures  
H. Vomiting or choking

If changes in the person’s physical condition and/or their expressions of distress give rise to concern, the restraint must stop immediately and should be treated as a medical emergency.

8.4 Termination of Physical Restraint  
The termination of a physical restraint should occur as soon as it is considered safe to do so. The patient should be informed of what is happening and what is expected of him/her after s/he is released. The ‘head person’ should obtain agreement on immediate future actions from the patient prior to termination. The level of holding should be managed in a phased reduction prior to release, as outlined in the taught syllabus.

The patient will now be entering the recovery phase and although the immediate crisis has passed, there is still a risk of recurrence of aggression. Where it is possible an explanation for the physical intervention should be given and queries answered. Otherwise conversation should be kept to a minimum, and stimulation reduced. The patient should be asked to stay on their bed to allow any medication that may have been administered to take effect and to give them time to continue to calm down.

8.5 Medication Used in Rapid Tranquillisation  
Please refer to Trust policy PHA03 Rapid Tranquilisation Policy (2013). The use of medication as an intervention must be reasonable and proportionate to the presenting risks, and it is advisable for all patients who may require medication for rapid tranquilisation to have it prescribed on the PRN part of their prescription chart.

8.5.1 This must be in accordance with the Trust’s Rapid Tranquillisation Guidelines (2013)

8.5.2 Medication must be prescribed by a doctor before it is given

‘Rapid tranquillisation’ refers to intramuscular injections and oral medication. Oral medication should always be considered first. Where rapid tranquilisation in the form of an intramuscular injection is required, the prescriber should indicate the preferred injection site having taken full account of the need to avoid face down restraint.
The use of medication to manage acutely disturbed behaviour must be a short-term strategy designed solely to reduce immediate risk. This is distinct from treating any underlying mental illness and the clinical need, safety of the patient, safety of others and any advanced directives made must be taken into account.

8.6 Post Incident Monitoring
Any person subject to a level 2 or 3 restraint should be placed on intermittent observation post incident for a minimum of 2 hours. Staff should make contact with the patient approximately four times an hour but should vary the time at which contact is made so that the patient cannot easily plan when the next contact may be. Any patient receiving rapid tranquilisation during a restraint must be monitored in line with the requirements set out in the Trust rapid tranquilisation guidelines (2013), and any physical monitoring should be actioned in line with the Trust’s Physical Health Policy (2013) and CPR and deteriorating patient policy (2013). Staff should monitor the service user for signs of emotional/psychological distress subsequent to any physical intervention. The exact manner of assessment should be determined through clinical judgement and stated service user preference. The use of intermittent observation for a 2 hour period will aid this however for some service users, it may be appropriate to engage in discussion at particular intervals. Patients should be supported to reintegrate to the ward milieu as soon as it is safe to do so.

9. Management of Violence with Older Adults – Practice guidance around Restraint and ‘Safe Assistance’
Physical interventions in older adults require a considered response due to frailty, co-morbid physical conditions, and proneness to bruising and abrasions. However, at times physical interventions may be necessary. The response must be proportionate to the age and physical condition of the patient, and the privacy and dignity of the patient must be preserved at all times.

Staff should consider the use of de-escalation techniques such as distraction in the first instance when working with people with dementia who are presenting a risk to themselves or others by their behaviour. However, it is recognised that there are situations where these techniques are either impractical or ineffective, and a physical intervention is necessary.

All patients should have regularly updated documented evidence of assessment of their capacity to make decisions about key areas of their lives having taken place, including around personal care. Consideration should be made of a patient’s ability to make decisions around personal care tasks and choices of
activity. Where a patient lacks capacity to agree to a specific care intervention, this should be clearly documented within their care plan.

If a patient lacks capacity to make decisions about their treatment, a Best Interests decision to provide care may need to be made, in accordance with the framework set out in the Mental Capacity Act (2005) and in consultation with each patient’s nominated decision maker. Any best interests’ decision must be clearly documented in the patients’ care plan. When making these decisions and planning interventions, the degree of restraint necessary to perform these tasks safely in the patients best interests should be considered and recorded. If the delivery of personal care, e.g. toileting, washing, dressing, requires patients to be held in such a way that restricts or limits their free movement, the degree of restraint should be clearly documented in the care plan and a copy of this should be signed and given to the relatives. These actions would be categorised as carrying out “safe assistance”, and these care plans will refer to the restraint as ‘safe assistance’ that is required in the completion of routine care.

The aggressive or agitated behaviour of some patients may mean that their care plans will also contain plans for containing behavioural risks that are not associated with routine care tasks, such as when a patient strikes or attempts to strike another patient. This should be identified as a potential care need in the patient’s assessment, referenced in their risk assessment, and the care plan developed to address/contain this behaviour in line with the protocol set out in section 5.2. Again, the patient’s capacity will need to be assessed in this relation to this need, and any Best Interests decision that may be made must be recorded on the electronic patient record (RiO currently).

There will be other occasions when restraint is required to manage unpredictable aggressive behaviour that has not been anticipated during the patient’s assessment or care planning. All instances of violent or aggressive behaviour whether anticipated or not should be regarded as ‘an incident’ and an incident report must be completed accordingly, using the description of levels of restraint given in section 7.2 of this policy when applicable.

If a patient has been subject to an unplanned restraint in response to these circumstances, a care plan must be developed detailing strategies to prevent future incidents.

10. Accident & Emergency and Community Settings
The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets
out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

The Mental Health Crisis Care Concordat states key principles that will be relevant to many service settings (in particular A&E settings, acute mental health services and the ambulance service). In services where hospital security staff may be needed to respond to emergency situations to assist in the management of violent or aggressive incidents, they should also adhere to the provisions of the Mental Capacity Act 2005 (MCA), as well as to Skills for Security good practice guidance.

The provisions of the Mental Health Act 1983 (MHA) will only very rarely authorise the application of restrictive interventions in community-based health and social care services and non-mental health hospital settings. The MCA will, if certain conditions are met, provide legal protection for acts performed in the care or treatment of people who lack the capacity to consent to the care or treatment (see paras 93-97). The MCA will be particularly relevant when staff in general hospitals are considering the use of restrictive interventions to protect the person. If the MHA and/or MCA do not apply, the use of force is only justified legally for the purposes of self-defence, the defence of others, prevention of crime, lawful arrest or to protect property and the same statutory and common law provisions apply within health and care services as elsewhere.

11. Reporting and Recording

11.1 Recording

Following all incidents of violence and/or aggression the following must be completed by the appropriate healthcare professional.

A. An incident form must be fully completed within 24 hours of an incident occurring. Following a serious incident a written statement should also be made for the purposes of the subsequent incident investigation

B. An entry containing details of the incident and any restrictive interventions used must be made in the patient’s EPR notes:
   - In the progress notes, and tagged as a risk incident using the ‘add to risk history’ checkbox located under the progress note text box
   - Where appropriate the risk summary section of the patient’s EPR may also need to be updated

8 http://www.crisiscareconcordat.org.uk/
9 DH(2014). Positive and proactive care: reducing the need for restrictive interventions)
11.2 Reporting
The Trust has an obligation both under Health and Safety Legislation and as an employer to ensure the health, welfare and well-being of its staff. To fulfil this obligation, and national reporting requirements set down by the Security Management Services, the Trust has implemented a full reporting system which not only monitors incidents but which enables the Trust to respond to incidents of violent, abusive or harassing behaviour in a positive and proactive manner. Furthermore, in the interests of public protection it is also important that other Public service providers such as the Police are notified of the details of individuals with a propensity to behave violently or aggressively, irrespective of their mental health.

Should an incident of physical or non-physical assault occur the staff member must:

A. Promptly report this to their team/line manager or a senior staff within the Service/Division.
B. Some non-physical assaults may amount to a criminal offence, such as racial abuse. In all cases of non-physical assault, the team/line manager should discuss with the victim the most appropriate course of action to be pursued. Should the victim wish to make a complaint to the Police the line manager should support the member of staff in this process. The incident must be reported on the Trust’s incident reporting system.

C. In cases of physical assault, the police must be informed as soon as possible, irrespective of whether the perpetrator has capacity or not. Where the perpetrator of the Physical assault has capacity, staff are strongly encouraged to make a formal complaint to the Police and assist the Police in pursuing criminal proceedings. The team/line manager should discuss the requirement to report and support the victim. Should the victim not wish to pursue criminal proceedings, the senior member of staff is required to report the crime to the Police but should mention in the report that the victim does not wish to make a formal complaint. All reports should be made by calling 9-101. Staff are required to obtain the
Police Computer Aided Dispatch (CAD) reference number and record this reference in the incident report. When criminal proceedings are being pursued, the Police will allocate a Crime Recording Information System (CRIS) reference. This reference must also be recorded in the incident report.

D. Managers must ensure that all incidents of Physical or non-physical assault are reported on the Trust’s incident reporting system and that all Physical Assaults are reported to the Police.

E. The Local Security Management Specialist (LSMS) will be available to support staff reporting crimes to the police. The LSMS will also monitor all physical assaults and ensure recording and reporting is carried out.

F. Managers should take any lesson learnt from an incident forward to other personnel and teams within the trust.

Out of hours, the following numbers are available to all disciplines to advise him/her of what has happened:

<table>
<thead>
<tr>
<th>Director on Call:</th>
<th>Duty Consultant Psychiatrist:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pager no. 07659 175 451</td>
<td>Phone No: 020 3317 3500</td>
</tr>
<tr>
<td>mobile no: 07810 0657 796</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Senior On Call Manager</th>
<th>Local Security Management Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile Phone No: 07768022062</td>
<td>Mobile Phone No: 07876 567 382</td>
</tr>
<tr>
<td>Pager: 07659153379.</td>
<td>(9 – 5 Mon –Fri only)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Police:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone No: (9) 101 (for outside line)</td>
<td></td>
</tr>
</tbody>
</table>

Staff should also report near misses that could have resulted in a serious incident. This will also ensure that any lessons learned can inform future risk management.
processes to ensure similar incidents do not recur. It also means that further preventive measures can be developed, sanctions taken (where appropriate) and increased publicity generated, creating a strong deterrent effect.

11.3 RIDDOR Reporting
The Governance and Performance team have a duty to report injuries to staff, patients and visitors. This is managed through the Datix reporting system:

11.3.1 If an incident causes more than seven consecutive days’ absence from work, there is a legal requirement for injuries to be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 (4th Edition 2012):

11.3.2 For incidents where a staff member is incapacitated and away from work for 4 – 7 consecutive days a record of this is kept by Governance and Performance staff.

12. Legal and Safeguarding Issues
All staff must work within the MHA Code of Practice (2008); the Mental Capacity Act (2005); the Mental Health Act (1983) and the Trust’s Safeguarding Adults Policy (CL22, 2012) at all times. Any departures from the Code of Practice must be clearly recorded and protocols for demonstrating actions have been considered as in the best interests of the patient must be followed.

For people who lack the capacity to consent to the use of a restrictive intervention, services must balance patient’s right to autonomy with the right to be protected from harm. Any decision to use restrictive interventions for a person who lacks capacity, must be made in the best interests of the person within the framework of the Mental Capacity Act 2005 (sections 4, 5 and 6). However, the Mental Health Act 1983 applies to any mental health treatment given to a person being treated under that Act.

Judgements as to the acceptability and legitimacy of restrictive interventions will always be based on all presenting circumstances. Without a clear ethical basis and appropriate safeguards such acts may be unlawful.

If carried out for any other purpose than those listed above concerns about the misuse of restrictive interventions should always be escalated through procedures and protocols set out in the Safeguarding Adults Policy (2012)
All staff have a ‘duty of candour’ and should use the Trust’s Whistle Blowing Policy (HR10, 2013) if any instances of restraint being used for any other purpose than is described in this policy are observed; or if the use of inappropriate force, or unauthorised restraint techniques being employed have not lead to the generation of a safeguarding alert.

13. Post Incident Review and Reconciliation
A post incident review should take place after every incident of violence. The manager and the member/s of staff involved will make arrangements for any further group or individual de-briefing that may be required. Where appropriate the Management of Serious Incidents policy will be implemented. Details of the debriefing of patients must be documented in their EPR progress notes, and noted in the managerial review section of the Datix report. Details of the debriefing of staff must be documented in the managerial review section of the incident report.

13.1 Post-incident reviews should:

A. Evaluate the physical and emotional impact on all individuals involved (including any witnesses)
B. Identify if there is a need, and if so, provide counselling or support for any trauma that might have resulted
C. Help patients and staff to identify what led to the incident and what could have been done differently
D. Determine whether alternatives, including less restrictive interventions, were considered
E. Determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
F. Where appropriate, recommend changes to the service’s philosophy, policies, care environment, treatment approaches, staff education and training
G. Where appropriate avoid a similar incident happening on another occasion
H. A member of the ward management team, deputised in their absence to the duty nurse or shift co-ordinator will co-ordinate the activities of others post incident, including any initial debriefing
I. A review of the patient’s Mental Health Act status should take place
J. The patient’s care plan and risk assessment should be reviewed and updated in accordance with the Clinical Risk Assessment and Management Policy (2013) and Recording of Risk on the electronic patient record, and communicated to the staff team.

K. A doctor must be in attendance within 30 minutes of a level 3 or prolonged restraint occurring, or if requested to attend by the nurse in charge to assess/ review the patient to agree the future management plan and physical monitoring.

L. Where an injury is detected after any violent or restrictive intervention incident, first aid must be carried out by a suitably trained member of staff in the first instance. A doctor must then attend within 30 minutes to assess the nature and degree of the injury and agree a plan of action.

13.2 Staff de-briefing
The senior member of staff on duty in a setting where a violent incident has occurred should ensure that debriefs occur. Facilitators of post incident reviews should invite all staff involved to attend. Participation must be left to personal choice. Facilitators of reviews must have appropriate skills and access to supervision. The post incident review process should be used to establish the facts surrounding the events, and to consider to the antecedents, behaviour displayed and consequence. The review should include reference to the service user’s behavioural support plan.

When factual events are established the information can contribute to the future prevention planning process. Post-incident review should not focus blame – it is a learning experience. An opportunity for those involved to safely acknowledge and discuss their feelings should also be allowed.

13.3 De-briefing patients
Patients should be offered the opportunity for a separate debrief in which they are able to talk openly about what happened. This should be facilitated in a safe and therapeutic environment and should only be conducted when the service user’s immediate risk of violence/aggression has diminished. The debrief should allow the service user to talk through their experience, discussing any psychological and physical impacts of the intervention, what they perceived as the cause and whether they feel alternative strategies could have been used to de-escalate the situation.

Patients should be made aware that they have a right to be supported or represented by an Independent advocate or a family member/carer if it is their wish, and that their narrative of events can be recorded in their notes if they wish.
Steps must be taken to ensure that communication needs are considered and catered for in order to ensure that all service users have equal opportunities to reflect on incidents in the same manner.

### 13.4 Witness de-briefing
Service users who have witnessed a violent incident and/or a subsequent restrictive intervention may be at risk of adverse emotional/psychological effects. Steps should be taken to facilitate debriefing for all service users witnessing these incidents. This may involve an individual patient or a group of patients and must be conducted in line with the trust policy and legislative guidelines on confidentiality.

### 14. Care of Staff after an Incident (refer to the Trust Trauma at Work Pathway; procedures for staff support – accessible on the Intranet)

The following actions are to be considered as a result of an incident:

1. Immediate first aid and medical treatment may be needed for an injured person. It may be necessary for the person to go to the Accident and Emergency Department or their GP

2. Not all injuries are physical and staff must be supported by their colleagues and line managers. Staff may require some time off work, either special leave or sick leave

3. Staff must receive continued support whilst on leave and on their return to work. If the staff member needs sick leave the manager should establish how frequently the staff member would like to be contacted. Staff may feel very isolated if they are away from work and unable to discuss the events. Managers should also check how staff are feeling when they return, at the return to work interview and at intervals following the incident. Each individual injury resulting from the use of approved restraint techniques will be reviewed. Managers must liaise with Human Resources and Payroll to ensure that the agreed salary payment is paid to the staff member during their period of absence

4. The staff member must be encouraged to talk about the incident and their feelings in supervision. The supervisor must be aware of the potential effects of an incident, including:

   - Anxiety
   - Guilt
   - Poor concentration
   - Reduced confidence
   - Anger
   - Recurrent dreams
   - Tearfulness
   - Flashbacks
5. The supervisor must be aware that recovering from an incident is a process and not an event. Therefore it will not be sufficient to have one supervision session and think that the matter has been dealt with.

6. It must be remembered that any incident is a whole service issue. Staff who are assaulted often feel very isolated, and they may even feel it was their fault. Sometimes staff prefer to see it as an individual's problem to distance themselves from the frightening thought that it may happen to them. It is vital the issues are discussed within the multi-disciplinary team, preferably in a reflective support group.

7. In cases of serious violence, staff involved should report the assault to the police. and should be supported throughout this process. Joint Police and Trust Protocols are in place to facilitate this, and the Local Security Management Specialist will advise on procedures and support individuals and teams through any necessary processes involving the Police.

8. If an incident has been reported to the police, staff are entitled to apply for compensation from the Criminal Injuries Compensation Scheme. Help in making an application is available from: Victim Support 020 7388 9550

15. Sanctions
The Trust is wholeheartedly committed to treating people suffering with mental disorder as responsible individuals who should be treated as normal citizens as far as that is possible. This means they should, where appropriate be held accountable when they are violent or aggressive. Hence, when a person with a form of mental disorder deliberately decides to be violent and aggressive, that person should be treated sensitively, but no less robustly, than a person without a mental disorder who committed the same crime. Furthermore, a key part of the medical treatment for persons with a dangerous mental health condition is to change the way that the patient see the world, interacts with other people and to get the patient to take responsibility for their own actions. Part of this process is encouraging patients to see a world where other people have feelings, interests and rights and that actions by the patient which infringe the rights of others lead to adverse consequences for the patient. These must be adverse consequences that matter to that patient.

There are a number of consequences or sanctions that must be considered:

1. A member of staff approaching the perpetrator and discussing the incident and agreeing on acceptable behaviour in the future. The consequences of any further incidents should be stressed. The discussion must be entered
into the patient notes and clear instructions given regarding the consequences to be imposed if a similar incident is repeated. Staff must be consistent and firm.

2. The perpetrator may be sent a letter. Such as:
   - An unacceptable behaviour warning letter
   - An acceptable behaviour agreement.
   - Exclusion from premises (with condition)
   - Change of location for receiving NHS services/change NHS Service provider.
   (examples of these can be found at Appendix 2)

3. The Trust will encourage the police to prosecute perpetrators of violence and other aggressive acts and reserves the right to take action in the Civil Courts against someone who has committed any such acts against a Trust employee or service users. The Trust Local Security Management Specialist (LSMS) advises staff on all matters related to police involvement and supports staff in any further action they wish to take.

4. Staff must ensure that repeated offending is challenged with an escalation in the severity of the sanction imposed.

16. Governance
The Director of Nursing is the Board Lead responsible for the implementation of recovery based approaches to reduce restrictive practice.

Approval of preventative strategies training content, and restrictive intervention techniques taught to Trust staff are taken by the Trust Board via the relevant Standing Committee of the Trust Board.

Approved PMVA course content will be shared with LODE educational commissioning group. Regular contract monitoring for PMVA training will be undertaken through HEI

Aggregated reports on:
1. Restrictive practices used
2. Reasons identified for use of restrictive practices
3. Staff compliance with PMVA training requirements
4. Numbers of staff medically unfit to fully engage in PMVA
5. Audits of behavioural support plans, including progress of action plans addressing any areas for development
6. Number of injuries sustained to staff and patients during PMVA are scrutinised as part of divisional performance reporting. These reports inform an annual board review of clinical risk assessment and management practice within the Trust. This incorporates a review of progress against the Trust clinical risk training plan. It should include details of ongoing training strategies for reducing restrictive interventions. Details of this annual board review and the subsequently agreed training strategy and restrictive practice action plan will be incorporated in the annual quality accounts, and will be shared with commissioners and made publicly available.

17. Statutory Responsibilities

17.1 The Health and Safety Executive
The Health and Safety Executive sets expectations of corporate responsibility, that organisations:

   A. Improve management systems to reduce injuries and ill health
   B. Demonstrate the importance of health and safety issues at board level
   C. Report publicly on health and safety issues within their organisation, including their performance against targets. ¹⁰

17.2 The Care Quality Commission
The Care Quality Commission (CQC) ‘Essential Standards of Quality and Safety’ require that staff are supported to undertake their work in a safe working environment where the risk of violence is minimised. Providers are not legally bound to meet these standards, however if they follow alternative arrangements, they should still be able to demonstrate that they have taken account of the standards when judging compliance with regulations.¹¹

17.3 The NHS Litigation Authority
The NHS Litigation Authority (NHSLA) handles civil legal liability claims and works to improve risk management practices in the NHS in England. The NHSLA has an active risk management programme to help raise standards of care in the NHS through Risk Management Standards for acute, mental health, ambulance,

¹⁰ http://www.hse.gov.uk/healthservices/violence/index.htm
¹¹ http://www.cqc.org.uk/
primary care and foundation trusts and independent providers of NHS care to reduce the number of incidents leading to claims.\textsuperscript{12}

18.0 Duties

18.1 Chief Executive
The Chief Executive is ultimately accountable for the safety and welfare of staff, including protecting them from violence and aggression. The Chief Executive must also ensure that the resources and support necessary to adequately implement and maintain this policy are available. In addition, they should:

- Ensure structures within management systems allow concerns to be reported and dealt with quickly
- Respond in a timely fashion when requests for advice or action is required
- Are compliant to the legal responsibilities defined by the Health and Safety at Work Act, Human Rights Act and Criminal Law Act
- Make available resources, including training for a highly skilled workforce
- Demonstrate a commitment to the reduction of restrictive interventions
- Seek assurance that these priorities are being met through regular feedback, outcomes and incident analysis

18.2 Director of Nursing and People
The Director of Nursing and People is the nominated director who undertakes responsibility for Security Management, Governance and Risk, and Health and Safety. This role takes leading responsibility at a board level for the Trust restrictive intervention reduction strategies. In addition they should:

- Ensure the delivery of high quality, compassionate, personalised care
- Ratify and monitor the effectiveness of policies, systems and procedures to prevent challenging behaviour
- Develop a positive culture where high quality care can flourish, and encourage staff to report concerns about poor practice
- Take swift, decisive action if suboptimal care is being delivered
- Show support to staff directly affected by a serious violent incidents

• Demonstrate strong organisational and clinical leadership

• Support staff to move forward criminal proceedings in the event of a serious violent incident

18.3 Local Security Management Specialist

The trust has a trained and accredited Local Security Management Specialist (LSMS) who takes the lead in security management. The LSMS is trained in matters of security management, and a priority area of work for the LSMS is preventing and managing violence and aggression in conjunction with the Trust policies and in accordance with Secretary of State Directions. The LSMS will work with key colleagues, such as the risk and health and safety representative staff, to manage violence and aggression in the provider (see http://www.nhsbsa.nhs.uk/Protect.aspx)

18.4 Risk and Safety Managers

The Trust Risk Managers are responsible for the systematic process of identifying, evaluating and addressing potential and actual risk, through a programme that prevents, controls and minimises risk exposure.

18.5 Health and Safety Manager

The Health and Safety Manager supports staff and managers to meet their health and safety obligations by producing effective policies, procedures and general guidance in relation to the therapeutic management of violence and aggression. They will also offer advice and guidance on specific situations.

18.6 Associate Divisional Directors, Divisional Clinical Leads, Operational Service Managers, Professional Leads, and Matrons

Associate Divisional Directors, Divisional Clinical Leads, Operational Service Managers, Professional Leads, and Matrons should take a lead within the Trust to ensure that a strategic and consistent approach is taken to encourage the therapeutic management of violence and aggression. To this end, they will ensure:

• Management systems allow concerns to be reported and dealt with in a timely fashion

• Compliance with the legal responsibilities defined by the Health and Safety at Work Act, Human Rights Act and Criminal Law Act

• Support for staff directly affected by a serious violent incident

• Support for staff to move forward criminal proceedings in the event of a serious violent incident
• Adequate recruitment to maintain safe operation of the service is maintained
• Audit and reporting system for monitoring risks and clinical quality is robust
• Effective measures are taken to protect the staff and patients for whom they are responsible
• Learning from serious incidents is incorporated into practice
• Complaints and safeguarding investigations are conducted in accordance with the Advice and Complaints policy (2011) and the Safeguarding Adults Policy (2012)

18.7 Ward/Team Managers
Ward/team managers are required to ensure:
• New staff are inducted into their role in emergencies and in how to summon assistance and make response calls
• Adequate numbers of staff are available to keep the ward safe, and staffing is flexible enough to cover (potential) violence. When this has not been possible to achieve this must be escalated, and a datix report completed
• Communication systems allow team members to be informed of risks associated with patients
• Clinical risk assessments and management plans are conducted and recorded on RiO in accordance with the Trust Clinical Risk Assessment & Management Policy.
• Damage to the environment is dealt with promptly
• Staff are released for appropriate training and updates, and are compliant with the mandatory training profile for their service
• Systems for reducing violence such as personal alarms, panic buttons, mobile phones and pagers are checked regularly
• De-briefing and other post incident support for patients involved in incidents takes place. There must be a debrief for staff involved, and a separate debrief for service users/ family/ carers, and any other witnesses.
• Effective measures are taken to protect staff and patients
• Regular audit of risk assessments and care planning is conducted to ensure the quality of risk assessments are adequate, that appropriate care
plans have been developed detailing the interventions to be delivered to reduce the possibility of harm

- Appropriate action is taken when significant risks are identified as detailed in the Clinical Risk assessment and Management Policy. Risk assessments must be reviewed where there is reason to believe that they may no longer be valid

- Learning from previous events is incorporated into practice
- Liaise with other departments and agencies as required
- Have an awareness of the dynamics occurring within the team and the effects on the potential for violence, intervening to reduce this where necessary
- Ensure relevant policies and procedures are available and known to staff
- Accurate reporting of incidents
- Are aware of the legal, ethical and professional aspects involved in the therapeutic management of violence

18.8 All Staff

It is the responsibility of all staff to minimise the risks they face in their daily jobs by:

- Complying with this policy
- Attending annual training in PMVA or breakaway as specified in the mandatory training profile for their place of work, and informing their manager and attending occupational health assessment if unable to do so
- Reporting any potential problems with individuals or buildings
- Not taking any unnecessary risks
- Accurately reporting of any incidents
- Attending designated training when required
- Supporting their colleagues in the management of a potential violent incident, or if an incident occurs, taking action appropriate to their skills and knowledge, as long as they do not place themselves at risk
- Acting in accordance with the Code of Conduct for their professional registering body. For unregistered members of staff, acting in accordance
with the Trust Code of Conduct for Non-Professionally Registered Staff at Band 2-7

- If a member of staff does not feel able to carry out their role in emergencies, he/she must discuss this with their Line Manager as soon as possible to allow appropriate steps to be taken
- All staff must carry a pinpoint alarm at all times when working in inpatient environments

19. Training Requirements
The Trust will provide training and supervision to support staff with differing degrees of specialism and seniority to maintain the competence associated with their role.

Staff involved in physical interventions must be trained to a level of basic life support and be fully aware of restraint related risks and medical emergency procedures. It is mandatory for qualified nurses and medics to undertake the Trust training on cardio pulmonary resuscitation. The Trust commissions training for staff in restraint techniques, which meets the recommendations from the CQC, NICE and NHS Security Management Services, and includes specific risk profiles for each technique taught.

All staff working in inpatient services must attend this training, including any updates in accordance with the Trust mandatory training protocols. Those unable to undertake this training or to practice due to pregnancy or medical problems should be referred to Occupational Health. A risk assessment should also be carried out by the site Matron to ascertain whether the person will be able to continue working in that specific area.

Conflict resolution and breakaway techniques should be included in this training, in order to equip staff with the necessary non-physical intervention skills to be able to identify and de-escalate potentially violent situations.

20. Review of this policy
This policy will be reviewed in July 2017 or earlier should a significant change in regulation or practice came to light.
21. Dissemination, Implementation, Monitoring and Audit Arrangements

21.1 Dissemination and Implementation
The policy is available to all staff on the Trust Intranet. Managers will ensure that all staff are briefed on its contents and on what it means for them. Any enquiries regarding the implementation of this policy should be directed to the Clinical and Corporate Policy Manager.
## 22 Monitoring and Audit Arrangements

<table>
<thead>
<tr>
<th>Elements to be monitored</th>
<th>Lead</th>
<th>How compliance will be monitored</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Acting on recommendations and leads</th>
<th>Changes in practice and lessons to be shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>How the organisation carries out risk assessments for the prevention and management of</td>
<td>Clinical Governance &amp; Performance</td>
<td>Audit of violent incidents from: Datix &amp; EPR notes</td>
<td>6 monthly</td>
<td>Report to Quality Committee</td>
<td>Required actions will be identified and completed in a specified timeframe</td>
<td>Required changes to practice will be identified and actioned within a specific timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
</tr>
<tr>
<td>violence and aggression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timescales for review of risk assessments</td>
<td>Clinical Governance &amp; Performance</td>
<td>Audit from Trust Dashboard</td>
<td>6 monthly</td>
<td>Report to Quality Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How action plans are developed as a result of risk assessments</td>
<td>Clinical Governance &amp; Performance</td>
<td>Audit from Trust Dashboard</td>
<td>6 monthly</td>
<td>Report to Quality Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) how the organisation trains staff, in line with the training needs analysis</td>
<td>Learning &amp; Development Team</td>
<td>Audit of training</td>
<td>6 monthly</td>
<td>Report to Quality Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of police reports and follow-up actions</td>
<td>LSMS</td>
<td>Datix</td>
<td>6 monthly</td>
<td>Report to Quality Committee</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
23. References


NHS Security Management Service (2004). Promoting Safer and Therapeutic Services: Implementing the National Syllabus in Mental health and Learning Disability Services


22.1 Links and recommended reading

Safewards
http://www.safewards.net

NHS Protect training videos
http://www.reducingdistress.co.uk/reducingdistress/training-videos/

NHS Security Management Service

Health & Safety Executive
http://www.hse.gov.uk/

Care Quality Commission
http://www.cqc.org.uk/
24. Associated Policies and Documents

9  Lone Worker policy (RM14, 2014)
10  Clinical Risk Assessment and Management policy (RM07, 2014)
11  Partnership Approaches: Mental Health Services and Metropolitan Police Joint Protocols (Sep 2008).
12  Management of Stress at Work policy (RM16, 2011).
13  Guidance for the use of clopixol acuphase (zuclopenthixol acetate) in adults policy (PHA11, 2011)
14  Rapid Tranquilisation Guidelines (PHA03, 2013)
15  Policy on the Use of Seclusion (CL12, 2013)
16  Safeguarding Vulnerable Adults policy (CL22, 2012)
17  Safety, Privacy and Dignity policy (CL10, 2012)
18  Valuing Diversity policy (HR30, 2012)
19  Workplace Alcohol, Drug, and Substance Misuse policy (HR09, 2013)
20  Whistleblowing policy (HR10, 2013)
21  Physical Health and Wellbeing policy (CL21, 2013)
22  Administration of Medication policy (PHA01, 2011)
23  Incident Reporting policy (RM03, 2011)
24  Clinical Records Management policy (COR03, 2013)
25  Data Protection policy (COR18, 2008)
26  Information Governance policy (COR22, 2014)
27  Clinical Records Management policy (COR03, 2013)
28  Management of Serious Incidents policy (RM05, 2014)
## Appendix 1

### Equality Impact Assessment Tool

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong> Is there any evidence that some groups are affected differently?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>3.</strong> If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>4.</strong> Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>5.</strong> If so can the impact be avoided?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>6.</strong> What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>7.</strong> Can we reduce the impact by taking different action?</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
**Appendix 2**

**Camden and Islington NHS Foundation Trust**

**Formal Response Letter to Individuals Who Are Violent or Abusive or Engage in Behaviour Amounting to Harassment**

**Letter to Patient/Service User**

Name ........................................
Address ........................................
................................................................
................................................................
................................................................
................................................................
EPR Number:.....................................

Date:

Dear .................

This is to inform you that your behaviour on ....................................at ................
has been formally recorded and that your behaviour is viewed by the Trust as unacceptable.

The behaviour noted included (Outline behaviour)

_________________________________________________________________

____________________________________

____________________________

Should you, on any occasion in the future act in a manner unacceptable to the Trust or repeat such behaviour outlined above you may become subject to further action that may include taking appropriate legal action and/or your immediate exclusion from the Trust premises by our security staff/police. Such an exclusion from Trust premises would not mean that you would not receive care, as your responsible clinician would make alternative arrangements for you to receive treatment.

Yours sincerely

Signature

Name

Divisional Manager/Divisional Clinical Lead/Consultant
Appendix 3
FLOW DIAGRAM OF RISK ASSESSMENT AND MANAGEMENT IN RESTRAINT

Initial Medical / Physical Assessment

• On Admission

• When indicated due to change in physical status (e.g., following illness) injury, rapid tranquillisation and use of restraint techniques.

Category of Risk

Low Risk
None or slight physical problems evident. No significant risk factors present. Low risk of harm due to use of C & R holds.

Medium Risk
Some risk factors present e.g.;
• Recent orthopaedic injuries.
• Arthritis
• Amputees
• Obesity
• Hemiplegia from CVA

High Risk
Significant risk factors present, risk of physical harm due to use of TMVA techniques e.g:
• Cardiac Problems – heart failure, angina recent mi
• Respiratory disease – moderate/severe asthma COPD
• Receiving anti-coagulant medication
• Hypertension
• Pregnancy
• Prescribed medication above BNF limits
• Sickle Cell Anaemia

Risk Management

Low Risk
• Routine C & R holds/techniques may be used as necessary.
• Routine observations following restraint.

Medium Risk
• Incorporate risks in Care Management Plan.
• Caution advised when using bent arm holds and /or prone restraint.
• Increase monitoring observation following restraint.

High Risk
• Incorporate risks in Care Management plan
• Use standing or sitting restraint techniques
• DO NOT restrain in prone position
• Use Supine (on back) for shortest possible time
• Constant 1:1 monitoring/observation following restraint (as agreed with Medical Staff)
Appendix 4

Risks associated with physical interventions

The following is based on a systematic review exploring the frequency of deaths associated with restraint in health and care settings in the UK (Patterson, et al. 2003) which identified four distinct factors associated with deaths under restraint;

These were:

- **Neck holds** - pressure exerted on the carotid arteries can rapidly induce unconsciousness but carries a significant risk that death rather than unconsciousness will result;

- **Mechanical restraint-related deaths** – generally these involved older people experiencing confusion, garments specifically designed for restraint purposes and in the persons attempts to escape the garment can effectively act as a ligature;

- **Prone restraint related deaths** – the most predominate identified from the review and describes a wide range of variations in which a person is held on the floor, generally ‘face down’. These included:

  - ‘hobble tying’ where the individual is in a face down position and both arms and legs are pinned behind the individuals back. To achieve this legs are bent and shoulders are pulled back. It is suggested that this and similar positions may significantly compromise the bellows aspect of respiration, forcing the chest wall into a hyper-expanded position and seriously limiting chest wall relaxation and expansion. This may be exacerbated if pressure is applied downwards on the patient’s back to hold the person more securely, particularly while administering medication

  - other restraint positions where the individual is in a position in upper torso is hyper flexed (i.e. leaning forward, bent over at the waist while seated or kneeling). Respiration is severely compromised, particularly if the individual is obese

  - obesity was a factor present in nearly all restraint-related deaths reviewed

  - positive testing for recreation drug use, particularly cocaine intoxication. Cocaine has been reported in association with agitated/excited delirium syndromes and offers a credible explanation for a number of deaths ascribed to ‘restraint asphyxia’. Among the physical symptoms were increased psychomotor activity, insomnia, dehydration, fatigue and elevation of temperature, and a fall in blood pressure
- In addition to recreational drugs, potential adverse effects of neuroleptic medications such as cardiac arrhythmia and respiratory failure have been linked to restraint-related deaths particularly where there has been a violent struggle and by impairing the individual’s ability to swallow or expectorate effectively leading to an increased risk of the inhalation of vomit.

- **Atypical restraint-related deaths** – these serve to draw attention to the need to recognise the potential dangers involved in all restraint positions where respiration may be compromised. For example, being restrained in a kneeling position, securing the arms and lying with the torso face down across a bed, chair etc., or being restrained in a ‘side lying’ position on a bed when a person lays across the torso to secure the individual on the bed, whilst others hold onto the arms and legs is clearly not without its own risks.
Appendix 5

Emergency Physical Monitoring Under Restraint Checklist
Readings to be taken every 5 minutes

Ward:……………………………………..
Patient name:……………………………
Date:……………………………………
Time restraint commenced:………………

<table>
<thead>
<tr>
<th>Time</th>
<th>Pallor</th>
<th>Ability to speak clearly</th>
<th>Respirations (per minute)</th>
<th>Pulse (bpm)</th>
</tr>
</thead>
</table>

Factors associated with asphyxia risk:

- Length of time spent under restraint
- Obesity
- Drug/alcohol intoxication
- Neuroleptic/sedative medication
- Delirium
- Prone position
- Cardiac disease and hypertension
- Respiratory disease
- Sickle Cell
- Pregnancy

Terminate restraint IMMEDIATELY if patient shows:
- Laboured breathing
- Hyperventilation
- Cyanosis
- Grey pallor
- Sudden passivity
- Fits/seizure
- Vomiting or choking
- Cardiac Distress

Signed:…………………………………..
Name:……………………………………
Role:……………………………………
This form must be scanned and uploaded to the EPR document store on termination of restraint.

This restraint monitoring form has been developed to identify respiratory or cardiac distress in service users who are held under restraint. It has been developed in line with the 2005 NICE Guidelines on the short-term management of violence and aggression in inpatient psychiatric settings and emergency departments, which state:

“During physical intervention, under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. The overall physical and psychological well being of the service user should be continuously monitored throughout the process.”

The Rocky Bennett Enquiry recommended that restraints be limited to 3 minutes, however there is a lack of empirical evidence to support this being a ‘safe’ length of time to be held under restraint. In their comprehensive review of the evidence NICE concluded:

“There are real dangers with continuous physical intervention in any position. Physical intervention should be avoided if at all possible, should not be used for prolonged periods, and should be brought to an end at the earliest opportunity. To avoid prolonged physical intervention, an alternative strategy, such as rapid tranquillisation or seclusion (where available), should be considered.”

The priority for Trust staff during a restraint is to maintain the safety of the patient and those around them; this includes recognising the inherent risks posed by physical interventions, and therefore seeking to end any restraint as soon as possible. NICE guidelines state that attempts to deescalate must continue throughout any physical intervention, which will be undertaken by the person controlling the patient’s head in line with the Trust’s Prevention and Management of Violence and Aggression (PMVA) Policy (2014) in order to support the safe management of the patient.

During a restraint the restraint controller is responsible for ensuring an appropriately trained member of staff has been allocated to provide additional monitoring of the physical and psychological wellbeing of the patient, and for ensuring that physical monitoring is undertaken and reported on this form. The Trust’s PMVA Policy (2014) states that a doctor must be present within 30 minutes of any level 3 or prolonged restraint, or if requested to attend by a nursing colleague.

If rapid tranquillisation has been administered, after the restraint has ceased physical monitoring must continue every 15 minutes for 2 hours using the patient’s
MEWS chart using guidelines detailed in PMVA Policy (2014) and Rapid Tranquilisation Policy (2013). All patients subject to level 2 or level 3 restraint must be placed on intermittent observations for at least 2 hours afterwards.

Reference:
