

University Hospitals Plymouth (UHPNT) Paediatric Physical Intervention Policy

Date	Version
September 2019	2
Purpose	
<p>This policy outlines the framework for the safety of patients and staff within UHPNT working with paediatric patients. This policy aims to raise awareness of the restrictive intervention guidance recently published by The Department of Health (“A positive and proactive workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health” (2014), “Positive and Proactive Care: reducing the need for restrictive interventions” (Department of Health 2014), and “Reducing the Need for Restraint and Restrictive Intervention Children and Young People with Learning Disabilities, Autistic Spectrum Disorder and Mental Health Difficulties “(draft) (Department of Health 2017).</p>	
Who should read this document?	
<p>Registered nurses and assistant practitioners, HCAs, Student Nurses, Medics, Play Specialists, Physiotherapists, Operating Department Practitioners and any person having contact with children and young people.</p>	
Key messages	
<p>This policy will direct the clinical team in the appropriate, legal and safe management of children and young people displaying challenging and distressed behaviours when all other alternative therapeutic strategies have been exhausted. It links to supporting documents which provide clinical risk assessment and decision making tools for the use of supportive/clinical/therapeutic holding, restrictive physical interventions. This policy outlines the training requirements for staff employed by UHPNT, that work with children and young people, in terms of Level 1 Conflict Resolution, Level 2 Conflict Resolution, and Level 3 Conflict Resolution. The legal framework relating to children and young people and physical interventions is also included in this document.</p>	
Accountabilities	
Production	Sophie King UHPNT Physical Interventions Lead Alison O'Neill Head of Safeguarding & Named Nurse Safeguarding Children
Review and approval	Safeguarding Steering Group
Ratification	Chief Nurse
Dissemination	All staff UHPNT
Compliance	All clinical staff working with children and young people employed by UHPNT
Links to other policies and procedures	
<p>UHPNT Safeguarding Vulnerable Adults Policy (CLI.SAF.POL.329.3) UHPNT Child Protection Policy/Supervision Policy UHPNT/CAMHS Child (16-17 years) Admitted (or pending admission) to adult or paediatric ward following deliberate self- harm UHPNT Record of Capacity and Best Interest (MCA) 2005 (A 16 & 17) UHPNT Restraining Therapies within Acute Hospital Setting for Adults (TRW.SAF.POL.496.2) UHPNT Restraining Therapies Appendix G UHPNT Procedure for Individuals who are Violent or Aggressive (TRW.SEC.POL/228/1) UHPNT Prevention of violence policy to staff at work (TRW/SEC/POL/234/1) UHPNT Violence and aggression in the workplace. (TRW/H&S/PRO/14/12/3) UHPNT Incident Management Policy UHPNT Uniform and Dress Code Policy (TRW.HUM.POL.165.5) UHPNT Workforce SOP for Staff with Health Restrictions UHPNT Decontamination Guidelines & Procedures (CLI.INF.GUI.32.9) UHPNT Moving & Handling People and objects UHPNT Mental Capacity Act Guide 2005 UHPNT Assessment of Capacity Checklist UHPNT Record of Supportive Holding /Physical Intervention Document, Children & Young People. UHPNT Risk Assessment for Planned Restrictive Physical Intervention for Children & Young People. UHPNT Management of Non-Physical and Physical Intervention (Restraint) for Adults in an Acute Hospital Setting UHPNT Flowchart Guide to Decision Making Before Using Planned Physical Restrictive Intervention on a Child or Young Person. UHPNT Request to Self-Discharge Against Medical Advice-Adults and Young Person. UHPNT Procedure 22b Guidance on the use of bedrails.(TRW/H&S/PRO/24/3/22b) UHPNT Debriefing Patients & Family/Carers of Children & Young People Document UHPNT Debriefing staff involved in a Physical Intervention Incident Document Children & Young People</p>	

GED		
1	12.09.2016	Approved by Safeguarding Steering Group 12.09.2016
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The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on the Trust Documents Network Share Folder (G:\TrustDocuments). Larger text, Braille and Audio versions can be made available upon request

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1.1 This policy has been written in conjunction with UHPNT Management of Non-Physical and Physical Intervention (Restraint) for Adults in an Acute Hospital Setting policy, and has been circulated to the following specialities/individuals to gather their feedback and advice: Safeguarding Team, Matrons for Acute Paediatrics and Community Children's Nursing, Children and Young People Learning Disability Lead, Ward Managers Acute Paediatrics, and all Matrons at UHPNT to include ED, Theatres and GUM Trust Legal Department, and Site Services Manager. This policy has been approved by the Safeguarding Steering Group. The owners of this policy wish to acknowledge the contribution of Plymouth Community Healthcare towards this document.

A literature search was conducted to ensure that this document is supported by a valid and up to date evidence base, existing policies and guidelines in similar acute settings with in England were also reviewed.

1.2 Restrictive interventions as defined by the Department of Health (DH) "Reducing the Need for Restrictive Interventions" 2014 are defined as "*deliberate acts on the part of other person(s) that restrict an individual's movement, liberty or freedom to act independently in order to:*

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

Physical intervention must only be used as a last resort, and only when alternative methods of therapeutic behaviour management have failed, and its use must be proportional to the risk of the situation. The method used must be the least restrictive, for the least amount of time, and be effective and safe.

Physical Intervention is the coordinated use of specific patient holding techniques, carried out by the minimum number of recommended staff dependant on the technique applied in order to manage certain behaviours in patients who are at risk of causing injury or harm to themselves, other patients or staff, or who may require emergency life -saving treatment. Physical interventions must never be used as part of a therapeutic programme of care, as they are an emergency response. Physical Intervention must only be used by staff who have attended approved training and been deemed competent. Staff must ensure that they keep their training up to date, and that they are always in date with their competency. Supportive holding must also be undertaken by staff that have received the appropriate training, and is designed to support patients who require it, through a specific procedure. At all times the human rights of the patient must be of paramount importance.

According to Duff et al (2011) even routine medical care involving taking blood or for other potentially painful procedures and clinical reasons (British Psychological Society 2010), can often lead to distress to the child or young person and their carers. Some children become so distressed that the procedure may be abandoned, or they are restrained, which often increases the anguish for all involved in the process.

Good preparation is vital in reducing potential distressful situation with children or young people (Jaaniste et al 2007, Kain et al 2005) which could lead to restrictive

physical interventions taking place, and according to Gaskell (2010) preparation should include ensuring where possible the environment is age appropriate, the patient and their family and carer are assessed, and basic rapport is established, that parents and carers should be actively involved, and that the child or young person should be given control when possible.

2 Purpose, including legal or regulatory background

This document provides information and guidance to staff on the use of restraining therapies for patients who are children and young people, within University Hospitals Plymouth Trust (UHPNT).

Employers have a duty to take reasonable care of employees in relation to “reasonably foreseeable risks”. Therefore there must be a clear written risk assessment, evidence of appropriate staff training, and existence of an individualised patient specific management plan for staff to follow.

Implementation of this policy will assist staff to address important outcomes for patients – choice, rights, independence and inclusion within objectives

- To minimise the use of physical intervention
- To reduce risk when such interventions are necessary through effective training, guidance and supervision.

UHPNT employees working in the community would not be expected to participate in any physical intervention other than breakaway techniques, and supportive holding where applicable. These guidelines emphasise the need to support staff through a variety of techniques in the recognition, prevention and de-escalation strategies as the first line in the management of challenging, unpredictable, aggressive, violent or harmful behaviour, and has a focus on reducing restrictive practice.

This policy specifies that physical intervention must only be used as a last resort when all other de-escalation interventions have been unsuccessful. Physical interventions are used within the best interest of the patient, and everything possible must be done to prevent injury and maintain the child or young person’s dignity. This policy is designed to define restrictive practice (physical interventions) and to allow the practitioner to ensure that the intervention that they are undertaking is lawful, necessary, proportionate, reasonable and the least restrictive option available.

This policy is not intended to be a comprehensive manual covering all methods of managing challenging, unpredictable, aggressive or violent behaviour; it is intended to outline a set of key principals that must be followed when caring for a child or young person who is displaying aggressive, violent or confused behaviour which could lead to them harming themselves or others in the immediate area, or for the child or young person who requires supportive holding for a therapeutic intervention.

Physical intervention incidents will be monitored through UHPNT Incident Reporting Procedure.

This policy considers physical intervention in the context of risk assessment; in particular recognition, prevention and de-escalation strategies, whilst working within Department of Health (2014 and 2019) guidance.

The Trust is committed to providing a safe environment for its patients, staff, carers and visitors, as well as recognising the needs and respecting the dignity and rights of the children and young people for whom it provides care. There may be a number of complex issues whereby a child or young person could become agitated or confused, which may lead to them endangering their own safety or the safety of others, if not effectively and appropriately managed. There will therefore be occasions when it is lawful and necessary for UHPNT employees to use physical intervention skills to protect the patient, themselves and others from imminent danger, which an individual may not or cannot consent to, and these are now defined as restrictive interventions. Thus it is essential that such interventions are conducted in accordance with best practice for that service group, e.g. Children and Young People, or in response to an appropriate prescribed treatment.

This document should be read in conjunction with UHPNT Management of Non-Physical and Physical Intervention (Restraint) for Adults in an Acute Hospital Setting, Restraining Therapies Appendix G UHPNT and Procedure for Individuals who are Violent or Aggressive UHPNT, Child Protection Policy/Supervision Policy UHPNT, and Safeguarding Vulnerable Adults Policy UHPNT.

Members of staff employed by UHPNT working with children and young people who undertake physical intervention/supportive holding, and as highlighted by their Line Manager should receive mandatory training in the following:

- Level 1 Conflict Resolution class session - minimum 3 yearly
- Level 2 Conflict Resolution (Physical Breakaway class session) – minimum yearly or more often as identified by Training Needs analysis/Datix Incidents.
- Level 3 Conflict Resolution (Physical Intervention Training) –minimum yearly or more often as identified by Training Needs analysis/Datix Incidents.

3 Definitions/Glossary

3.1 Restrictive Intervention – see introduction to guidance, this is an overall term used to describe a variety of interventions which are seen as restrictive. Physical Interventions/Supportive Holding are such techniques.

3.2 Supportive Holding – this means immobilisation by using limited force. It is a method of helping children and young people to manage a painful or unwelcome procedure as quickly and effectively as possible.

Practitioners must be aware that supportive holding if applied inappropriately and without the child's consent or assent may lead to the child or young person feeling anxious, afraid and out of control. Supportive holding is encompassed within physical intervention.

3.3 Physical Intervention (PI) - Physical intervention is the co-ordinated use of specific patient holding techniques, to manage aggressive, violent or unsafe behaviour in patients who are at risk of causing injury or harm to themselves, other patients or staff.

3.4 Breakaway – is a set of physical techniques used by an individual to limit injury and/or to escape from a potentially risky situation. Breakaway techniques

may also be used to de-escalate a situation where a patient may be confused or frightened.

3.5 Challenging Behaviour- (Reducing Distress NHS Protect 2014) refers to any non-verbal, verbal or physical behaviour by a patient which makes it difficult to perform clinical tasks and/or poses a safety risk. It can describe actions, but can also include non-compliance, particularly if staff need to intervene to deliver treatment or care.

3.6 Restrictive Physical Intervention – describes the use of force to limit the movement and freedom of an individual and can involve bodily contact, mechanical devices, chemical restraint (e.g. the use of medication to alter or change a person's behaviour), or changes to a person's environment. Staff using restrictive physical intervention (restraint) on patients must be trained in Trust approved physical interventions techniques and assessed as competent. Staff must attend regular training as identified in this document to ensure that their competency, skills and knowledge are up to date and in date.

3.7 Non-Restrictive Physical Intervention- allows a greater degree of freedom where the individual can move away from the physical intervention if they wish to do so. This would include prompting and guiding a patient to assist them walking, also defensive interventions such as disengagement for protecting oneself from assault.

3.8 Least Forceful Aversive Intervention- describes the physical intervention with the least force and potential for injury in achieving a given objective.

3.9 Children and Young People – throughout these guidelines references are made to “children and young people”, these terms refer to children and young people who have not yet reached their 18th birthday.

3.10 Vulnerable Child- children under the age of 18 years are protected by the Children Act 1989 and other relevant legislation and guidance for example Adoption & Children Act 2002, Children Act 2004.

3.11 Containment –the action of keeping something harmful under control (English Oxford Dictionary). This is the physical restraint which prevents the patient leaving, harming themselves (or others), or causing serious damage to property (Royal College of Nursing 2003).

3.12 Mechanical Restraint- This refers to certain aids or devices that can be used to aid restraint, for example bed rails/posey mitts.

3.13 Pharmacological or Chemical Restraint- Pharmacological or chemical restraint is defined as.... “A drug used as a restraint to control behaviour or to restrict the patient's freedom of movement and is not standard treatment for the patient's medical or psychological condition” (Martin et al, 2000:299)

3.14 Environmental restriction- The design of the environment to limit people's ability to move as they might wish, such as locking doors or sections of a building, complicated locking mechanisms and door handles, electronic key pads with numbers to open doors.

4.1 Matrons/Line Managers and Team Leaders are responsible for:

Ensuring that all staff have access to and comply with this policy in relation to the use of appropriate physical intervention procedures to prevent self-harm, harm to others and the destruction of UHPNT property.

Ensuring that their staff understand what physical interventions are.

Ensuring that their staff understand the legal and ethical frameworks relevant to physical interventions.

Ensuring that staff understand the circumstances in which restrictive interventions may be legally or ethically required.

Ensuring that staff know what to do if they suspect inappropriate or abusive use of physical interventions.

Ensuring that person centred care is provided, that minimises the need for physical intervention.

Ensuring staffing levels are appropriate to the risk identified through assessment – (see Risk Assessment for Planned Restrictive Physical Intervention for Children & Young People).

Establishing local mechanisms for regular evaluation of the implementation and effectiveness of this policy document.

Ensuring that any changes to this policy are approved through the ratification process.

Ensuring that all incidents across UHPNT involving restrictive physical interventions with children and young people are reported in line with UHPNT Reporting of Incidents Procedures.

Providing appropriate and timely feedback to UHPNT staff involved in any incident involving physical intervention. De-brief should take place as soon as is practically possible following any incident involving physical intervention, both with the staff and the patients (and families/carers) involved.

Reviewing each incident of physical intervention in order to learn lessons and improve practice.

Carefully consider the impact of resource management on the use of physical intervention.

Ensuring that staff are supported to attend training as appropriate to the assessed needs of the work area and the role that the staff have within that area.

Ensuring that staff that are not capable of physical intervention techniques in a work area where by it has been recognised that there may be a requirement for such techniques, are risk assessed and appropriate precautions taken.

Ensuring that learning incidents are fed back to the appropriate line manager, and actions are taken as needed.

4.2 Clinical Educators and line managers are responsible for

Ensuring that their area training needs analysis accurately reflects training requirements for staff in relation to physical intervention training.

Identifying physical intervention training needs from learning outcomes from Incidents, and from latest DH guidance. Working with UHPNT Physical interventions Lead to ensure relevant training is identified for staff in their areas.

Working to ensure all appropriately identified staff attend physical intervention training, to include refresher training within appropriate timescales.

Ensuring that records are kept to evidence that the training has taken place.

Working with approved UHPNT trainers to ensure that the any physical intervention training accurately reflects the needs of both staff and patients with in their clinical area.

4.3 All Staff employed by UHPNT, who are required to carry out physical intervention techniques, are responsible for:

Ensuring that they work within the framework of this policy.

Ensuring that they familiarise themselves with their role and responsibility in relation to implementation of the identified level of physical intervention that may be required.

Ensuring awareness of current legislation, as well as their own Professional Codes of Conduct.

Identifying the need for any change to this policy document as a result of becoming aware of changes in practice and advising their line manager accordingly.

Attending the identified level of training, accept advice and engage in supervision as needed.

Ensuring that they undertake and document a risk assessment if a foreseeable physical intervention is required (see Risk Assessment for Planned Restrictive Physical Intervention for Children & Young People).

Ensuring that the use of physical intervention is clearly documented within the patient's care plans and appropriate monitoring forms.

Ensuring that anytime a physical intervention is used it is clearly reported using UHPNT Incident Reporting Procedures (see UHPNT Incident Management Policy).

Any injury to a patient, member of staff or visitor involving the use of physical intervention therapies must be considered a clinical incident/accident, and reported according to UHPNT policy.

Providing information as necessary as requested as part of an incident investigation.

Informing their line manager if there is any reason that they are not able to undertake physical intervention techniques, (e.g. health issue, injury, pregnancy). This must then be assessed and appropriate precautions implemented. This may include temporary or permanent redeployment from any work areas assessed as high risk.

4.4 Involvement of Security team in the restraint of children and young people:

Sometimes situations may occur when additional support is required. In these cases the security team should be contacted. The aim of this service is to assist staff in maintaining the health and safety of patients, staff and visitors.

For children and young people, if necessary, staff may call Trust Security Team for assistance regarding any threatening or violent physical behaviour from the patient including serious attempts of self-harm. Security staff are not clinically trained, so it is vital that any such situation involving Security is led by a clinical staff member, who will be aware of the patient and the care and treatment that patient requires. Staff who are familiar with the patient will have a far greater understanding of what is in the patient's "best interests", and must advise the security team accordingly.

In unplanned emergency situations where clinical staff feel unable to carry out a specific restrictive physical intervention without the support of Security, and the Security Team are not available or not trained to assist in a specific restrictive physical intervention episode, then the Police should be contacted. Whenever there is Police or Security involvement it must be reported following Trust Incident Management Policy.

4.5 Discontinuation of Restrictive Physical Intervention:

The healthcare team must continually monitor the patient for any potential physical and psychological effects during and after a restrictive physical intervention. If the risks outweigh the benefits then the intervention must stop immediately. The effect of the restrictive physical intervention must be evaluated throughout, using the Record of Capacity and Best Interests tool. The restrictive intervention must be discontinued at the earliest opportunity. This may be because treatment has been successfully administered, the child or young person's behaviour no longer renders the need for restrictive physical intervention, or that the intervention has worsened the patients agitation, and that the risk to outweighs the benefit of the intervention.

Please refer to the Risk Assessment for Planned Restrictive Physical Intervention for Children and Young People for guidance on agreed restraint techniques for the patient. If this has not been completed and it is anticipated that there will be repeated Requirement for restraining the patient this must be completed.

Reasons for discontinuation of restraint must be clearly documented. Following on from an episode of physical interventions patients must be monitored for a period of time to ensure that they do not suffer from any effects of the physical interventions, NHS England Patient Safety Alert (2015), NICE (2015).

4.6 Reporting of injuries:

Any injury to the patient, member of staff or visitor to the Trust Premises, involving the use of restrictive physical intervention must be considered a clinical accident/incident and reported according to Trust policy. Incidents must also be documented in the nursing/multidisciplinary notes. The use of restrictive physical

Intervention in an emergency situation requires the completion of a Trust incident form, as it is viewed as a critical incident.

4.7 Evaluation and Audit of Restrictive Physical Interventions:

The use of restrictive physical interventions must be evaluated in terms of its effectiveness, and alternatives must be considered if possible. For planned use of restrictive physical intervention for clinical therapy/treatment, a discussion with the multi-disciplinary team must take place at to include input from the lead clinician. The factors which indicate the use of restrictive physical intervention and its appropriateness should be discussed and reviewed by the ward team.

4.8 Monitoring of this Policy:

The implementation of this policy will be monitored through UHPNT area Matrons, Ward Managers and the Clinical Educators, with the aim to:

- Oversee and facilitate the training and support of staff in the implementation of this policy
- Monitor and review the effectiveness of this policy
- Utilise the patient/family forum to ensure the views of patients and relatives are considered, and to ensure that any patient information is appropriate.

5 Proactive Management of Challenging, Aggressive, Violent and or Unsafe Behaviour

5.1 Core Principals:

Any child or young person that has been identified to have the potential for aggression, violence or unsafe behaviour must be risk assessed, and this must be documented in the patients care plan/records. Any assessment must take into account known triggers, advanced decisions, and appropriate strategies. Discussions must be captured on the patients care plan; (DH guidance “Reducing the need for Restrictive Interventions” (2014), makes reference to Behaviour Support Plans). Any plan where possible should be written with the patient/family/carers, or rationale recorded as to why this did not happen.

Physical intervention must only be used as a last resort and when all other measures (including de-escalation) have been unsuccessful and the situation is deteriorating.

The physical intervention selected must be appropriate, justifiable, reasonable and proportionate to the specific situation and applied for the minimum possible time. It must take into account the child or young person’s physical disabilities, physical and mental health issues, and emotional state.

It is important that children and young people who have the potential to be violent or exhibit aggressive/unsafe behaviour are not treated less favourably on the basis of culture , gender, diagnosis, sexual orientation, gender orientation, disability, ethnicity, religious or spiritual beliefs.

Planned physical intervention must only be carried out by staff who have reached the required competency (competency is assessed during training by approved Trust trainers). All staff present at the time of an incident must agree to the need to implement the planned intervention at that time. Any dissent in the decision making process must be recorded and must be addressed within the later debrief.

All staff involved in the physical intervention must be clear regarding their role within the team, including the techniques to be used.

Consideration must be given to the overall context of care: therefore staff must take into account the detrimental effect the use of physical intervention may have to all involved, and have the ability to respond appropriately.

All incidents of physical intervention must be reported in accordance with UHPNT Incident Reporting Procedures.

Every Incident should be followed by a debrief and this must be recorded on the incident form and within the patient's records/care plan. The debriefing of the staff involved should be undertaken by the line manager within 24 hours or at the earliest opportunity.

5.2 Risk Assessment:

Potential risks of applying restrictive physical intervention- The use of chemical or physical restraint may potentially cause unintended adverse physical and psychological consequences to the child or young person.

Physical:

Limb injury
Aspiration
Tissue damage
Strangulation
Tachycardia
Positional asphyxia

Psychological:

Anxiety
Agitation
Depression
Anger
Confusion
Distress
Feelings of loss of control and dignity

5.3 Aggressive/ violent/challenging & distressed behaviour is not always predictable although certain factors can indicate an increased risk and must be considered when completing a risk assessment, such as:

- History of violent or aggressive behaviour
- History of substance abuse
- Family or carers reporting previous anger or violent behaviour
- Previous expression of intent to harm self or others
- Previous dangerous or impulsive acts

- Denial of previous established dangerous or impulsive acts
- Severity of previous acts
- Anticipated reluctance or non-compliance to a prescribed treatment.
- Evidence of recent severe stress
- Known personal trigger and situational factors
- Previous use of weapons to harm self/others
- Verbal threat of violence to self or others

5.4 Clinical variables must also be taken into consideration when assessing risk:

- Misuse of substances and or alcohol
- Drug effect (disinhibit ion)
- Active symptoms of psychological disorder for example extreme paranoia
- Pre-occupation with violent fantasy
- Poor collaboration with suggested /prescribed treatments
- Children and young people with additional needs for example Autistic Spectrum conditions, Learning Disability, Mental Health issues.
- Brain injury

5.5 Situational variables must be taken in account when assessing the risk of aggressive or violent behaviour including the following:

- Extent of family/social support
- Immediate availability of potential weapon if self -harm or harm to others is strongly suspected.
- Environmental factors
- Involvement of other services for example CAMHS.

The risk assessment process will include a structured and sensitive interview with the child or young person if applicable/possible, and parents/carers. The parent or person with parental responsibility should be present.

Any physical condition which may increase the risk of patient injury during physical intervention must be clearly documented in the risk assessment and care plan, and communicated to appropriate staff. This may include (*this list is not exhaustive*)

- Muscle and joint impairment (arthritis)
- Epilepsy
- Asthma
- Pregnancy
- Size of patient e.g. very frail or obese
- Substance misuse
- Learning Disability
- Increased sensitivity to pain or physical touch
- Sensory Difficulties

If it is foreseeable that the child or young person may need physical intervention the risk assessment must show that the risk of employing the intervention is lower than the risk of not doing so. This should involve the named nurse and multi-disciplinary team. Rationale for all decisions made must be clearly documented within the care plan/records.

The components of risk are dynamic and may change according to circumstance; the risk assessment must be reviewed after each episode of violent or aggressive behaviour and documented within the care plan/patient records. Consideration must be given to:

The patient's behaviour and underlying condition and treatment- Understanding a patient's behaviour and responding to their individual needs must be at the centre of patient care. All patients must be thoroughly assessed to establish what therapeutic behaviour management interventions may be of benefit.

Every effort must be made to reduce the negative effects of the care environment. Examples of negative environmental factors include: High levels of noise or disruption, inappropriate temperature, inappropriate levels of stimulation.

5.6 Care Planning:

It is an essential first step in care planning to understand the reason behind the child or young person's behaviour. The patient's needs and must be assessed in order to establish which therapeutic physical intervention may help them if required.

All patients and family /carer with parental responsibility must be fully involved in their care. Listening to the patients and family/carers views and taking them seriously is regarded as an important factor in managing aggressive and violent behaviour.

Clear and effective communication is essential when developing a care plan. This is of even greater importance if the child or young person, their family/carer has a hearing, visual or cognitive impairment, or whose first language is not English. Where necessary staff must access interpreters or staff with other specific communication skills such as Speech and Language Therapists, or those qualified in sign language or augmentative communication techniques. All available resources must be utilised to ensure effective collaboration between children and young people, families/carers and staff.

Care plans will describe specific techniques that have been discussed with and agreed by the patient and or person with parental responsibility, and the multi-disciplinary team, and must include:

- Strategies that prevent behaviours that precipitate violence and aggression
- Strategies for de-escalation and recovery
- Explicit explanation as to what circumstances physical intervention may be used
- Rationale for decisions made including reasons for/against a decision.

Staff may only use physical intervention on a child or young person when it is the only practicable means of securing the welfare of the child or young person and there are exceptional circumstances – staff should believe that:

- The child or young person will cause harm to themselves or others
- The child or young person will abscond and will put themselves or others at immediate risk
- The child or young person will cause significant damage which is likely to have a serious emotional effect or create physical danger

- The child or young person would be at risk of harm if a specific clinical intervention did not take place at that time, and if aged 16 or above were not assessed to have capacity to make a decision regarding the treatment or intervention.

It is important that staff consider the following factors when completing a risk assessment for young people under 18 years of age:

- Age and build of the person
- Emotional and intellectual development
- History of abuse
- Learning Disability, Autism or Mental Health.
- Gender, religion, ethnicity, social background.

Young people must always be involved and kept as fully informed, and must receive clear and detailed information concerning their care and treatment in devising the care plan. It must be explained in a way they can understand and in a format that is age appropriate.

Consent must be obtained from the young person and their parent or the person with parental responsibility must be consulted regarding any situation that is not an immediate emergency and may require physical intervention. Advice must also be sought from CAMHS, and other members of the multi-disciplinary team, for example Psychologists, Safeguarding, Play Therapist, or Paediatric Learning Disability Nurse. Any discussions with the young person must take into account their personal circumstances and any additional needs.

The professional practice of staff in such situations needs to be clearly understood by all staff, young people and their parents/carers. Parents/carers must be informed at the earliest opportunity and provided with a full update regularly for continued incidents.

Where physical intervention techniques are used all actions taken must be fully recorded within the young person's clinical records and ensure that it is clearly and comprehensively reported in line with UHPNT Incident Reporting Procedures.

Staff must be aware that close proximity to young people who are highly agitated can make the situation worse and increase the level of risk. All staff must seek to promote an atmosphere of calm, consistency and order so that young people and staff feel secure.

5.7 Legal Frameworks:

The lawful use of restrictive physical interventions in respect of people who lack capacity based on the Mental Capacity Act 2005 which applies to all persons 16 years or older, covers the following core principles:

- A person must be assumed to have capacity. A lack of capacity has to be clearly demonstrated by formally assessing and recording capacity at the time.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
- Any act done or decision made, for or on behalf of a person who lacks capacity must be in their best interests.

- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- Any decision must show that the least restrictive option or intervention is achieved.

The Mental Capacity Act requires us to make an assumption of capacity unless proven otherwise. Evidence that a patient lacks capacity must be clearly rationalised within the patient's care plan/records by an appropriate clinician.

For further information on Mental Capacity Act 2005 please refer to the 2005 Mental Capacity Guide and the Mental Capacity Act 2005 Code of Practice., both of which can be accessed on Trust Documents.

This policy takes account of relevant law and guidance which affects the treatment of children, including in particular the following:

The Mental Capacity Act 2005
 The Mental Health Act 1983
 The Children Act 1989
 The European Convention on Human Rights

The Code of Practice to the Mental Capacity Act,
 The Code of Practice to the Mental Health Act
 The UN Convention on the Rights of the Child

As a matter of law, a child is a person under the age of 18. Commonly, law and guidance will distinguish between young persons (aged 16 or 17) and children (aged under 16), but both groups are children for the purposes of the Children Act 1989. The distinction arises where certain rights are afforded to young persons but not to children. The Mental Capacity Act 2005 does not apply to people aged under 16.

By way of brief summary:

- A young person who is capable of making decisions about treatment must normally have his wishes respected. Any restraint or application of force, or even touching, without consent is potentially an assault.
- A child who is *Gillick competent* in relation to decisions about treatment should normally have his wishes respected. Any restraint or application of force, or even touching, without consent is potentially an assault.
- *Capacity* and *Gillick competence* for all practical purposes mean the same even though the tests to apply are slightly different.
- If the capable young person or a competent child refuses treatment or needs to be restrained, that refusal can be overridden provided:
- The treatment or restraint is authorised by an appropriate Court.
- The treatment or restraint is needed so urgently that without it the child will die or suffer severe permanent injury and there is no time to obtain authorisation from a Court.
- If the admission and treatment is for a mental disorder and the capable young person refuses it his wishes cannot be overridden by someone with parental responsibility.
- A young person who is incapable may be restrained or treated if it is in his best interests to do so in accordance with the Mental Capacity Act 2005.

- An incapable young person may be treated or restrained if consent is given by a person with parental responsibility and that treatment is within the scope of parental responsibility.
- A child who is incompetent may be restrained or treated where it is in that child's best interests.
- A child who is incompetent may be treated or restrained if consent is given by a person with parental responsibility and that treatment is within the scope of parental responsibility.

Capacity/competence

Young Persons

Capacity for young persons is determined under the same statutory test as for adults. The essential question is: Does the young person have a temporary or permanent impairment or disturbance in the functioning of their mind or brain which means they are incapable of making the decision about treatment? Further,

1. Can they understand the information relevant to the decision?
2. Can they retain the relevant information?
3. Can they use or weigh that relevant information in the balance?
4. Can they communicate their decision?

Parliament has recognised in statute that the older a young person gets, the greater the weight that should be attributed to their views. If a young person has capacity, their consent alone is sufficient authority for the treatment. It is not necessary to obtain parental consent; although those with parental responsibility for the young person should generally be consulted (subject to any valid refusal of consent to share information).

Children

For those under the age of 16, the *Gillick* test is used to determine whether they are competent to make the decision. The test is whether the child is of "*sufficient maturity and understanding to take a decision of the seriousness in question.*" This means "*not merely an ability to understand the nature of the proposed treatment...but a full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side effects and... the anticipated consequences of a failure to treat.*"

More recently, case law indicates that there is an expectation on practitioners to also apply the test for capacity as set out in the MCA 2005 (albeit, strictly speaking, that Act does not apply to those under 16). The practitioner must ensure that practicable steps are taken to help the child make the decision.

If a child is *Gillick competent* and wishes to receive treatment, their consent alone is sufficient authority without the need to obtain parental consent; although those with parental responsibility for the child should generally be consulted (subject to any valid refusal of consent to share information).

Duress/Undue Influence/Coercion

As with adults, a young person or child may have capacity (within the meaning of the MCA 2005)/be *Gillick* competent to make a decision about treatment/care, but be unable to provide valid consent because they are overwhelmed or unduly influenced or coerced.

In such circumstances, the consent of the young person/child is insufficient authority to treat or provide care (even where the young person/child is agreeing to it). Alternative authority must be obtained, for example Court of Protection.

Parental Responsibility

Persons with parental responsibility are able to provide consent for children and young persons for decisions which fall within the "scope of parental responsibility". It is therefore essential that practitioners take steps to identify who has parental responsibility.

Parental responsibility is a concept defined by the Children Act 1989. Broadly speaking it extends to:

- Biological mother,
- Father (if married to the mother at the time of birth, or after 1 December 2003 If named on the child's birth certificate or if so ordered by the Court); or
- Any person granted parental responsibility by the Court.
- Civil Partners including same sex civil partners covered by section 42 of the Human Fertilisation and Embryology Act 2008.

In addition to having parental responsibility, consent from someone with parental responsibility is only sufficient if the decision which is being taken is one which is within the scope of parental responsibility.

Whilst, strictly speaking, the scope of parental responsibility is a term defined within the 2015 Code of Practice to the Mental Health Act, the Code does not limit its application to treatment for mental disorder. Practitioners would therefore be well advised to apply it more generally to all treatment.

In determining whether it is a decision that would fall within the scope of parental responsibility, practitioners must ask two questions:-

1. Is this a decision that a parent should reasonably be expected to make? Factors to consider include:

- What is considered normal practice in our society?
- The type and invasiveness of the proposed intervention;
- The age, maturity and understanding of the particular child/young person;
- The extent to which the child/young person agrees/resists;
- Any relevant human rights' decisions of the Court;

And

2. Are there any factors that might undermine the validity of this particular person's parental consent? Factors to consider include:

- Parent cannot make decision – e.g. incapacitated;
- Parent unable to focus on the best interests of the child/young person;
- Significant distress of parent – i.e. to the extent that they're overwhelmed;
- Disagreement between parents.

If the decision is one which a parent would not reasonably be expected to make, or if relying on that parental consent would not be appropriate, the decision must be referred to the Court.

Unless the treatment in question is irreversible or is an immunisation, the consent of one person with parental responsibility is usually sufficient. It will not be appropriate, however, to rely on parental consent if another person with parental responsibility strongly disagrees with the decision and is likely to take action to prevent intervention. If consensus cannot be reached, the decision must be referred to the Court.

Where a young person lacks capacity (in accordance with the statutory test laid down in the MCA 2005) – as opposed to being overwhelmed or unduly influenced – and therefore cannot provide capacitated consent, a person with parental responsibility *can* provide consent on their behalf. This means that 16 and 17 year olds are distinct from adults under the MCA 2005; insofar as consent can be provided on their behalf by someone with parental responsibility, where the young person is incapable.

Deprivation of Liberty

Where the restraint of the young person or child goes beyond restraint, it may amount to a deprivation of liberty. That is determined by considering whether the step involved means that the child will not be free to leave the hospital or treatment centre and will be under continuous supervision and control. Being under continuous supervision and control does not require the person to be watched at arm's length continuously, it is only to ensure that the child's whereabouts are known at all times. Having a door locked does not mean that a person is free to leave, especially, for example, if the patient would be allowed to leave if he asked. If, however, doing so depends on the assent of a member of staff that may amount to a deprivation of liberty.

Any deprivation of liberty must be authorised in accordance with a procedure prescribed by law where the person concerned is incapable or incompetent.

Such authorisation can be secured via the Mental Health Act 1983, the Mental Capacity Act or the High Court. In appropriate circumstances, a parent may give a valid consent to the deprivation of liberty of their child where that child is aged up to 15.

Human Rights

All children have a right to freedom under Article 5 of the European Convention on Human Rights. That right can only be interfered with if in accordance with a procedure prescribed by law. A child's right to liberty must be informed by Article 37 of the United Nations Convention on the Rights of the Child. Although the UN convention is not a part of English Law it sets out general principles which can be helpful in understanding how Article 5 applies.

Children have a right to autonomy under Article 8 of the European Convention on Human Rights. That can be interfered with if done so in accordance with the law and to the extent that it is a reasonable, proportionate response. Likewise, parents have a right to respect for family life under Article 8, which includes the concept of parental responsibility for the care and custody of minor children.

These principles are reflected in this policy and must underpin all steps taken in respect of children.

**(Bevan Brittan LLP
25 April 2016)**

5.8 Patients who have capacity or who are considered to be Gillick/Fraser competent:

If the patient is age 16 or over and has capacity under the Mental Capacity Act 2005, or are under the age of 16 and deemed by a qualified clinician to be Gillick/ Fraser competent, and they do not consent or comply with care or treatment offered, then to restrain or hold could be classed an assault. In these circumstances please refer where possible to the named consultant and safeguarding teams for further advice. There may be instances when unplanned physical intervention has to take place to ensure the safety of the patient and others, and will form part of the overall duty of care. Careful consideration of whether the procedure is really necessary and whether the urgency in an emergency situation prohibits the exploration of alternatives or the postponement of a treatment or procedure must take place and be documented in the care plan/notes.

In all but the youngest children, obtain and document the patient's consent or assent (expressed agreement), or if the child is very young the consent from the person with parental responsibility. Dissent from a young person for treatment can be overruled by someone with parental responsibility, particularly in younger children. For patients over 16, the Mental Capacity Act (2005) can be used (this is the decision of the Consultant, in discussion with the Multi-disciplinary team) if the young person is felt to lack mental capacity to make a specific decision (document).

In a medical emergency staff can act in the young person's interests without consent. In the rare event that restraint is likely for a specific procedure, for example emergency NG feeding, then a full risk assessment must take place, the Consultant must make the decision to use restraint, and the intervention must be documented in patient notes and reported via Trust incident reporting procedure. A patient/parent discussion should take place as soon as possible afterwards, and a staff de-brief for those involved in the intervention should take place within 24 hours.

It is important to remember that restrictive physical intervention must only be used as a last resort, once alternative methods of therapeutic behaviour management have failed. Its use must be proportional to the risk of the situation. The method used must be the least restrictive, whilst being effective and safe. Restrictive physical intervention needs to be reasonable and proportionate otherwise staff may face allegations of assault. When all other alternative therapies have failed and as a last resort, it may be deemed that there are situations where it would be seen as lawful and reasonable to use force to restrain a patient, such as:

- To prevent self-harm or risk of physical injury.
- Where staff are in immediate risk of physical assault.
- To prevent dangerous, threatening or destructive behaviour (RCN 2004).

If staff are unsure of the legal implications of a restrictive physical intervention, then expert advice must be sought from UHPNT Head Legal Manager. If ethical advice is required, then it would be appropriate to refer to Trust Ethical Committee.

Healthcare Professionals must only apply Restrictive Physical Restraint that:

- Is proportionate to the risk of harm posed to the child or young person.
- Is used as a last resort, and is the least amount of restraint for the least amount of time.
- Takes into account the safety of the patient and others at the time.
- Balances the wishes and Human Rights of the young person against the threat of immediate harm to themselves or others.
- Adheres to Department of Health Guidelines (2014), Department of Health Guidelines (draft) (2017), NICE Guidance 10 (2015) and Patient Safety Alert (2015), Stage one: Warning The importance of vital signs during and after restrictive interventions/manual restraint.
- They have been trained and assessed as competent to use physical intervention techniques (although *in an emergency situation staff have a duty of care to intervene to keep the patient and others safe*).
- Adheres to UHPNT policies, guidelines and procedures.

Health Care Professionals have a responsibility to act in the “best interests” of an incapacitated patient and thus protect them from harm.

5.9 Exclusions:

This policy does not include situations involving violence and / or aggression, by patients or members of the public who **have mental capacity**. Employees have the right to request a security/and or police presence in circumstances where they believe there is a potential for an act of violence to take place or the need for physical restraint exists. Staff must refer to the UHPNT Violence and Aggression Policy, Violence and aggression in the workplace, and the Policies and Procedures for people who are violent or aggressive and Prevention of violence to staff at work (UHPNT).

6 Levels of Intervention

6.1 Pre-planning Prior to any potential distressing and /or painful procedure which has the potential to increase the levels of anguish for the child or young person, their families/carers and the staff carrying out the procedure, it is vital that full consideration must be given to the pre-procedure planning phase (Duff et al 2011). Remember that play specialists can play a key role in helping children and young people to overcome procedural related anxiety and distress. Distraction techniques are recognised as an effective intervention to mediate reductions in fear and pain (Uman et al 2008). If the situation escalates due to increase in the child or young person’s anxiety levels, stay calm and avoid conflict or coercion (Duff 2003).

Consideration must be taken regarding the available options for example taking a “time out” before reintroducing the procedure, postponing the procedure to allow for further preparation, or if it is essential that the procedure is carried out at that moment in time and sedation (chemical restraint, rapid tranquilisation) is not an

option then the least restrictive physical interventions techniques for the least amount of time may be considered. Thus there are combinations of approaches and strategies that can be considered in the pre-planning stage which should reduce the need for restrictive physical interventions, and these are outlined in more detail in The Royal College of Nursing Guidelines (2010), and The British Psychological Society Essential Guidelines (2010).

For planned use of physical interventions (restraint) the Risk Assessment for Planned Restrictive Physical Intervention for Children and Young People must be completed.

6.2 De-Escalation techniques:

This relates to staff coming into contact with children and young people e.g. Nurses, Operating Department Practitioners, Health Care Assistants, Play Specialists, and Administration teams.

These are techniques to reduce the level and intensity of a difficult situation. De-escalation means making a risk assessment of the situation and using verbal and non- verbal communication skills in combination to diffuse the situation.

It may be appropriate to use a quiet room for de-escalation purposes if one is available. This is primarily a facility where by the patient or aggrieved person may be taken to take time out to discuss their concerns in private. This can afford the patient a safe and reduced stimulus environment thereby minimising the risk of significant physical or psychological harm to themselves or others, and may allow them the opportunity reduce their challenging and distressed behaviours.

All Medics, Nurses, Health Care Professionals, Health Care Assistants, Play Specialists, Health Care Professionals, and front line Administration staff working with Children, Young People and their families should receive mandatory Level 1 Conflict Resolution Training on a three-yearly basis.

6.3 Breakaway:

Breakaway is a physical technique used by an individual to limit injury and/or to escape from someone who is attempting to physically assault a member of staff.

Staff who have face to face patient and parent /carer contact should receive mandatory Level 2 Conflict Resolution (Breakaway) training as a minimum once every year, unless otherwise indicated by local Training Needs Analysis or Datix incident.

6.4 Emergency situations:

In an unplanned emergency situation, staff that have not been trained in formal physical intervention techniques are entitled to, and indeed may have a duty of care to use physical intervention (breakaway/self- protection and or restraint) to the best of their ability when their safety or the safety of the patient or others is in jeopardy. All members of the Multi -Disciplinary Team regardless if they are trained in physical intervention must offer assistance to staff, for example make sure that the area is clear of other people, reassurance to other patients if they find the situation stressful, calling for additional help, ensuring that the ward area remains safe. However the use of untrained staff for planned physical interventions must be avoided where ever possible.

6.5 Supportive Holding: - This must be pre-planned wherever possible ensuring that the patient and person with parental responsibility are aware of the reasons for the supportive holding episode, and how this will be achieved. All staff involved in the procedure aligned with the supportive holding episode must be clear of their role prior to the intervention taking place, and this intervention must be recorded in the patient notes. This kind of intervention uses only limited force, (Duff et al 2011) and should be used to make the child or young person “feel safe”. Always use the parents and carers as much as possible for supportive holding, and play specialists if appropriate and available.

6.6 Restrictive Physical Interventions (restraint):

Before physical intervention techniques are implemented it must be ascertained as far as possible whether the patient is in possession of anything that could be used as a weapon. If there is any doubt police assistance must be considered and efforts must be made to make the environment as safe as possible.

Anyone with in the immediate area must be supervised throughout an incident. If there are staff on duty that are not required for the incident, they must remain with other patients and visitors in the area, who are not involved in the incident.

Once physical intervention techniques have been initiated, the team involved has a duty of care to the individual and must ensure the restraint is discontinued as soon as the situation is considered to be safe. The patient must be monitored during the restraint episode and for a period of time after the restraint episode to ensure that there has been no harm from the restraint episode (NPSA 2015, NICE 10 2015).

The purpose of physical intervention is to take control of a dangerous situation and secondly to limit the patient’s freedom for no longer than necessary to end or reduce significantly the threat to themselves or others. Physical intervention must only be used when all other less intrusive methods have been explored and considered not suitable or have failed.

Throughout the situation staff must continue to employ de-escalation techniques, one member of staff must talk and explain the reason for actions to the patient, this is usually the lead person. Physical restraint must be brought to an end at the earliest opportunity.

Staff not trained in physical intervention techniques still have a duty of care for their patients and must act in a manner reasonable to the situation and in good faith, bearing in mind the principals within this policy, e.g. the use of reasonable force, duty of care, best interests, Human Rights.

6.7 Implementation of Physical Intervention techniques:

Approved physical intervention techniques must only be used when all other options are no longer practicable and intervention is in the best interests of those involved.

Physical intervention techniques must only be undertaken by staff that are appropriately trained and competent. It is recognised that in an emergency situation, staff who have not been trained but who still have a duty of care may become involved in an unplanned physical intervention.

In a situation where a staff member finds themselves isolated and at risk, approved breakaway techniques may be used to protect from assault/injury.

Where physical intervention is inevitable an appropriate staff team must be found in accordance with the risk assessment (see Risk Assessment for Planned Restrictive Physical Intervention for Children and Young People). Staff should only restrain patients to prescribed levels as identified on the Risk Assessment for Planned Physical Intervention for Children and Young People, and should not deploy restraint techniques that they have not been trained in, to minimise risk of injury to both patient and staff.

Staff must be allocated to calm and reassure other patients and visitors who witness the event if this is possible.

In circumstances where the patient has left or attempts to leave the ward area, and de-escalation and non-restrictive and least forceful aversive intervention techniques have failed, staff must consider seeking the assistance of security and/or the police, and seek clinical advice and support from an available Line Manager. For patients between 16-18 years of age consideration must be given to their mental capacity.

If the nurse in charge believes that the incident is becoming beyond the control or expertise of nursing staff they should consult with senior colleagues if available or call for security or police assistance.

It is important to remember that sometimes restrictive interventions can cause the patient psychological and physical harm (Nice 2015), and therefore vital signs must be monitored during and for a period after restrictive interventions (Patient Safety Alert NHS/PSA/W/2015/011, 2015). The patient should be monitored post restraint episode for a period of time until the health care practitioner has no further concerns.

6.8 Unacceptable Methods of Restriction- The following methods of restriction are unacceptable, however if the patient requests or is consenting to any of the following it may be considered and applied as appropriate. This must be clearly documented. Inappropriate use of restrictions may be viewed as abuse and a safeguarding concern. The following list is not exhaustive.

Inappropriate bed height. This is an unacceptable form of restraint, one reason being that it increases the risk of injury resulting from a fall out of bed.

Inappropriate use of wheelchair safety straps. The safety straps on wheelchairs should always be used, when provided for the safety of the user. However patients must only be seated in a wheelchair when this type of seating is required, not as a means of restraint.

Chairs whose construction immobilises patients e.g., reclining chairs, bucket seats. Reclining chairs must be used for the comfort of the user and not as a method of restraint.

Locked doors. On the occasion that doors are locked clear signage must be displayed informing patients and the public that doors are locked and who they should ask to have them unlocked to exit the ward. If a patient is asking to leave and being prevented by the locked door that patient is being restricted.

Arranging furniture to impede movement. Other methods of dealing with behaviour such as wandering must be pursued. Any equipment, including furniture, must only be used for the purpose for which it is intended.

Isolation. It is important to note that patients may be “isolated” for infection control reasons, or to prevent potential harm or disruption to other patients. If a patient is cared for in a side room, when he or she wishes to be on the main ward, this may be construed as restraint. This is a complex issue, which must be discussed on a case by case basis with the multidisciplinary team, including the Infection Control Team.

Planned prone physical restraint. The utilisation of a planned prone restraint must not be used other than exceptional circumstances e.g. medical reason. Utilisation of seated, supine or release of person to be considered as alternatives. Should a patient accidentally end up in the prone position as a result of an uncontrolled descent to the floor they must be placed into the supine position as soon as is possible. Restraint must not take place in the prone position, (unless *the patient has been admitted with a documented care plan stating prone restraint is preferred and has carers with them who have been trained in this. In this instance a member of the Physical Interventions Team must be contacted for advice*).

7 Reporting

7.1 Clear and accurate recording of all interventions is required to inform the Trust regarding their use, embedding learning and to enable planning in how to reduce such interventions.

It is important that the Trust capture information on all incidents requiring physical intervention, so that these may be learnt from. Incident reports will inform the on-going risk assessment process and may also provide added protection for staff and the Trust in the event of any subsequent legal action.

Instances where a physical intervention on child or young person take place must be reported in accordance with Trust Incident Reporting Procedure, and completed within 24 hours of the incident taking place. The incident form must detail the following:

- Names of all the people involved
- Age of patient involved
- Reason for using the specific type of intervention
- Types of intervention used
- Date and duration of intervention
- Whether any injuries to the patient, staff or visitors were sustained, and actions taken as a result.

The Safeguarding Children team must be informed via Trust Incident Reporting if a child or young person under the age of 18 years has had a physical intervention.

The senior nurse must be informed of the incident as soon as appropriate.

7.2 Debriefing Patients: (see Debriefing Patients/Carers document)

There should be a planned de-brief for the patient/person with parental responsibility. The debrief must not happen whilst the patient is still agitated, and should be undertaken at an appropriate time following the incident. The agenda for this debrief must include:

- Who would the patient like to be present?

- Would the patient like to talk to anyone else about it, for example a family member or ward manager?
- Does the patient understand why it happened?
- How did it feel for the patient?
- Would the patient like it to be different?
- How could we avoid having to do it again?
- Ask the patient if they have sustained any injuries following on for the PI, these must be mapped on body maps, and appropriate treatment sought.
- Does the patient wish to make a formal complaint about any aspect of the incident?
- Consider if there is a specific need for emotional support in response to the potential for trauma during any incident, and this must be documented in the patient notes.

7.3 Debriefing Staff :(see Debriefing Staff Document).

Following all physical Interventions a debrief and review must take place at the earliest opportunity, preferably within 24 hours. Every effort must be made to ensure that all members of staff involved in the incident are able to attend. The aim of the debrief should be to evaluate the impact of the intervention, identify needs, determine alternatives, recommend changes. The debrief should be conducted by Line Manager, and a record attached to the datix/noted in the datix.

Debriefing will include a discussion about whether physical intervention is still seen as an appropriate intervention for that child or young person, and any doubts should be discussed as soon as possible with the multi-disciplinary team.

8 Training

8.1 Nurses, Health Care Assistants, Play Specialists, Operating Department Practitioners and front line Administration staff should receive a minimum of Level 1 Conflict Resolution (de-escalation- face to face) at least once every 3 years and Breakaway training, at least once every year.

For staff to be deemed competent they must have attended and taken part in Physical Intervention /Breakaway training.

A programme of training is available at different levels which ensure that all ward areas and staff groups as previously highlighted, receive the appropriate level of training which reflects their respective patient groups.

Please note that although the training below is to be undertaken as a minimum of once every 1 or 3 years (dependant on level) , this may be more frequent depending upon local Training Needs Analysis and incidents.

8.2 Level 1 Conflict Resolution – (Theory Conflict de-escalation class room session), at least once every 3 years, (UK Core Skills Framework 2018, 1.5 Subject 4).

8.3 Level 2 Conflict Resolution (Breakaway) - Practical session, at least once every year.

8.4 Level 3 Conflict Resolution (Restrictive Physical Intervention Training) – To include theory elements and practical competency sign off, at least once every year,

for identified staff in the Trust. This training will be tailored to suit the needs of the clinical area/patient group, and will be agreed via training needs analysis with the client (for example Matron, Clinical Educator, Ward Manager) and the Physical Interventions Lead.

8.5 Level 4 Conflict Resolution (Highly Restrictive Physical Intervention) – this is only for identified staff with in the Trust.

Please note that a health declaration is required to be completed by staff before Breakaway, and Physical Intervention training, which may lead to a requirement for a risk assessment to be undertaken by the staff member and their line manager, in accordance with UHPNT Workforce SOP for staff with health restrictions.

9 Monitoring Compliance and Effectiveness

Monitoring of all incidents involving physical intervention is essential in order to identify where lessons can be learnt and to prevent the build-up of unsafe practice.

Line managers or a nominated person will monitor each incident that occurs within their area, and will analyse and collate the detail of physical intervention incidents taking place in order to identify any particular patterns.

This policy will be subject to review yearly or earlier must any significant issue be identified, if learning requires implementing or these is a change in DH guidelines or legislation.

10 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set as default of two years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the Safeguarding Steering Group and ratified by the Director of Nursing.

Non-significant amendments to this document may be made, under delegated authority from the Director of Nursing, by the nominated author. These must be ratified by the Director of Nursing and must be reported, retrospectively, to the approving group or committee.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades that are directly affected by the proposed changes.

11 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the named Director of Nursing and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

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UHPNT Prevention of Violence Policy to Staff at Work (TRW/H&S/PRO/24/3/22b) <http://staffnet.plymouth.nhs.uk>

UK Core Skills Training Framework (2018) Statutory/Mandatory Training Guide V1.5 subject 4.

Uman.LS, Chambers.CT, McGrath. PJ. Et al. (2008) A systematic review of randomized controlled trials examining psychological interventions for needle – related procedural pain and distress in children and adolescents: Journal Pediatric Psychology **33**:842-54

United Nations Convention on the Rights of the Child. www.unicef.org

University Hospitals Bristol NHS Foundation Trust (2011). Buswell, J. Marshall, A. Clinical Holding Guidelines For Use With Children

TRW.ACP.POL.1022.2 TRUST Paediatric Physical Intervention Policy

2015 Code of Practice to The Mental Health Act <https://www.gov.uk/.../news/new-mental-health-act-code-of-practice>

Dissemination Plan	Appendix 1
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Core Information				
Document Title	UHPNT Paediatric Physical Intervention Policy			
Date Finalised	September 2016			
Dissemination Lead	Sophie King Physical Interventions Lead			
Previous Documents				
Previous document in use?	Paediatric Physical Interventions Policy V.1			
Action to retrieve old copies.	Information Governance			
Dissemination Plan				
Recipient(s)	When	How	Responsibility	Progress update
All staff UHPNT working with Children & Young People		Email	Document Control	

Review		
Title	Is the title clear and unambiguous?	Y
	Is it clear whether the document is a policy, procedure, protocol, and framework, APN or SOP?	Y
	Does the style & format comply?	Y
Rationale	Are reasons for development of the document stated?	Y
Development Process	Is the method described in brief?	Y
	Are people involved in the development identified?	Y
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Y
	Is there evidence of consultation with stakeholders and users?	Y
Content	Is the objective of the document clear?	Y
	Is the target population clear and unambiguous?	Y
	Are the intended outcomes described?	Y
	Are the statements clear and unambiguous?	Y
Evidence Base	Is the type of evidence to support the document identified explicitly?	Y
	Are key references cited and in full?	Y
	Are supporting documents referenced?	Y
Approval	Does the document identify which committee/group will review it?	Y
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A
	Does the document identify which Executive Director will ratify it?	Y
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Y
	Does the plan include the necessary training/support to ensure compliance?	Y
Document Control	Does the document identify where it will be held?	Y
	Have archiving arrangements for superseded documents been addressed?	Y
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y
	Is there a plan to review or audit compliance with the document?	Y
Review Date	Is the review date identified?	Y
	Is the frequency of review identified? If so is it acceptable?	Y
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Y

Core Information	
Manager	Care Group Manager
Directorate	Safeguarding UHPNT
Date	September 2016
Title	UHPNT Paediatric Physical Intervention Policy
What are the aims, objectives & projected outcomes?	The procedures described in this document are intended to support staff in remaining safe in complying with the stated Trust policy, and to ensure the patient care is safe and effective.

Scope of the assessment

All protected characteristics have been considered when developing the policy.
 Workforce and Service user monitoring, analysis and publication will be undertaken to ensure compliance with legislative requirements and to meet CQC requirements.

Collecting data

Race	<p>There is no evidence to suggest that there is a negative impact on race regarding this policy.</p> <p>Workforce and service data is currently monitored, analysed and published on the Trust website. Areas of concern will be addressed through appropriate action plans.</p> <p>Data from workforce surveys, complaints and service user surveys will be monitored and analysed as required.</p>
Religion	<p>There is no evidence to suggest that there is a negative impact on Religion or belief and non-belief regarding this policy.</p> <p>Workforce and service data is currently monitored, analysed and published on the Trust website. Areas of concern will be addressed through appropriate action plans.</p> <p>Data from the workforce surveys, complaints and service user surveys will be monitored and analysed as required.</p>
Disability	<p>There is no evidence to suggest that there is a negative impact on Disability regarding this policy.</p> <p>Workforce and service data is currently monitored, analysed and published on the Trust website. Areas of concern will be addressed through appropriate action plans.</p> <p>Data from the workforce surveys, complaints and service user surveys will be monitored and analysed as required.</p>
Sex	<p>There is no evidence to suggest that there is a negative impact on gender regarding this policy.</p> <p>Workforce and service data is currently monitored, analysed and published on the Trust website. Areas of concern will be addressed through appropriate action plans.</p> <p>Data from the workforce surveys, complaints and service user surveys will be monitored and analysed as required.</p>

Gender Identity	There is no evidence to suggest that there is a negative impact on gender identity regarding this policy, currently workforce and service data for this area is not collected, due to the current provision on the data collection systems.
Sexual Orientation	There is no evidence to suggest that there is a negative impact on sexual orientation regarding this policy. Workforce and service data is currently monitored, analysed and published on the Trust website. Areas of concern will be addressed through appropriate action plans. Data from complaints and service user surveys will be monitored and analysed as required.
Age	This policy will benefit children and young people Workforce and service data is currently monitored, analysed and published on the Trust website. Areas of concern will be addressed through appropriate action plans. Data from complaints and service user surveys will be monitored and analysed as required.
Socio-Economic	There is no evidence to suggest that there is a negative impact on socio-economic regarding this policy.
Human Rights	Workforce and service data is currently monitored, analysed and published on the Trust website. Areas of concern will be addressed through appropriate action plans. Data from complaints and service user surveys will be monitored and analysed as required.
What are the overall trends/patterns in the above data?	There are currently no trends or patterns in the data that is produced. Workforce and service data is currently monitored, analysed and published on the Trust website, although there is an issue with the systems collecting all protected characteristics. Areas of concern will be addressed through appropriate action plans. Data from complaints and service user surveys will be monitored and analysed as required.
Specific issues and data gaps that may need to be addressed through consultation or further research	Analysis of workforce and service user data needs to be undertaken on a regular basis.
Involving and consulting stakeholders	
Internal involvement and consultation	UHPNT Child Health Clinical Governance, Matron Acute Paediatrics, Ward Managers Acute Paediatrics, Operating Department Practitioners, Anaesthetists, Play Specialist Lead, Adult and Children /Young People Safeguarding, Modern Matrons, the Safeguarding Steering Group, CCN LD Lead Nurse, CCN Teams, Site Services Manager, Trust Legal Department.

External involvement and consultation	Bevan Brittan Solicitors, Plymouth Community Healthcare (Live Well), Janet Kelsey Associate Professor (Senior Lecturer) Health Studies (Paediatric) Faculty of Health and Human Sciences Plymouth University.
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Impact Assessment

Overall assessment and analysis of the evidence	<p>Workforce and service data is currently monitored, analysed and published on the Trust website although there is an issue with the systems collecting all protected characteristics. Areas of concern will be addressed through appropriate action plans.</p> <p>Data from complaints and service user surveys will be monitored and analysed as required.</p>
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Action Plan

Action	Owner	Risks	Completion Date	Progress update