Restrictive interventions for managing violence and aggression in adults

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/violence-and-aggression
NICE Pathway last updated: 06 November 2020

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.

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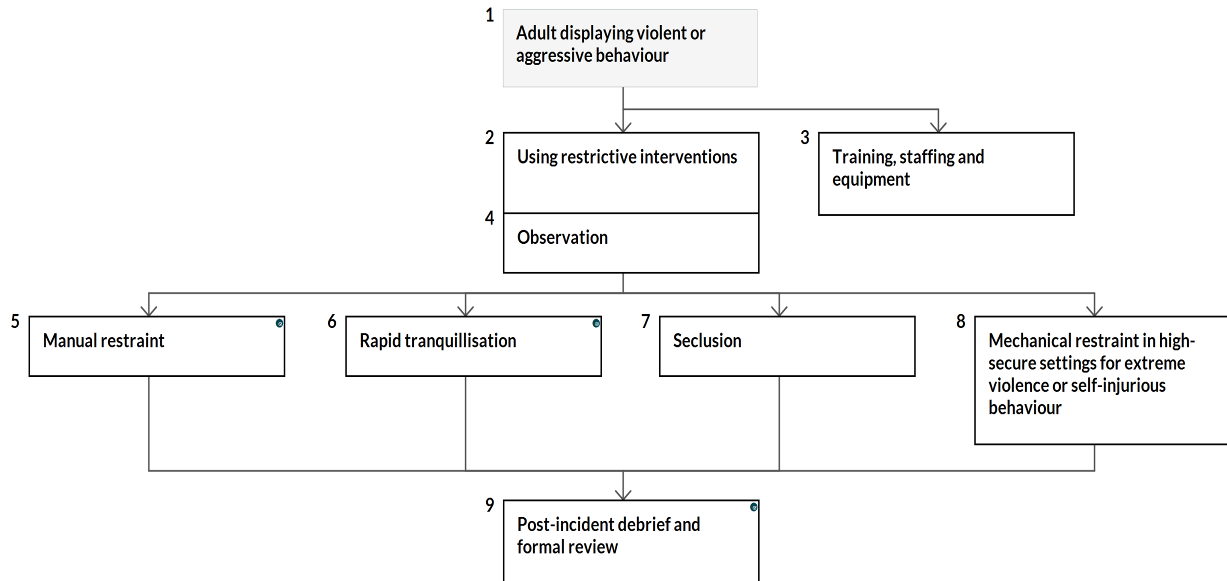

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1 Adult displaying violent or aggressive behaviour

No additional information

2 Using restrictive interventions

Use a restrictive intervention only if de-escalation and other preventive strategies, including p.r.n. medication, have failed and there is potential for harm to the service user or other people if no action is taken. Continue to attempt de-escalation throughout a restrictive intervention. (For help with implementation: getting started see NICE's guideline on violence and aggression.)

Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance. (For help with implementation: getting started see NICE's guideline on violence and aggression.)

Ensure that the techniques and methods used to restrict a service user:

- are proportionate to the risk and potential seriousness of harm
- are the least restrictive option to meet the need
- are used for no longer than necessary
- take account of the service user's preferences, if known and it is possible to do so
- take account of the service user's physical health, degree of frailty and developmental age.

Emergency departments

If a service user with a mental health problem becomes aggressive or violent, do not exclude them from the emergency department. Manage the violence or aggression in line with the recommendations in this path and do not use seclusion. Regard the situation as a psychiatric emergency and refer the service user to mental health services urgently for a psychiatric assessment within 1 hour.

Community and primary care settings

Community mental health teams should not use manual restraint in community settings. In situations of medium risk, staff should consider using breakaway techniques and de-escalation. In situations of high risk, staff should remove themselves from the situation and, if there is immediate risk to life, contact the police.

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3 Training, staffing and equipment

Staff training

Health and social care provider organisations should train staff working in inpatient psychiatric settings to undertake restrictive interventions and understand the risks involved in their use, including the side-effect profiles of the medication recommended for rapid tranquillisation in this guideline, and to communicate these risks to service users.

Staffing and equipment

Health and social care provider organisations should:

- define staff:patient ratios for each inpatient psychiatric ward and the numbers of staff required to undertake restrictive interventions
- ensure that restrictive interventions are used only if there are sufficient numbers of trained staff available
- ensure the safety of staff during the use of restrictive interventions, including techniques to avoid injuries from needles during rapid tranquillisation.

Health and social care provider organisations should ensure that resuscitation equipment is immediately available if restrictive interventions might be used and:

- include an automatic external defibrillator, a bag valve mask, oxygen, cannulas, intravenous fluids, suction and first-line resuscitation medications
- maintain equipment and check it every week.

Staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend an emergency if restrictive interventions might be used. (For help with implementation: getting started see NICE's guideline on violence and aggression.)

Health and social care provider organisations should ensure that wards have sufficient staff with a mix of skills and seniority levels that enable them to:

- conduct an immediate post-incident debrief
- monitor and respond to ongoing risks, and contribute to formal external post-incident reviews (see post-incident debrief and formal review [See page 11]).

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aggression.)

4 Observation

General principles

Staff should be aware of the location of all service users for whom they are responsible, but not all service users need to be kept within sight.

At least once during each shift a nurse should set aside dedicated time to assess the mental state of, and engage positively with, the service user. As part of the assessment, the nurse should evaluate the impact of the service user's mental state on the risk of violence and aggression, and record any risk in the notes.

Observation policy

Health and social care provider organisations should have a policy on observation and positive engagement that includes:

- definitions of levels of observation (see below)
- who can instigate, increase, decrease and review observation
- when an observer should be male or female
- how often reviews should take place
- how service users' experience of observation will be taken into account
- how to ensure that observation is underpinned by continuous attempts to engage therapeutically
- the levels of observation necessary during the use of other restrictive interventions (for example, seclusion)
- the need for multidisciplinary review when observation continues for 1 week or more.

Levels of observation

Staff in psychiatric inpatient wards (including general adult wards, older adult wards, psychiatric intensive care units and forensic wards) should use the following definitions for levels of observation, unless a locally agreed policy states otherwise.

- Low-level intermittent observation: the baseline level of observation in a specified psychiatric setting. The frequency of observation is once every 30–60 minutes.
- High-level intermittent observation: usually used if a service user is at risk of becoming

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- violent or aggressive but does not represent an immediate risk. The frequency of observation is once every 15–30 minutes.
- Continuous observation: usually used when a service user presents an immediate threat and needs to be kept within eyesight or at arm's length of a designated one-to-one nurse, with immediate access to other members of staff if needed.
- Multiprofessional continuous observation: usually used when a service user is at the highest risk of harming themselves or others and needs to be kept within eyesight of 2 or 3 staff members and at arm's length of at least 1 staff member.

Using observation

Use observation only after positive engagement with the service user has failed to dissipate the risk of violence and aggression.

Recognise that service users sometimes find observation provocative, and that it can lead to feelings of isolation and dehumanisation.

Use the least intrusive level of observation necessary, balancing the service user's safety, dignity and privacy with the need to maintain the safety of those around them.

Give the service user information about why they are under observation, the aims of observation, how long it is likely to last and what needs to be achieved for it to be stopped. If the service user agrees, tell their carer about the aims and level of observation.

Record decisions about observation levels in the service user's notes and clearly specify the reasons for the observation.

When deciding on levels of observation take into account:

- the service user's current mental state
- any prescribed and non-prescribed medications and their effects
- the current assessment of risk
- the views of the service user, as far as possible.

Record clearly the names and titles of the staff responsible for carrying out a review of observation levels (see above) and when the review should take place.

Staff undertaking observation should:

- take an active role in engaging positively with the service user
- be appropriately briefed about the service user's history, background, specific risk factors

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- and particular needs
- be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment
- be approachable, listen to the service user and be able to convey to the service user that they are valued.

Ensure that an individual staff member does not undertake a continuous period of observation above the general level for longer than 2 hours. If observation is needed for longer than 2 hours, ensure the staff member has regular breaks.

When handing over to another staff member during a period of observation, include the service user in any discussions during the handover if possible.

Tell the service user's psychiatrist or on-call doctor as soon as possible if observation above the general level is carried out (see above).

5 Manual restraint

Health and social care provider organisations should ensure that manual restraint is undertaken by staff who work closely together as a team, understand each other's roles and have a clearly defined lead.

When using manual restraint, avoid taking the service user to the floor, but if this becomes necessary:

- use the supine (face-up) position if possible **or**
- if the prone (face-down) position is necessary, use it for as short a time as possible.

(For help with implementation: getting started see NICE's guideline on violence and aggression.)

Do not use manual restraint in a way that interferes with the service user's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose.

Do not use manual restraint in a way that interferes with the service user's ability to communicate, for example by obstructing the eyes, ears or mouth.

Undertake manual restraint with extra care if the service user is physically unwell, disabled,

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pregnant or obese.

Aim to preserve the service user's dignity and safety as far as possible during manual restraint.

Do not routinely use manual restraint for more than 10 minutes. (For help with implementation: getting started see NICE's guideline on violence and aggression.)

Consider rapid tranquillisation or seclusion as alternatives to prolonged manual restraint (longer than 10 minutes).

Ensure that the level of force applied during manual restraint is justifiable, appropriate, reasonable, proportionate to the situation and applied for the shortest time possible.

One staff member should lead throughout the use of manual restraint. This person should ensure that other staff members are:

- able to protect and support the service user's head and neck, if needed
- able to check that the service user's airway and breathing are not compromised
- able to monitor vital signs
- supported throughout the process.

Monitor the service user's physical and psychological health for as long as clinically necessary after using manual restraint.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

3. Physical health during and after manual restraint

6 Rapid tranquillisation

Use either intramuscular lorazepam on its own or intramuscular haloperidol combined with intramuscular promethazine for rapid tranquillisation in adults. When deciding which medication to use, take into account:

- the service user's preferences or advance statements and decisions
- pre-existing physical health problems or pregnancy
- possible intoxication

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- previous response to these medications, including adverse effects
- potential for interactions with other medications
- the total daily dose of medications prescribed and administered.

If there is insufficient information to guide the choice of medication for rapid tranquillisation, or the service user has not taken antipsychotic medication before, use intramuscular lorazepam.

If there is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram has been carried out, avoid intramuscular haloperidol combined with intramuscular promethazine and use intramuscular lorazepam instead.

If there is a partial response to intramuscular lorazepam, consider a further dose.

If there is no response to intramuscular lorazepam, consider intramuscular haloperidol combined with intramuscular promethazine.

If there is a partial response to intramuscular haloperidol combined with intramuscular promethazine, consider a further dose.

If there is no response to intramuscular haloperidol combined with intramuscular promethazine, consider intramuscular lorazepam if this hasn't been used already during this episode. If intramuscular lorazepam has already been used, arrange an urgent team meeting to carry out a review and seek a second opinion if needed.

When prescribing medication for use in rapid tranquillisation, write the initial prescription as a single dose, and do not repeat it until the effect of the initial dose has been reviewed.

After rapid tranquillisation, monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. Monitor every 15 minutes if the BNF maximum dose has been exceeded or the service user:

- appears to be asleep or sedated
- has taken illicit drugs or alcohol
- has a pre-existing physical health problem
- has experienced any harm as a result of any restrictive intervention.

(For help with implementation: getting started see NICE's guideline on violence and aggression.)

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Rapid tranquillisation during seclusion

If rapid tranquillisation is needed while a service user is secluded, undertake with caution following the recommendations above and:

- be aware of and prepared to address any complications associated with rapid tranquillisation
- ensure the service user is observed within eyesight by a trained staff member
- undertake a risk assessment and consider ending the seclusion when rapid tranquillisation has taken effect.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

4. Physical health after rapid tranquillisation

7 Seclusion

Use seclusion in adults only if the service user is detained in accordance with the Mental Health Act 1983. If a service user not detained under the Mental Health Act 1983 is secluded in an emergency, arrange a mental health assessment under the Mental Health Act 1983 immediately.

Services that use seclusion should have a designated seclusion room that:

- allows staff to clearly observe and communicate with the service user
- is well insulated and ventilated, with temperature controls outside the room
- has access to toilet and washing facilities
- has furniture, windows and doors that can withstand damage.

Carrying out seclusion

Record the use of seclusion in accordance with the Mental Health Act 1983 Code of Practice.

Ensure that seclusion lasts for the shortest time possible. Review the need for seclusion at least every 2 hours and tell the service user that these reviews will take place.

Set out an observation schedule for service users in seclusion. Allocate a suitably trained member of staff to carry out the observation, which should be within eyesight as a minimum.

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Ensure that a service user in seclusion keeps their clothing and, if they wish, any personal items, including those of personal, religious or cultural significance, unless doing so compromises their safety or the safety of others.

For recommendations on the use of rapid tranquillisation during seclusion, see rapid tranquillisation [See page 8].

8 Mechanical restraint

Health and social care provider organisations should ensure that mechanical restraint in adults is used only in high-secure settings (except when transferring service users between medium- and high-secure settings – see below), and its use reported to the trust board.

Use mechanical restraint only as a last resort and for the purpose of:

- managing extreme violence directed at other people **or**
- limiting self-injurious behaviour of extremely high frequency or intensity.

Consider mechanical restraint, such as handcuffs, when transferring service users who are at high risk of violence and aggression between medium- and high-secure settings. In this context, restraint should be clearly planned as part of overall risk management.

9 Post-incident debrief and formal review

Immediate post-incident debrief

After using a restrictive intervention, and when the risks of harm have been contained, conduct an immediate post-incident debrief, including a nurse and a doctor, to identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses.

Use the framework for anticipating and reducing violence and aggression to determine the factors that contributed to an incident that led to a restrictive intervention, identify any factors that can be addressed quickly to reduce the likelihood of a further incident and amend risk and care plans accordingly.

Advise the service user experience monitoring unit, or equivalent service user group, to start a formal external post-incident review.

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Ensure that the service user involved has the opportunity to discuss the incident in a supportive environment with a member of staff or an advocate or carer. Offer the service user the opportunity to write their perspective of the event in the notes.

Ensure that any other service users who may have seen or heard the incident are given the opportunity to discuss it so that they can understand what has happened.

Ensure that all staff involved in the incident have the opportunity to discuss their experience with staff who were not involved.

Discuss the incident with service users, witnesses and staff involved only after they have recovered their composure and aim to:

- acknowledge the emotional responses to the incident and assess whether there is a need for emotional support for any trauma experienced
- promote relaxation and feelings of safety
- support a return to normal patterns of activity
- ensure that everyone involved in the service user's care, including their carers, has been informed of the event, if the service user agrees.

Ensure that the necessary documentation has been completed.

Formal external post-incident review

The service user experience monitoring unit or equivalent service user group should undertake a formal external post-incident review as soon as possible and no later than 72 hours after the incident. The unit or group should ensure that the formal external post-incident review:

- is led by a service user and includes staff from outside the ward where the incident took place, all of whom are trained to undertake investigations that aim to help staff learn and improve rather than assign blame
- uses the information recorded in the immediate post-incident debrief and the service user's notes relating to the incident
- includes interviews with staff, the service user involved and any witnesses if further information is needed
- uses the framework for anticipating and reducing violence and aggression to:
  - evaluate the physical and emotional impact on everyone involved, including witnesses
  - help service users and staff to identify what led to the incident and what could have been done differently
  - determine whether alternatives, including less restrictive interventions, were

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- - discussed
  - determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
  - recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training, if appropriate
  - avoid a similar incident happening in future, if possible.

The service user experience monitoring unit or equivalent service user group should give a report to the ward that is based on the formal external post-incident review.

The trust board or equivalent governing body should ensure that it receives regular reports from each ward about violent incidents, the use of restrictive interventions, service users' experience of those interventions and the learning gained.

(For help with implementation: getting started see NICE's guideline on violence and aggression.)

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

5. Immediate post-incident debrief

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Glossary

Advance statements

a written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care – an advance statement is not legally binding

Advocate

a person who represents someone's interests independently of any organisation, and helps them to get the care and support they need

Breakaway techniques

a set of physical skills to help separate or break away from an aggressor in a safe manner; these techniques do not involve the use of restraint

Carer

a person who provides unpaid support to a partner, family member, friend or neighbour who is ill, struggling or disabled

De-escalation

the use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. p.r.n medication can be used as part of a de-escalation strategy but p.r.n medication used alone is not de-escalation

Incident

any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (but not observation) – to manage violence or aggression

Manual restraint

a skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment; its purpose is to safely immobilise the service user

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Mechanical restraint

a method of physical intervention involving the use of authorised equipment, for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare professionals; its purpose is to safely immobilise or restrict movement of part(s) of the body of the service user

Observation

a minimally restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with a service user to ensure the service user's safety and the safety of others

Positive engagement

an intervention that aims to empower service users to actively participate in their care – rather than 'having things done to' them, service users negotiate the level of engagement that will be most therapeutic

p.r.n.

refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression; it does not refer to p.r.n. medication used on its own for rapid tranquillisation during an episode of violence of aggression

Rapid tranquillisation

use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed

Restrictive interventions

interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation

Seclusion

defined in accordance with the Mental Health Act 1983 Code of Practice: 'the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely

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disturbed behaviour that is likely to cause harm to others'

Sources

Violence and aggression: short-term management in mental health, health and community settings (2015) NICE guideline NG10

Your responsibility

Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the

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individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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