ALIGNMENT

nonviolent crisis intervention
a CPI specialised offering

The *Nonviolent Crisis Intervention*℠ Training Programme and the Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres

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The *Nonviolent Crisis Intervention*SM Training Programme and the Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres

"The Commission believes that adherence to this code will ensure that the rights of residents are respected and that a culture of respect is fostered within approved centres." Oct 2009 MHC

Programme Alignment

Code of Practice on the Use of Physical Restraint in Approved Centres	*Nonviolent Crisis Intervention*SM Training Programme
Part 1: Introduction Principles Underpinning the Use of Physical Restraint The following general principles should underpin the use of physical restraint at all times.	
1.1 Physical restraint should be used in rare and exceptional circumstances and only in the best interests of the resident when he or she poses an immediate threat of serious harm to self or others.	1.1 The *Nonviolent Crisis Intervention*SM training programme provides instruction in the use of CPI *Personal Safety Techniques*SM and physical restraint techniques. The restraint techniques are viewed as emergency procedures to be used as a last resort, only when an individual is an imminent danger to self or others.
1.2 Physical restraint should only be used after all alternative interventions to manage the resident's unsafe behaviour have been considered.	1.2 CPI's restraint techniques are taught only as a last resort, when other less-restrictive interventions have failed and the individual is a danger to self or others.
1.3 Physical restraint is not prolonged beyond the period that is strictly necessary to prevent immediate and serious harm to the resident or others.	1.3 CPI teaches that a physical restraint should be used as a temporary emergency measure to take control of another person only until that person has regained control of his or her own behaviour and is no longer a danger to self or others.
1.4 The use of physical restraint should be proportional and minimal force should be applied.	1.4 The CPI *Crisis Development Model*SM identifies different behaviour levels of a crisis situation. The model also gives examples of how staff can appropriately and effectively respond to each level of a crisis situation with proportionate responses defined through the overarching concept of Integrated Experience.
1.5 Physical restraint is used in a professional manner and is based within an ethical and legal framework.	1.5 CPI recommends that all facilities develop policies and procedures to professionally address behaviour management issues and use of restrictive physical interventions. Facilities should ensure that policies and procedures are in compliance with applicable laws, as well as appropriate regulatory bodies such as the Mental Health Commission. CPI's Instructor Services can help organisations develop new policies and procedures or improve existing policies and procedures. Restraint should never be used as coercion, discipline, convenience, or retaliation or for any reason other than to protect the individual or others from imminent harm.

Code of Practice on the Use of Physical Restraint in Approved Centres	*Nonviolent Crisis Intervention*SM Training Programme
1.6 Physical restraint is used in settings where the safety of service users, staff, and visitors is regarded as being essential and equal.	1.6 The core philosophy of the *Nonviolent Crisis Intervention*SM training programme is the *Care, Welfare, Safety, and Security*SM of all within the service setting.
1.7 Use of physical restraint is based on a risk assessment.	1.7 Classroom models of restrictive physical intervention are independently risk assessed and available for organisations to utilise within their own Risk Assessment (RA) models. Where the organisation does not have an RA model in place, a sample is available to Certified Instructors as an addendum to their Instructor Manual.
1.8 The use of physical restraint is based on best available evidence and contemporary practice.	1.8 CPI seeks to operate a system of continuous review and improvement of training models. Therefore, appropriate accreditation and endorsement are sought and based upon evidence-based models accommodating practice-based evidence.
1.9 Cultural awareness and gender sensitivity are demonstrated when considering the use of and when using physical restraint.	1.9 Issues and considerations relating to gender and cultural awareness have been signposted at key junctures within the *Nonviolent Crisis Intervention*SM training programme. These have been identified, assessed, and evaluated specifically as part of CPI's BILD accreditation, and current accreditation is maintained.
2. Purpose of the Code 2.1 Section 33(3)(e) of the 2001 Act requires the Mental Health Commission to: "prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services." 2.2 The 2001 Act does not impose a legal duty on persons working in the mental health services to comply with Codes of Practice, but best practice requires that they be followed to ensure the 2001 Act is implemented consistently by persons working in the mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings. 2.3 As required by Section 33(3)(e) of the 2001 Act, the Commission shall review Codes of Practice periodically, after consultation with appropriate bodies. This Code shall be reviewed no later than five years from the date of commencement.	

Code of Practice on the Use of Physical Restraint in Approved Centres	*Nonviolent Crisis Intervention*SM Training Programme
3. Scope of the Code 3.1 The scope of the Code is prescribed for in the 2001 Act by the provisions of Section 33(3)(e). The Code is intended as guidance for persons working in approved centres, and in particular for staff involved in the use of physical restraint in approved centres. The Code is intended to be complementary to the 2001 Act, which should always be referred to for its precise terms. 3.2 The Code is applicable to all residents, that is, persons receiving care and treatment in an approved centre. 3.3 The Code does not purport to be all encompassing. The Mental Health Commission, however, hopes that it will enable mental health professionals to work together effectively in the management of unsafe behaviour.	
4. Definition of Physical Restraint 4.1 For the purpose of this Code, physical restraint is defined as "the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident's body when he or she poses an immediate threat of serious harm to self or others."	4.1 CPI would signpost this definition to organisations utilising the *Nonviolent Crisis Intervention*SM training programme and recommend its adoption into their policies and procedures.
Part 2: Use of Physical Restraint **5. Orders for Physical Restraint** 5.1 Physical restraint should only be initiated and ordered by registered medical practitioners, registered nurses, or other members of the multidisciplinary care team in accordance with the approved centre's policy on physical restraint. 5.2 A designated member of staff should be responsible for leading the physical restraint of a resident and for monitoring the head and airway of the resident. 5.3 The consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist should be notified by the person who initiated the use of physical restraint as soon as is practicable, and this should be recorded in the resident's clinical file. 5.4 As soon as is practicable, and no later than three hours after the start of an episode of physical restraint, a medical examination of the resident by a registered medical practitioner should take place.	5.1 CPI requires that use of *Nonviolent Physical Crisis Intervention*SM be enacted within the framework of an organisational policy and procedures that reflect current legislation and guidance, such as this MHC code. 5.2 Within Unit VIII of the *Nonviolent Crisis Intervention*SM training programme, the monitoring of the physiological and psychological well-being of the individual being restrained is identified as a key duty. A range of options to ensure this occurs is offered.

Code of Practice on the Use of Physical Restraint in Approved Centres	*Nonviolent Crisis Intervention*SM Training Programme
5.5 An order for physical restraint shall last for a maximum of 30 minutes. 5.6 An episode of physical restraint may be extended by a renewal order made by a registered medical practitioner following an examination, for a further period not exceeding 30 minutes. 5.7 a) The episode of physical restraint should be recorded in the resident's clinical file. b) The relevant section of the "Clinical Practice Form for Physical Restraint" should also be completed by the person who initiated and ordered the use of physical restraint as soon as is practicable and no later than three hours after the episode of physical restraint. c) The clinical practice form for physical restraint should also be signed by the consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist as soon as is practicable and in any event within 24 hours. 5.8 The resident should be informed of the reasons for, likely duration of, and circumstances that will lead to the discontinuation of physical restraint unless the provision of such information might be prejudicial to the resident's mental health, well-being, or emotional condition. In the event that this communication does not occur, a record explaining why it has not occurred should be entered in the resident's clinical file. 5.9 a) As soon as is practicable, and with the resident's consent or where the resident lacks capacity and cannot consent, the resident's next of kin or representative should be informed of the resident's restraint and a record of this communication should be placed in the resident's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred should be entered in the resident's clinical file. b) Where a resident has capacity and does not consent to informing his or her next of kin or representative of his or her restraint, no such communication should occur outside the course of that necessary to fulfill legal and professional requirements. This should be recorded in the resident's clinical file.	

Code of Practice on the Use of Physical Restraint in Approved Centres	*Nonviolent Crisis Intervention*SM Training Programme
6. Resident Dignity and Safety	
6.1 Staff involved in the use of physical restraint should be aware of and have considered any relevant entries in the resident's care and treatment plan pertaining to his or her specific requirements/needs in relation to the use of physical restraint. This may include "advance directives."	
6.2 Special consideration should be given when restraining a resident who is known by the staff involved in restraining him or her to have experienced physical or sexual abuse.	6.2 Issues and considerations relating to abuse and re-traumatisation awareness have been signposted at key junctures within the *Nonviolent Crisis Intervention*SM training programme. These have been identified, assessed, and evaluated specifically as part of CPI's BILD accreditation, and current accreditation is maintained.
6.3 Where practicable, the resident should have a same-sex member of staff present at all times during the episode of physical restraint.	
6.4 The resident should be continually assessed throughout the use of restraint to ensure his or her safety.	6.4 Within Unit VIII of the *Nonviolent Crisis Intervention*SM training programme, the monitoring of the physiological and psychological well-being of the individual being restrained is identified as a key duty. A range of options to ensure this occurs are offered.
6.5 The use of holds intended to deliberately inflict pain is prohibited.	6.5 Key elements of *Nonviolent Physical Crisis Intervention*SM responses include: ▪ No element of pain involved. ▪ Used to protect—not to punish.
6.6 The following should be avoided: a) Neck holds b) The application of heavy weight to the resident's chest or back.	6.6 The elements of neck holds and application of weight to chest and back are not taught within any CPI Classroom Model.
6.7 Limited use of physical restraint involving the resident in the "prone," or facedown, position is permitted in exceptional circumstances by staff who have received appropriate training. A record of the use of prone restraint should be entered in the resident's clinical file.	6.7 Recognition of the need to manage safety for an individual who has been placed on the floor and represents a risk as defined in 1.1 is contained within CPI's *Applied Physical Training*SM programme. Use of these emergency management techniques is available only to those trained and certified in their use.

Code of Practice on the Use of Physical Restraint in Approved Centres	*Nonviolent Crisis Intervention*SM Training Programme
7. Ending the Use of Physical Restraint	
7.1 The use of physical restraint may be ended at any time by the person responsible for leading the physical restraint of the resident and monitoring the head and airway of the resident.	7.1 Within Unit VIII of the *Nonviolent Crisis Intervention*SM training programme, continual assessment of a move toward Tension Reduction and identifying opportunities to re-establish Therapeutic Rapport with the individual are identified as a key duty.
7.2 Following physical restraint, the resident concerned should be afforded the opportunity to discuss the episode with members of the multidisciplinary team involved in his or her care and treatment as soon as is practicable.	7.2 Within Unit X of the *Nonviolent Crisis Intervention*SM training programme, CPI offers a model called Postvention, which serves as a tool to consider the importance and value of debriefing the incident from the perspective of the service users as well as staff.
8. Recording the Use of Physical Restraint	
8.1 All uses of physical restraint should be clearly recorded in the resident's clinical file.	
8.2 All uses of physical restraint should be clearly recorded on the Clinical Practice Form for Physical Restraint (see Appendix) in accordance with Provision 5.7.	
8.3 The completed form should be placed in the resident's clinical file and a copy should be available to the Inspector of Mental Health Services and/or the Mental Health Commission on request.	
9. Clinical Governance	
9.1 Physical restraint should never be used to ameliorate operational difficulties, including where there are staff shortages.	
9.2 a) Each approved centre should have a written policy in relation to the use of physical restraint. The policy should address the provision of information to the resident and identify who may initiate and who may carry out physical restraint. b) The approved centre should maintain a written record indicating that all staff involved in physical restraint have read and understand the policy. c) The record should be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request. d) An approved centre should review its policy on physical restraint as required, and at least on an annual basis.	

Code of Practice on the Use of Physical Restraint in Approved Centres	*Nonviolent Crisis Intervention*SM Training Programme
9.3 Each episode of physical restraint should be reviewed by members of the multidisciplinary team involved in the resident's care and treatment and documented in the resident's clinical file as soon as is practicable and in any event no later than two normal working days (i.e., days other than Saturday/Sunday and bank holidays) after the episode of restraint.	9.3 Within Unit X of the *Nonviolent Crisis Intervention*SM training programme, CPI offers a model called Postvention, which serves as a tool to consider the importance and value of debriefing the incident from the perspective of the service users as well as staff.
9.4 All information gathered regarding the use of physical restraint should be held in the approved centre and used to compile an annual report on the use of physical restraint at the approved centre. This report should be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.	
10. Staff Training	
10.1 Approved centres should have a policy and procedures for training staff in relation to physical restraint. This policy should include, but is not limited to, the following:	
a) Who will receive training based on the identified needs of residents and staff;	
b) The areas to be addressed within the training programme, including training in the prevention and management of violence (including "breakaway" techniques) and training in alternatives to physical restraint;	b) The *Nonviolent Crisis Intervention*SM training programme presents a curriculum designed to de-escalate situations to minimise and avoid use of physical restraint. Unit VII includes CPI's *Personal Safety Techniques*SM (including breakaway techniques), and Units I–VI present alternatives to restraint.
c) The frequency of training;	
d) Identifying appropriately qualified person(s) to give the training; and	d) CPI provides a guide for organisations on whom they might consider for Certified Instructor training.
e) The mandatory nature of training for those involved in physical restraint.	
10.2 A record of attendance at training should be maintained.	

Code of Practice on the Use of Physical Restraint in Approved Centres	*Nonviolent Crisis Intervention*[SM] Training Programme
11. Child Residents In addition to sections 2–10, which apply to all residents, the following considerations apply to children being provided with care and treatment in approved centres. 11.1 An approved centre physically restraining a child should ensure that the child's parent or guardian is informed as soon as possible of the child's physical restraint. 11.2 An approved centre physically restraining a child should have in place child protection policies and procedures in line with relevant legislation and regulations made thereunder. 11.3 An approved centre physically restraining a child should have a policy and procedures in place addressing appropriate training for staff in relation to child protection.	