

Restrictive Interventions Guidance:

Managing acute disturbance in the context of COVID-19

As with current practice, it is important that restrictive interventions are kept to the minimum necessary. Also, that managing acute disturbance in the context of infection risk is underpinned by the usual levels of proportionality, balance, compassion and does not create difficulties that could otherwise have been avoided.

Primary Interventions

Many patients and staff may be fearful of the COVID-19 situation, such anxieties can be also be very infectious. Caution should be exercised in not exacerbating an already difficult situation.

- Ensure patients have sufficient information about the risks and recommendations in relation to COVID-19 (Appendix 1: Patient information)
- Discuss risks relating to COVID-19, local plans and the possibility of isolation with the patient. Complete a formal capacity assessment and agree on an “advanced statement” (Appendix 2: Positive support plan template)

Unit-based activity programmes

- Unit based activity programmes are useful for minimising disturbance and improving cooperation.
- As access to facilities areas off the unit diminish, resources to provide unit based activity should be given equal status to other priorities.

Secondary Interventions

The unit should have a clear method of identification of patients who may present risk if infected, either to themselves or to others.

Where infection risks are confirmed

- A specific care plan of intervention and engagement, taking into account the specific mental state and behaviour of the patient should be devised.
- Those experiencing mental and behavioural disturbance who are generally able to follow direction and cooperate, should be maintained in an area or zone consistent with local procedures for isolation of those presenting infection risk.
- For those subject to isolation, an assessment should be made of items available to the patient which could improve cooperation and experience of isolation, reducing the potential for disturbance. This should include identified Calm Down Methods where possible.
- Items helpful in meaningfully occupying time should be allocated for the patient’s individual use, and not re-introduced to general unit use until cleaning or disposal consistent with infection control recommendations.

Tertiary interventions

In rare circumstances, it is possible that a person who is positive for COVID-19 and experiencing acute mental and behavioural disturbance, or for other reasons, may inadvertently, or in extreme cases deliberately, increase infection risk to others.

- It is possible that this may involve the patient actively and persistently resisting the isolation care plan.
- Such actions could be considered as disturbed behaviour in the context of their mental condition representing a significant risk to others.
- This should be considered along with the other risk behaviours that may provide the basis for restraint or seclusion/segregation and fall under the safeguards detailed in the MHA CoP (2015).

When a patient is suspected as COVID-19 positive due to displaying symptoms, they may also act in a manner which may cause harm to others (eg spitting). Restrictive interventions may be used if appropriate as they would if these behaviours were present in a non-COVID-19 positive patient, where such actions would otherwise be considered as disturbed behaviour in the context of their mental condition. Contact the Positive and Safe team for advice or seek legal advice (see below) if required.

Seclusion/segregation

- While all effort should be made to avoid the need for tertiary interventions, it is preferable to use segregation and/or seclusion in circumstances where close physical contact such as extended holds (restraint) are the only alternative.
- Seclusion/segregation may need to continue throughout the period of time that the person with COVID-19 presents with behaviour that is a significant risk to others.
- It is of the utmost importance that an ethical balance is maintained safeguarding the patient and others. This will require careful thought in difficult circumstances on a case by case basis. Where infection control is a major concern for any secluded/segregated patient, account should be taken of the infection period duration during the reviews (7 days isolation).
- As soon as possible, seclusion/segregation should be discontinued in favour of lesser restrictive isolation where infection risk remains.
- Methods of seclusion/segregation may vary between units depending on the format of intensive nursing suites, extra care areas and seclusion rooms.
- It is possible that there may be no alternative to using bedrooms or locking off areas of a unit or ward.
- For a patient representing risk of infection, an individual care plan should be developed with the aim of maintaining cooperation with isolation and diminishing the need for physical intervention or other restrictive practices (as detailed above). All effort should be made to achieve agreement and cooperation.

- The care plan supporting seclusion/segregation should have provision for recognising and dealing with any physical deterioration related to the known course of COVID-19, or for other reasons.

Mental Health Act Code of Practice (MHA COP 2015)

Chapter 26 of the Mental Health Act Code of Practice (2015) governs the use of restrictive interventions.

- Where the patient is detained under the Mental Health Act 1983, then the Trust can control the nature of that detention and wherever possible adherence to the Code should be maintained. Only where there is a **cogent reason** should there be a departure from the code.
- Where a cogent reason can be documented to depart from the **Mental Health Act Code of Practice 2015** this can be acceptable.
- Once it has been **appropriately established** that the patient represents a significant risk of infection, this can provide the basis for extended isolation for the period of the infection risk.
- If in doubt regarding any restraint, isolation, segregation or seclusion issue, contact the Positive and Safe team, legal advice (see below) or the local ethics committee.

Mental Capacity Act (MCA)/DoLS

- The MCA is used when an individual lacks the mental capacity to make a specific decision. Staff can make a best interest decision on behalf of their patient unless there is a Health and Welfare Lasting Power of Attorney or Court Appointed Deputy who can be contacted to make the decision.
- Proportionate restriction or restraint, which does not amount to a “deprivation of liberty”, is permitted under the Mental Capacity Act for the protection of the individual.
- The Mental Capacity Act cannot be used for the protection of others. Where the patient lacks mental capacity in regards to specific decisions around self-isolation, coronavirus investigations, treatment or disclosures of information, any decisions in relation to medical investigations, treatment and discharge must be made on their behalf and in their best interests.
- The capacity assessment should be thoroughly documented and decision specific as above. The best interests process as detailed in the Trust’s MCA and DoLS policy must be followed.
- An IMCA should be appointed where necessary.
- If any proposed restrictions amount to a deprivation of liberty, ensure that an authorisation for the deprivation of liberty safeguarding is submitted immediately.

Informal patients

- If an informal patient is not cooperating with the local recommendations to reduce risk, assess for discharge or detention as appropriate.

- Consider informing the police if a patient is discharged who has refused to self-isolate on the ward.
- **“THE HEALTH PROTECTION CORONAVIRUS REGULATIONS” (2020) detailing “Isolation of persons suspected to be infected with Coronavirus”** gives the police powers to detain a person who they have reasonable grounds to suspect is, or may be, infected or contaminated with coronavirus, might infect others and where necessary to direct, remove or detain the person in their interest or for the protection of others or to maintain public safety. This power lasts for up to 24 hours and the police can take the person to hospital or keep them at a hospital they are already in.
- The local authority also has the power to make an application to a justice of the peace under the Public Health (Control of Diseases) Act 1984 and the Regulations.
- The police, Public Health England (PHE)/directors of PHE in the local authority should be contacted to discuss how such cases should be dealt with: www.gov.uk/government/contacts-public-health-england-regions-local-centres-and-emergency

COVID-19 SWAB TESTING for all inpatients and legal framework considerations including restraint

Legal status	Patient agrees	Has capacity and disagrees	Lacks capacity and disagrees
Informal	Swab test completed	<ol style="list-style-type: none"> 1. Powers under the Coronavirus Act are the only legal provision. 2. Consider if the patient can be discharged and managed by HBT/CMHT 3. Consider if detention under the MHA is necessary due to ‘risk to self/others. 4. If PHE powers are not available consider isolation for 14 days 	<ol style="list-style-type: none"> 1. A capacity assessment to be completed 2. Is it clear that the patient does not have capacity and it is in their best interests to prevent harm to themselves by not having a swab test (not others)? 3. IS legal advice required (See below)
Detained MHA	Swab test completed	<ol style="list-style-type: none"> 1. Is the refusal of a swab test a manifestation of the Mental Disorder? If so consider if legal advice required (See below) 2. If the refusal is not a manifestation of the mental disorder follow PHE powers and consider isolation for 14 days 	<ol style="list-style-type: none"> 1. Is the refusal of a swab test a manifestation of the Mental Disorder? If so consider if legal advice required (See below) 2. If the refusal is not a manifestation of the mental disorder follow steps 1-3 above.

- A) Forceful Isolation: If a non-consenting patient refuses a test, we cannot force the patient to isolate unless the refusal is directly related to their mental disorder. If forceful isolation is considered to be essential, legal advice may be required.
- B) Case by case considerations: In summary, there is no solution as each scenario will bring its own concerns. Therefore decisions should be on a case by case basis with every effort being made to gain consent. Restraint of a non-consenting patient in order to carry out a swab test is not something that would be easily and safely achievable and legal advice may be required if a decision is made that restraint is necessary.

Legal Advice

The RC should contact Chris Diamond (Head of Mental Health Legislation) or Chris Thompson (Senior MHA Manager) at the earliest Opportunity. They will discuss with the referrer and decide whether advice from the trust legal team is required. It is preferable for the RC to email the rationale why they feel legal advice is required – Paris ID must be provided.

Christine.diamond@gmmh.nhs.uk Chris.thompson@gmmh.nhs.uk

Medication use for acute disturbance

- See [MM03 Policy for the use of medication to control & prevent violence, aggression and severe agitation \(rapid tranquilisation\)](#).
- If a patient with suspected or diagnosed COVID-19 is acutely disturbed, and there are no signs of respiratory compromise (decreased or increased respiratory rate), cardiovascular disease or decreased level of consciousness; then medication can be used with caution as the full effects of COVID-19 are still unknown.
- Consider short-acting medication as a patient's physical health condition may rapidly deteriorate.
- Ensure the medication for acute disturbance is an effective dose as an ineffective dose may lead to the increased need for additional injections.
- Where possible, oral medication is preferred and should be offered as the first choice.
- Parenteral medication is also more likely to cause dose related side effects such as respiratory depression, postural drop, QTc prolongation and extra—pyramidal side effects (EPSEs).
- COVID-19 is known to affect the respiratory function of patients. Psychotropic medications, especially benzodiazepines, can cause respiratory depression. The use of benzodiazepines for rapid tranquilisation in patients with acute pulmonary insufficiency is not recommended and any use would need to be clearly clinically justifiable.
- Lorazepam would be the preferred benzodiazepine as it has a shorter half-life.
- Simultaneous injections of olanzapine and benzodiazepines can result in excessive sedation and cardiorespiratory depression so must be given at least an hour apart, as per Trust policy.
- Ensure immediate access to flumazenil is available if benzodiazepines are given.
- If there is evidence of cardiovascular disease, including a prolonged QTc interval, or no recent electrocardiogram (ECG), avoid intramuscular haloperidol combined with intramuscular promethazine.
- Febrile individuals with a history of seizures may have their seizure threshold altered by some medications. Medical advice should be sought if there is any doubt.
- All antipsychotics can cause Neuroleptic Malignant Syndrome (NMS). If NMS occurs, immediately discontinue antipsychotics and other drugs that may contribute to the underlying disorder, monitor and treat symptoms, and treat any concomitant serious medical problems
- Physical health monitoring is paramount, especially respiratory rate and level of consciousness. These should always be carried out when rapid tranquillisation is given.

Considerations of infection control in restraint

Please ensure Positive Support Plans or other care plans relating to the use of restrictive interventions are updated with identified infection control risks and measures to be taken prior to any physical restraint intervention. Wherever possible this must be developed and discussed with the patient.

Mitigating infection control risk is more straightforward for planned interventions, such as self-care or administering of medication. However, consideration should also be given to how emergency interventions can be carried out in the safest way possible.

Observing staff 'getting ready' to physically restrain by putting on PPE equipment, or being approached by staff wearing PPE can create high anxiety and could be a flashpoint for further aggressive behaviour. It may be perceived that the decision to physically restrain has already been reached, implying that the patient no longer has any control over the situation. Staff must be aware of this and provide reassurance and verbal de-escalation prior to any intervention as usual.

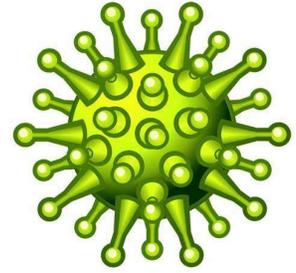
Use of PPE in restraint

- All staff should adhere to usual infection control measures, as per Trust procedure.
- Gloves and masks are to be made available for staff to carry. They should also be available in all airlocks for response staff.
- Prior to any restraint staff should ensure they are wearing gloves and masks.
- Masks with visor to be worn in cases of suspected/confirmed COVID-19 and if there is a risk of bodily fluids e.g., from spitting and/or self-injurious behaviour.
- Following physical contacts with others during a restraint, remove and dispose of gloves immediately. Avoid touching your face and limit contact with hard surfaces before immediately washing hands and arms, if bare.
- Keep hands clear of the eyes, mouth and nose of yourself and others during incidents of physical restraint.
- Consider changing in to your uniform at work and change out of your uniform prior to leaving work, especially if you have come in to physical contact through physical restraint. On arriving home, shower and change clothing prior to greeting other members of your household.
- Plastic aprons are not advised, they are easily ripped and may become a hazard, and also during a physical restraint they will offer little protection to body parts in contact with others.
- In cases of suspected/confirmed COVID-19 and where high risk behaviour is present e.g. deliberately spitting at staff, high risk of unavoidable bodily fluids or where a patient is considered to be 'weaponising' COVID-19, the use of a protective body suit is advised.

Only staff that are required to be present for the safe deployment of physical restraint must be in the room. One additional staff member maybe required to ensure PPE stays in situ.

Coronavirus (COVID-19)

Common questions answered



Where is the safest place to go for a walk?

There may be less people in the hospital grounds, which means there is much less chance of catching or spreading the virus. Please ask staff where the best place to go for a walk is as this will depend on which hospital you are in.



Can I catch the virus from staff dealing with other patients who have symptoms?

It is very unlikely that you will catch the virus from staff – they are taking precautions like washing their hands and limiting other social contact.



Is everyone going to die?

No! Most people who catch the coronavirus (COVID-19) say it is like a bad cold, or the flu. Most people make a full recovery after about 7 days.



How long will it take for things to get back to normal?

This is hard to know, but experts say that the worst should be over by around June.



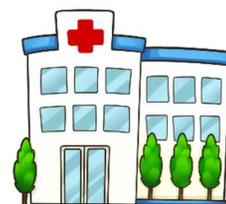
Why are the Government closing everything and telling people to stay at home?

The Government talk to experts who know how viruses work and how to slow them down so that they can keep more people safe. The Government is doing what the experts recommend and they are not trying to scare people. If you follow the advice, there is no need to worry.

Coronavirus (COVID-19) – what the Government says



Community leave has reduced - you can still have leave in the grounds



If someone shows symptoms, they are to self-isolate. This means staying away from other people.

You can call or Skype your family - for now we have had to stop visits to the ward

Coronavirus (COVID-19)

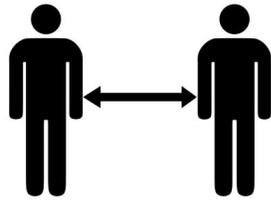


It is really important to wash your hands often and not touch each other



People are not allowed in big groups

- Try not to be too close to each other



- Open windows to let fresh air in



- Wash your hands more often – especially before and after leaving the ward, before meals and after going to the toilet



- No touching at all – not even handshakes or fist bumps



Coronavirus (COVID-19) – what you can do to help



Please try to stay calm and listen to the staff.



Remember that we are all in this together, and that the changes are upsetting and difficult for all of us.



Think about things that you can do on the ward to keep busy – like helping out keep the place clean and tidy.



Try to find activities that you can do on your own that you enjoy.



Please try not to get annoyed or angry with the staff, we are trying our best to help you and keep you safe.



Please try not to get annoyed or angry with other patients, they might not understand. Try to help them understand, or offer to them an activity to do with you.



Work as one big team with the patients and staff.



Remember that this will come to an end and things will get back to normal.

My Positive Support Plan:

What happens when I reach crisis point?

Provide a list of things that I do, or things that I say when I am in crisis.

What triggers this and why does it happen?

What situations upset me, how do I feel, what am I thinking?

What does this look like?

Describe build up, physical signs, what would someone else notice?

What helps me?

Green

What helps me stay calm?

What I can do:

What others can do:

What doesn't help:

Amber

Early on.....

What I can do:

What others can do:

What doesn't help:

Red

How can we manage crisis safely

What I can do:

What others can do:

What doesn't help:

Debrief and reassurance..... Let's look at this plan regularly and change it if we need to.