Twenty four hour medical emergency response teams in a mental health in-patient facility – New approaches for safer restraint

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Abstract

The National Institute for Clinical Excellence (2005) published guidance on the management of disturbed behaviour in mental health settings and emergency departments. The guidance included some of the recommendations made in the Independent Inquiry into the death of David Bennett (2003). One important recommendation requires that staff implementing physical interventions (restraint) and/or parenteral rapid tranquilisation are able to effectively manage the physical health of the patient including any immediate complications that may arise.

This article provides background and a syllabus for training for staff to be able to meet the physical assessment skills and interventions required by recent UK national guidance. Also reported is the creation, role and deployment of a 24-hour Medical Emergency Response Team in an in-patient mental health setting to ensure responses to both medical and psychiatric emergencies offer improved safety and adhere to the new guidance. The article describes the provision of a person with the sole responsibility monitoring a patients physical safety during restraint, 24 hour a day, 7 days a week.

The article will be of interest to those working in in-patient mental health and learning disability services, especially those where they are not served by a resuscitation team as part of a District General Hospital and where there is no resident Duty Medical Officer.

Keywords

Physical restraint; physical intervention; rapid tranquilisation; psychiatric emergency; medical emergency

INTRODUCTION AND BACKGROUND

During the evening of the 30th October 1998, Mr. David Bennett, then a patient detained in a medium secure unit, died whilst being physically restrained by healthcare staff. The Independent Inquiry into his death (2003) concluded that resuscitation should have been attempted earlier and that there should have been nurses available who were trained in the use of defibrillators.

The use of physical intervention (PI) (restraint) remains controversial and has been linked to serious injury and death (Miles & Irvene, 1992). Paterson et al. (2003a, b) undertook a review of deaths associated with physical restraint and identified twelve cases of restraint related deaths in mental health care settings. Four ‘clusters’ emerged within the cases reviewed. These included the use of neck holds, mechanical restraints; prone position in restraint and a-typical restraint where patients were restrained in non-approved or taught positions. Despite the concerns relating to deaths associated with PI there remains no statutory requirement for service providers to report instances of restraint for national monitoring.
Beyond established responsive methods of emergency management of sudden cardiac or respiratory failure, patient who are subject of PI are also at increased risks arising from the application of PI itself. Parkes (2002) suggested that facilities that utilise PI should ensure that staff are aware of the associated risks associated including that a medical emergency during an episode restraint can be preceded by the patient becoming quiet and still. Staff may respond to the cessation of resistance with relief rather than an appreciation of the serious situation that may be developing. Parkes (2002) recommended that where a violent struggling patient suddenly stops resisting, staff should immediately conduct a brief check for signs of consciousness and adequate ventilation.

Although there has been a legitimate increase in concern about the risks of PI, Paterson & Leadbetter (2004) commented that any increase in the use of enhanced resuscitation skills by mental health staff are still more likely to be related to a patient collapsing as a result of factors unrelated to PI.

As a result of recent concerns regarding safety during PI the National Institute for Mental Health in England (NIMHE) (2004) produced interim guidance on the management of disturbed behaviour. A number of recommendations regarding staff working within in patient units were made, specifically in relation to the use of PI and the administration of rapid tranquilisation (RT) medication. These are summarised in Table 1.

Subsequently National Institute for Clinical Excellence (NICE) (2005) produced guidance on the short-term management of disturbed behaviour in mental health in patient units and Emergency Departments. A number of recommendations for training were made, one of which requires those who prescribe, administer and monitor patients to whom parenteral RT has been administered, should be trained to Immediate Life Support (ILS) standard (Resuscitation Council UK, 2004). Also that a “crash bag” including: automatic external defibrillator (AED), a bag valve mask, oxygen, cannulas, fluids, suction and first-line resuscitation medication is available within 3 min of RT, PI and seclusion being used. In addition, all staff who utilise PI techniques must be trained, as a basic minimum, to adult basic life support (ABLS) standards. These recommendations were made at the same time new working time regulations for junior doctors were being implemented. As a result many Mental Health and Learning Disability providers were unable to provide an onsite resident Duty Medical Officer (DMO) (Department of Health, 2004). Many units where PI and RT may be utilised are also stand alone facilities (Beer et al., 2005). Subsequent guidance from the Resuscitation Council UK (2005) significantly expands and supersedes the interventions of ABLS for healthcare professionals and describes the use of AED’s to be an integral component of that ABLS process.

The inquiry into the death of David Bennett (2003) identified that the DMO was not an onsite resident. During the night of Mr. Bennett’s death, due to a failure of the transportation arrangements, the DMO was unable to respond in a timely manner to an incident where a nurse had been punched unconscious and David Bennett had collapsed during restraint. As a result it was recommended that settings that utilise parenteral RT, seclusion and PI are required to have “fool proof” systems to ensure that Medical staff are able to respond within 30 min, when either RT, PI or seclusion is implemented. Even then, a response time of 30 min would be insufficient to provide assistance with resuscitation and is also a particularly long delay in providing an assessment of a deteriorating patient.

**SAFETY DURING PHYSICAL INTERVENTION: DEVELOPING MEDICAL EMERGENCY RESPONSE TEAM TRAINING**

Over 40 years ago, interventions such as closed chest massage, identified by Kouwenhoeven et al. (1960), has resulted in the development of cardio

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**Table 1. Staff training recommendations for physical care and observation during restraint – NIMHE (2004)**

1. Basic life support skills and attend annual updates
2. The physical risks associated with restraint, i.e., positional asphyxia/sudden collapse
3. Recognising conditions of physical and respiratory distress, signs of physical collapse, side effects of medication and how to take appropriate action
4. Use of emergency equipment
5. Knowing how to summon appropriate assistance (resuscitation)
pulmonary resuscitation (CPR) techniques taught in ABLS training. Whilst this intervention is adequate in maintaining circulation and ventilation, successful resuscitation also requires defibrillation as well as the prompt application of ABLS. Early defibrillation is crucial in increasing the chances of survival, where the delay between collapse and delivery of the first shock is the single most important determinant of survival (Resuscitation Council UK, 2005). Stenhouse & Cunningham (2002) emphasised the need to modernise education and training to encourage team working and maximise the benefits for patient care including a focus on the prevention of cardiac arrest.

In addition, staff involved in the administering, prescribing and monitoring of parenteral RT are also required to be proficient in the use of Pulse Oximetry (NICE, 2005). Training staff within the existing (ILS, 2002) syllabus would not have ensured that all the training requirements were met as this training is primarily focused on staff working in District General Hospitals (DGHs). Therefore, a new syllabus for the training of Medical Emergency Response Team’s (MERT) course had to be specifically designed for use in Community Hospitals and Mental Health/Learning Disability settings (Keyte & Worthington, 2005). One of the significant differences is the assumption that medical staff are not immediately available and that the first responders who have advanced resuscitation skills are likely to be Ambulance Paramedic staff.

DEFINING COURSE CONTENT AND SETTINGS FOR DEPLOYMENT OF MERT

The following describes the content of a MERT training programme which was implemented in an 84 bedded acute mental health in-patient facility. Schein et al. (1990) concluded that a cardiac arrest was often neither a sudden nor an unpredictable event. Therefore, staff should be able to provide a skilled response to a deteriorating patient including an assessment using an agreed pre-arrest call criteria. However, pitfalls to such systems have previously been identified by Daffurn et al. (1994) who found that staff frequently did not follow the agreed procedures when the established pre-arrest criterion was met.

The Pre-Arrest Call Criteria adopted within the MERT training programme was based on existing published evidence (Hall et al., 1997; McQuillian et al., 1998; Goldhill et al., 1999; Bristow et al., 2000). Prior to the establishment of the Pre-Arrest Call Criteria for the purposes of MERT there was no predetermined criterion to call a medical emergency within the Hospital. The Pre-Arrest Call Criteria was ratified by local Ambulance Service NHS Trust and the local Primary Care Resuscitation Committee. A role out programme of MERT training to the Trust’s ten other in-patient units was established and has been adapted for use in Community Hospitals operated by a neighbouring Primary Care Trust.

The syllabus and Learning Outcomes shown in Table 2 were structured to ensure that a variety of different teaching methods were utilised to ensure maximum benefit to the staff. Lilford (2003) identified a number of successful methods of teaching when analysing the structure and provision of resuscitation training. These methods included a course duration of 8 hours; distribution of workbooks prior to the course commencing, the use of manikins for practical skills training and the use of role play. The putative benefits of using role play and creating a reality for the staff, to enable knowledge and psychomotor skills to be turned into practice is an important part of skills training. Role play also has particular importance to staff participating in MERT Training. Scenarios enable staff to be exposed to the considerations and difficulties unique to a non-co-operative struggling patient who maybe at risk of collapse.

The course enables staff to develop their knowledge and skill to ensure that a variety of assessments and interventions could be applied to a patient who had received parenteral RT and/or been subject to PI. As a result staff participated in six different scenarios after completing the skills station training. A description of scenarios is listed in Table 3.

The Resuscitation Council (UK) (2005) stress the importance of preventing cardiac arrest in all patient groups. Courses have been established to address the need to provide staff with skills in earlier assessment and recognition of a patient who is deteriorating and to enable access to appropriate care to prevent
 cardiac arrests. Changes to medical staffing arrangements have also generated demand for such courses including the Acute Life Threatening Events – Recognition and Treatment course (Smith, 2003) is such a course. Consideration to the suitability of pre-existing courses was undertaken and assessed as not adequate in meeting the requirements of the NICE (2005) and NIMHE (2004) recommendations, in managing the physical condition of in-patients who may be subject to PI and RT. The pre-existing skills and knowledge level of staff was also assessed as being limited in their levels of competence as compared to the guidance of the Resuscitation Council (UK) (2004).

### Table 2. Aim, learning outcomes and syllabus

**Aim of course**
To train health care providers working in in-patient psychiatric and learning disability settings to work as members of a medical emergency response team

Enabling staff to act appropriately until the arrival of an emergency ambulance, in cases where parenteral RT or PI have occurred or where patients have experienced cardiopulmonary arrests

**Learning outcomes**
By the end of the training day staff will be able to:

1. Gain knowledge and have an understanding of the NICE, NIMHE guidelines for management of aggressive/violent behaviour the related Resuscitation Council (UK) guidelines

2. Recognise the sick patient using the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach within the context of a patient subject to PI, RT and other factors increasing risk

3. Have an understanding of the roles and responsibilities of team members

4. Administer oxygen correctly, manage an airway effectively using a pocket mask or bag valve mask and use simple airway adjuncts

5. Demonstrate knowledge and skill in performing ABLS techniques for a timed 3 min assessment

6. Demonstrate safe, correct and appropriate practice using the defibrillator

7. Manage a medical emergency situation individually or as a member of the Medical Emergency Response Team, leading the team where appropriate.

<table>
<thead>
<tr>
<th>Time</th>
<th>Plan (min)</th>
<th>Course programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.45</td>
<td>15</td>
<td>Registration</td>
</tr>
<tr>
<td>09.00</td>
<td>15</td>
<td>Introduction</td>
</tr>
<tr>
<td>09.15</td>
<td>15</td>
<td>Lecture 1 – Recognising the sick patient</td>
</tr>
<tr>
<td>09.30</td>
<td>15</td>
<td>The ABCDE approach</td>
</tr>
<tr>
<td>09.45</td>
<td>10</td>
<td>Pre-arrest call criteria and cardiac arrest/pre-arrest form</td>
</tr>
<tr>
<td>09.55</td>
<td>20</td>
<td>Case studies</td>
</tr>
<tr>
<td>10.15</td>
<td>Coffee</td>
<td></td>
</tr>
<tr>
<td>10.35</td>
<td>30</td>
<td>Lecture 2 – The Medical Emergency Team Response</td>
</tr>
<tr>
<td>11.05</td>
<td>10</td>
<td>Lecture 3 – Airway management</td>
</tr>
<tr>
<td>11.15</td>
<td>20</td>
<td>Skill Station 1 – Airway management</td>
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<tr>
<td></td>
<td>20</td>
<td>Skill Station 2 – Emergency bag</td>
</tr>
<tr>
<td>11.55</td>
<td>65</td>
<td>Adult Basic Life Support assessment</td>
</tr>
<tr>
<td></td>
<td>65</td>
<td>Skill Station 3 – Patient observations</td>
</tr>
<tr>
<td>13.00</td>
<td>Lunch</td>
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<tr>
<td>13.45</td>
<td>30</td>
<td>Lecture 4 – Defibrillation (The Heartstart FR2)</td>
</tr>
<tr>
<td>14.15</td>
<td>10</td>
<td>Defib demonstration</td>
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<tr>
<td>14.25</td>
<td>20</td>
<td>Skill Station 4 – Defibrillation</td>
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<td>14.45</td>
<td>Tea</td>
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<tr>
<td>15.05</td>
<td>20</td>
<td>Scenario 1 – Control and restraint</td>
</tr>
<tr>
<td>15.25</td>
<td>20</td>
<td>Scenario 2 – Hanging (cardiac arrest)</td>
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<tr>
<td>15.45</td>
<td>20</td>
<td>Scenario 3 – Self harm (cardiac arrest)</td>
</tr>
<tr>
<td>16.05</td>
<td>20</td>
<td>Scenario 4 – Respiratory arrest</td>
</tr>
<tr>
<td>16.25</td>
<td>20</td>
<td>Scenario 5 – Vaso vagal</td>
</tr>
<tr>
<td>16.45</td>
<td>20</td>
<td>Scenario 6 – Chest pains</td>
</tr>
<tr>
<td>16.55</td>
<td>10</td>
<td>Questions and evaluation</td>
</tr>
<tr>
<td>17.00</td>
<td>Finish</td>
<td></td>
</tr>
</tbody>
</table>
SPECIFIC CONSIDERATIONS ASSOCIATED WITH THE USE OF PI AND RT

Leadbetter & Patterson (2004) suggest a number of components that should produce safer practice when implementing PI. These include clear policies, the ethos of an organisation, staffing levels, competence, conformance to taught interventions. There is also a need to increase an awareness of the specific risks which arise with patients with mental health problems subject to PI and RT. Patterson et al. (2003a, b) and described seven risk factors which may increase a persons susceptibility to death during restraint these are listed in Table 4. Wright (1999) also identified agitated delirium, acute excited status as contributory factors.

ESTABLISHING A MEDICAL EMERGENCY RESPONSE TEAM

The MERT system was initially implemented in a 82 bedded (Wotton Lawn Hospital, Gloucester) acute mental health hospital. The system ensured that an appropriately trained team were available 24 h a day and has subsequently been implemented in a second trust operated 52 bedded acute in–patient facility. There are plans for the MERT programme to be further rolled out to stand alone Learning Disability in–patient units and Older People Services residential units. Both Registered and Non-registered Nurses are trained and respond to Medical/Psychiatric Emergencies.

STANDARD OPERATIONAL PROCEDURE FOR MERT

The MERT procedure ensures that during every episode of restraint, an independant and specially trained member of staff is engaged in the sole purpose of closely monitoring the patients physical health.

At the commencement of each shift a Registered Nurse who is also MERT trained is nominated via an established rota to act as the MERT Assessor for the hospital. The rota is established 6 months in advance and is the responsibility of the Matron Manager. This person responds to all emergency

### Table 3. Medical emergency response training – role play scenarios

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Incident</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Positional asphyxia</td>
<td>Patient being restrained face down stops, initially struggling and then becomes unresponsive. MERT Assessor calls Medical Emergency. Patient to be fully assessed, oxygen to be given, all observations to be taken and recorded</td>
</tr>
<tr>
<td>2</td>
<td>Hanging</td>
<td>Patient found in bedroom with ligature around neck hanging from bed. Medical Emergency called. 1VF shock then into asystolic cardiac arrest due to hypoxia</td>
</tr>
<tr>
<td>3</td>
<td>Stabbing</td>
<td>Medical Emergency called. Knife found by patient’s side, stab wound in left side of chest spurring blood under pressure. Patient unresponsive with very shallow breathing, weak rapid pulse, then into PEA arrest due to hypovolaemia</td>
</tr>
<tr>
<td>4</td>
<td>Respiratory arrest</td>
<td>Drug induced hypoxia. Found as respiratory arrest. With effective treatment and oxygenation patient will make full recovery, otherwise after 4 + min the patient will have PEA arrest due to hypoxia</td>
</tr>
<tr>
<td>5</td>
<td>Vaso vagal episode</td>
<td>Patient faints due to hypotension, Medical Emergency Response Team called. To be assessed and blood pressure taken, oxygen to be given</td>
</tr>
<tr>
<td>6</td>
<td>Chest pain</td>
<td>Conscious patient with chest pain, Pre-Arrest Call criteria met. Medical Emergency called, team arrive. To fully assess, oxygen to be given, observations taken and recorded</td>
</tr>
</tbody>
</table>

### Table 4. Factors which increase susceptibility to death during restraint

(Patterson et al., 2003a, b)

<table>
<thead>
<tr>
<th>Factors</th>
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</thead>
<tbody>
<tr>
<td>Obesity</td>
</tr>
<tr>
<td>Prolonged struggle – continual combative ness</td>
</tr>
<tr>
<td>Physical ill health</td>
</tr>
<tr>
<td>Acute mental disturbance</td>
</tr>
<tr>
<td>Prescribed medications</td>
</tr>
<tr>
<td>Illicit drug misuse</td>
</tr>
<tr>
<td>Restraint procedure that impairs respiration</td>
</tr>
<tr>
<td>Extream psychotic fear</td>
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</tbody>
</table>
incidents of PI and works with the PI team to ensure that the physical aspects of care are monitored and recorded during and post-episode of PI and or RT. This person is directly contactable via the internal paging system. The MERT Assessor has immediate access to a small bag which contains equipment required to undertake a range of physical observations. The contents are listed in Table 5. Should a medical emergency be called in the hospital all MERT trained staff respond with staff on allocated wards bringing specific equipment to the incident.

### ROLE OF THE MERT DURING AN INCIDENT OF PI/RT

During an incident of PI the MERT Assessor will monitor the airway, respirations and circulation of the patient and whenever possible utilise pulse oximetry. This function is independent to the PI team, however, is carried out in conjunction with the staff member responsible for holding the head of the patient during the PI episode.

With careful consideration to the Pre-Arrest Call Criterion, the MERT Assessor will ensure that the patient’s well-being is monitored and physical observations are recorded. This process is assisted by their independence from the PI team, in that their sole concern is the physical health of the patient. Physical observations are assessed against the Pre-Arrest Call Criteria (Table 6).

If the patient’s presentation deteriorates and the Pre-Arrest Call Criteria are met, a Medical Emergency is immediately called. This would ensure all other MERT trained members of staff respond to the patient, ensuring oxygen, an emergency grab bag (containing equipment for airway management, physical assessment and monitoring, intravenous access/fluids, 1st line emergency drugs) and a defibrillator arrive on scene.

Following the PI, the MERT Assessor will liaise with the Nurse-in-Charge. If the Senior House Officer (SHO) or DMO has not been able to immediately respond to the incident then the Nurse-in-Charge will liaise with them to agree a frequency for the undertaking of physical observations for the next 24 h period. Kaplan & Wheeler (1983) identified a post-incident recovery phase, where an incident of conflict or violence is more likely to reoccur if antagonised in the immediate 90 minutes after the incident. A balance, therefore, has to be achieved between the need for post-incident monitoring and the risk of exacerbating a situation or reigniting the previous episode. Where it is assessed that obtaining physical observation recordings would be counter productive, a rationale for not undertaking such recordings should be entered in the patients health record on the physical observations chart.

During training, staff are taught to undertake aspects of patient assessment and resuscitation skills as identified in the syllabus. Items of emergency equipment are located in different ward areas and the tendency is for staff to identify with the skills and procedures associated with the specific item that they bring to the incident. The MERT course Learning Outcomes enable all participants to be trained in all aspects of defined Medical Emergency Response procedures and equipment. Also, the team

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### Table 5. Contents of MERT Assessors bag

- Pulse oximeter
- Thermometer
- Manual sphygmomanometer and stethoscope
- Blood glucose monitoring machine
- Pocket face mask
- Selection of guedal airways
- Variety of first aid equipment including gloves and gauze
- Tuff cut shears
- Ligature cutters
- Pen torch
- Paperwork Inc.: pen, dry wipe pen, log book, pre-arrest call criteria, record of cardiac arrest form and physical observations chart

### Table 6. Pre-Arrest call criteria

- All cardiac arrests
- All respiratory arrests
- Chest pains
- Patient is unrousable/deteriorating and has 1 or more of the following signs:
  - Respiratory rate <10/min
  - Respiratory rate >30/min
  - Heart rate <50/min
  - Heart rate >130/min
  - Blood pressure <90 mm Hg systolic
  - Oxygen saturation <92% on air
  - Blood sugar <4 mmol/l and not responding to treatment
take into account the need to ensure that an emergency call to the Ambulance Service is made whenever the Pre-Arrest Call Criteria is met.

THE FIRST YEAR OF MERT DEPLOYMENT

After the initial MERT training programme was introduced in January 2005, staff were anxious with the new responsibilities and the expectations placed upon them. Written guidance was provided and skills were practiced through the running of different unannounced simulation exercises across the working week incorporating the three different shift patterns. Scenario’s ranged from physical restraint with no underlying medical problems being presented to a patient in cardiac arrest. During the following months, the written guidance was refined based on learning identified during these events and amendments were made to temperature pulse respiration (TPR) charts, PI and cardiac arrest audit forms and policies for parenteral RT, medical and psychiatric emergencies.

Guidance was extended to introduce a MERT Assessor to be called in non-emergency situations to assist with assessment and monitoring of a service user who potentially could be physically deteriorating until the DMO or SHO arrives. The service was fully launched in June 2005. All equipment must be checked weekly (AED daily).

An audit of MERT trained staff indicates that a MERT team has been available (minimum of three staff) from June 2005 when the staff training programme was completed. Within the first 6 months of full operation there were 130 recorded incidents of where a PI team was called to assist. Of these incidents which may have resulted in the use of PI, none developed into a Medical Emergency. MERT teams have responded to six Medical Emergencies during the past year. Observed response times for Medical and Psychiatric Emergencies across the site are less than 1 min. Within cardiac arrest simulation exercises on all occasions the first advisory shock was delivered within the 3 minute window.

RESOURCE IMPLICATIONS

NICE (2005) provide an assessment tool to calculate the cost of implementation of such guidance. However, there are other direct and non-direct costs which impact on the provision of resuscitation and resuscitation training. The Resuscitation Training Officers capacity to providing whole day training for sufficient numbers of staff to implement medical emergency response team, 24 h per day, 7 days a week across numerous units throughout the trust has had significant consequences. One such consequence is the reduced capacity to directly train ABLS to other staff within the trust. In response it has been necessary to employ an additional Resuscitation Trainer to cover the loss in capacity in providing ABLS training at significant cost.

The purchasing of equipment for the MERT team and MERT Assessor can be significant depending on the availability of existing resuscitation equipment, e.g., defibrillators. Many items need to be purchased in duplicate to ensure that the training is provided using the actual equipment staff will be using.

Continued high turnover of staff away from in patient work means the need for ongoing training never diminishes.

CONCLUSION

The Chief Nursing Officer (2000) identified ten key roles for nurses, one of which was to ensure that nurses developed greater skills in resuscitation including the use of defibrillators. The introduction of Medical Emergency Response Teams within a mental health hospital is an opportunity to ensure that the existing skills of the staff team are enhanced to provide better assessment and monitoring of a patient’s physical safety during incidents where they are at risk from sudden death. Procedures ensure that staff are routinely maintaining their skills in assessment of physical observations.

Establishing MERT within a service would require an organisation to undertake an assessment of access to existing resources, to review and develop policies relating to both medical and psychiatric emergencies. Policies on the use of PI and identifying response times from medical and paramedical staff, trained in ILS are required to meet the recommendations identified by NIMHE and NICE, this however poses a particular challenge to stand alone units who are geographically isolated.
Episodes of disturbed behaviour which require PI/RT pose an increase level of risk for patients and staff alike. Recent reports of serious injury or death during PI/RT mean that professional staff can no longer ignore the physical aspects of care associated with those interventions and have a duty to improve their skills.

The introduction of MERT training in the two acute in-patient units will provide secure foundation from which to audit the impact on safety for patients subject to PI, RT and seclusion. Remaining questions for future evaluation of the programme could include evaluating course content, the impact on the physical care of patients during PI/RT and identifying if staff retain knowledge and skills following training to implement them in real life.

References


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