Sheffield Health and Social Care NHS
NHS Foundation Trust

Policy: Aggression and Violence: Respectful Response and Reduction

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Policy Version and advice on document history, availability and storage
This is version 2.0 of this policy. This version replaces version, ratified in October 2014. This version was reviewed and updated as per policy development and review process.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version of October 2014 should be destroyed and if a hard copy

is required, it should be replaced with this version.

Contents

1. Introduction

The staff of Sheffield Health and Social Care NHS Foundation Trust (SHSC) work across a wide variety of contexts. At times, staff may find themselves faced with incidents of aggression or violence. These may involve service users, or other members of the public. They may be directed either at staff members themselves, or at other people in the environment.

SHSC acknowledges that such incidents can be distressing for all concerned, service users and staff alike. SHSC does not support the use of any physical interventions which rely on the deliberate use of pain or discomfort to ensure compliance. Further to this, SHSC does not support the deliberate use of the prone position as a means of containing an aggressive or violent service user or the maintenance of service users in the prone position.

SHSC is committed to providing a safe a supportive culture by ensuring that staff have appropriate skills, training and support to enable them to work in such a way that incidents are avoided as far as possible. Where it is not possible to avoid an incident, SHSC is committed to ensuring that staff have the appropriate skills, training and support to keep themselves and others safe, in a way that is the least restrictive of the rights and freedoms of all involved and is in line with the law.

RESPECT training highlights that it is essential to foster an open, honest, trusting and professional relationship with service users. This process must begin from the point of admission to a service, and continue throughout the time they are with the service.

If there is likelihood that the physical intervention will be prolonged with no diminishment of the aggression/violence, then consideration should be given to the use of medication or, as a last resort, to a period of seclusion as a means of mitigating risk.

SHSC is proud to be part of the “Positive and Safe Champions Network”; this network of organisations have been invited to support the implementation of the “Positive and Proactive Care initiative”(DoH, April 2014).

2. Scope

This policy applies to all health and social care staff working for SHSC, including those seconded in, those on fixed term or temporary contracts or on the flexible workforce. SHSC staff who are working in other Trusts and organisations should familiarise themselves with local policy and procedure pertaining to those other trusts and organisations. It covers the full range of SHSC services. Staff using this policy must ensure that they also make reference to other relevant policies (see below).

The policy does not cover situations in which physical interventions may be used in circumstances other than as a response to aggression and violence.

3. Definitions and terminology

Violence and aggression: A range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear (NICE Guidelines 10 (2015)).

Assault: “The intentional application of force against the person of another without lawful justification, resulting in physical injury or personal discomfort” NHS Security Management Service (2003, updated 2012)).

Non-physical assault: "The use of inappropriate words or behaviour causing distress and/or constituting harassment" NHS Security Management Service (2004, updated 2012)).

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 (NICE Guidelines 10 (2015)).

Restraint: "Someone is using restraint if they use force – or threaten to use force – to make someone do something that they are resisting, or restrict a person's freedom of movement, whether they are resisting or not" (Mental Capacity Act 2005 Code of Practice (2007))

RESPECT: RESPECT training is aimed at producing the safest, most effective and ethical solutions to preventing and managing behaviours that challenge. It has been designed with service user consultation and approved by service user / carer groups. The emphasis of training is on engagement and prevention as reflected in the RESPECT model of 70% proactive, 20% active and 10% reactive strategies.

Physical Interventions: Physical restraint refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person (MHA Code of Practice (2015))

Notes on terminology:

- It is acknowledged that there are a range of terms used to describe actions that are sometimes necessary to take in response to aggression or violence and that there are varying views about the appropriateness of each. Any such action is categorised under the broad term of a 'restrictive intervention' and will be subject to audit and scrutiny by the Restrictive Interventions Reduction Programme Board which is chaired by the Deputy Medical Director and reports to the Trust Board. For simplicity, this policy will use the term *'physical intervention'*. This should be taken to include actions known as *'physical restraint'*, *'supportive techniques'* and *'natural therapeutic holding'* and any other synonyms for these actions;
- The policy describes legislative functions and duties and provides guidance. Whilst the whole of the policy should be followed, please note that where **'must'** is used, it reflects legal obligations in legislation (including other legislation such as the Human Rights Act 1998) or case law, and must be followed. Where the policy uses the term **'should'** then departures from the policy must be acknowledged and the rationale for this documented and recorded. Where the policy gives guidance using the terms '**may', 'can' or 'could'** then the guidance in the policy is to be followed wherever possible.

4. Purpose

The policy provides a framework for staff to respond in situations that they face with regards to violence and aggression (both where they can plan and where an incident is unforeseen), that is set firmly within the legal context and links with other policies and procedures of SHSC. The policy is written to be entirely consistent with the RESPECT training delivered in SHSC. This document assists practitioners by promoting best practice principles and ensuring consistency across the Trust.

The Mental Health Act 1983 Code of Practice (Updated 2015) sets out a number of guiding principles which should be considered when making decisions about a course of action under the Act. These guiding principles apply to all actions taken under the Mental Health Act.

The Guiding Principles are as follows:

- Least restrictive option and maximising independence;

- Empowerment and involvement;
- Respect and dignity;
- Purpose and effectiveness; and
- Efficiency and equity.

The principles inform decisions, they do not determine them. Although all the principles should inform every decision made under the Act, the weight given to each principle in reaching a particular decision will depend on the context in each situation. (For further information on using the guiding principles please see Chapter 1-3 of the MHA Code of Practice 2015).

5. Duties

5.1 **Chief Executive** is responsible for ensuring that the systems on which the Board relies to govern the organisation are effective. The Statement of Internal Control is signed annually indicating that systems of governance, including risk management are properly controlled. The Trust's Chief Executive through the Executive Director of Operations is responsible for keeping the policy is updated and available for staff.

5.2 **Clinical and Service Directors** are responsible for ensuring that all managers in their areas are aware of this policy and support its implementation and that ongoing leadership and co-ordination via a senior manager is provided to RESPECT Trainers. The Service Directors are also responsible for maintaining a suitably experienced clinical individual in a lead/co-ordination role for the continued implementation and maintenance of the training programme. Directors are responsible for delegating responsibility for risk assessing the level of resuscitation skills; training and equipment required in each service area (see SHSC Resuscitation Policy).

5.3 **Trainers** are responsible for delivering training (as appropriate to job role requirements) within SHSC. Trainers will maintain their knowledge base. They should have up to date resuscitation training. Lead trainers will keep the training provision under on-going review in order to be consistent with current national policy, new developments, best practice guidance and evidence.

5.4 **Ward/Team/Department Managers** are responsible for:

- Ensuring that this policy is fully implemented within the ward environment/the team/the department that they manage.
- Ensuring that this policy is readily available to all staff at all times.
- Ensuring that the recording and auditing of incidents of physical intervention is completed in line with this policy.
- Responding appropriately to any concerns regarding the attitude of staff members around issues of aggression, violence or physical intervention.
- Ensuring that there is a regular and comprehensive general risk assessment to ensure the safety of the environment (for inpatient psychiatric settings, see NICE 2005).
- Maintaining training and equipment levels in their ward/team/department. This will include ensuring that are staff appropriately trained to monitor physical health as per risk assessment of the physical interventions that are likely to take place in that service.

5.5 **Shift coordinators/team leaders** must ensure that all relevant decisions and actions are appropriately recorded using the relevant documentation (e.g. **Rapid Tranquillisation, Seclusion and Post-Restraint Physical Health Monitoring Form,** Insight records) and relevant parties informed in a timely manner of incidents. The shift coordinator/team leader may delegate these duties to other staff, however their completion remains the responsibility of the shift co-ordinator/team leader. If a physical intervention takes place on a ward, the shift coordinator/team leader must inform the Responsible Medical Officer, Responsible Clinician or Deputy as a matter of urgency. In other environments, the shift coordinator/team leader (or

the person to whom they have delegated responsibility) should take responsibility for obtaining a medical review for the person as soon as possible.

5.6 **Responsible Medical Officer, Responsible Clinician, or Deputy** will review any service user who is on an inpatient ward and is involved in an incident requiring the use of physical intervention. They will have responsibility to determine the level of priority, in line with their other clinical commitments.

5.7 **Restrictive Interventions Reduction Programme** which is chaired by the Deputy Medical Director will review the use of all restrictive interventions implemented in the organisation with the aim of identifying any misuses or misapplication of these, and how the organisation can impact on reducing the implementation of such restrictions (CoP 26.5).

5.8 **Education, Training & Development Department**. Will maintain a database of all staff who have undergone RESPECT Training. This will specify via risk assessment the level of training different groups of staff require and the frequency of training and updates (NICE 2005).

5.9 **Staff members** are responsible for ensuring that their practice is safe. Clinical staff have a Duty of Care to ensure that they act in ways that are consistent with any codes of practice relevant to their profession The Trust also has a Duty of Care towards its employees and towards service users, which is fulfilled by the implementation of this policy.

All staff members are required to ensure they (and anyone they line manage) abide by SHSC requirements as set out in this policy.

6. Process: Specific Details

6.1 Principles

- This policy is set within a context of service philosophy of non-invasive interventions, increasing peoples' skills and status, and helping individuals and teams make sound judgements by taking only those actions that are appropriate in an assessed situation.
- Staff members must ensure that, at all times, they are acting within the law (see section 6.4, below). Physical intervention should always be a last resort, when all other less restrictive methods of management of the problem are not sufficient to achieve safe outcomes (that is, the least restrictive alternative under the circumstances should be used).
- Communication with the service user should take into account issues arising from having English as a second language, hearing difficulties, autistic spectrum disorders, learning disability or other sensory impairments.
- 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. (NICE Guidance 10, 1.4.5).
- 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.

  (NICE Guidance 10, 1.4.7)
- Service users with a history of abuse who are restrained may experience re-traumatisation in the form of flashbacks, hallucinations, dissociation, aggression, self-injury or depression. Where service users have an identified history of trauma, advance

statements about the use of restrictive practise may be beneficial including preferences about the gender of staff who carry out such interventions (CoP 26.43).

- Service users should not be restrained in a way that impacts on their airway breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure on the neck region, rib cage and/or abdomen (CoP 26.70).
- SHSC does not train staff to use the prone or face down position. Unless there are cogent reasons for doing so, there must be no planned or intentional restraint of the service users in the prone position. Should this situation occur an incident report should be made and the relevant clinical manager or on call manager informed (CoP 26.70).
- Full account should be taken of the individual's age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment which may all add additional risks to the service user (CoP 26.71). See 6.4 for specific guidance relating to Young people.
- A member of staff should monitor the individual's airway and physical condition throughout any use of physical intervention.
- Every service user's physical health will be monitored every hour until there are no concerns or every 15 minutes if there any concerns using the Physical Health Monitoring Form for Rapid Tranquilisation Seclusion and Restraint (see Appendix G).
- The degree of physical intervention used must be proportionate to the risk and to the likelihood of harm and consideration should be given to discontinuing with restraint if the patient is physically deteriorating.
- The RESPECT principle of "no pain, no panic" should be followed at all times. No deliberate infliction of pain is allowed as a part of routine practice or care planning. It would only ever be appropriate in extreme emergency situations in which there is no other option and life/health and safety is at serious and immediate risk. In order to be able to rely on the common law of self-defence the defence of others the person inflicting the pain would need to be able to show that they were using "reasonable force".
- "Reasonable force" is always a matter of personal judgement, as no two situations are the same. The force must be the minimum necessary to deal with the harm that needs to be prevented. Whilst the staff member involved has the right to use reasonable force, they also have a responsibility to be able to show that they did only what they honestly believed was reasonable in the circumstances.
- One member of staff should take the lead to ensure the wellbeing of other service users and move them away from the area where the incident has taken place.
- Emergency resuscitation equipment should be available and staff should be trained in its use (CoP 26.71).
- For an extremely small number of people (e.g., individuals with particular physical issues) it is possible that risk assessments will indicate that there may be no appropriate, standard RESPECT techniques. In such cases, advice should be sought as a matter of urgency from the RESPECT trainers, who will help to care plan for that individual.
- For guidelines on the safe use of physical interventions with service users who are pregnant (see Appendix J**)**.
- The Policy aims to create a culture of open acknowledgement of when physical intervention is used and the reasons for this. This enables the organisation to derive an accurate view of the levels of violence and/or aggression in services.
- In all parts of the service, consideration should be given to whether environmental alterations could reduce the possibility for aggression and violence or mean that it is less likely that physical intervention would be needed if that occurred. Environments should be welcoming, clean, homely and convey respect. Wear and tear or damage to the environment however caused should be rectified promptly. De-escalation techniques as taught in RESPECT training should be employed as a first line where possible before any recourse is given to physical interventions. It may be of benefit to access the Green Room space for the purposes of de-escalation. Green Rooms exist on Endcliffe Ward, Maple ward and Burbage ward. All other inpatient areas will have access to Green Boxes, which contain items which may support the process of de-escalation.
- Consideration should always be given to equality and diversity issues, to make sure that the work of the Trust is carried out in a person-centred way.

6.2 Procedures around the prevention and management of aggression and violence

There are a number of different contexts in which aggression and violence may occur. The principles for how these are responded to will always be the same (see above). However, the level of planning possible will be different depending on the situation. Situations can broadly be divided into two types:

- An anticipated risk – if a service user has been referred into the service or has an existing relationship with the service and some information is known about them and the risks that may be present;
- An unanticipated risk – this may be a risk posed by a service user that has not been anticipated, or a risk posed by someone who is not a service user.

It is always worth considering the following before physically intervening with a service user:

1. Do I need to do this?
2. Do I need to do this now?
3. What is the worst outcome should I not do anything?

Note: Physical intervention is not always the best or the safest course of action to take. Active steps to prevent behavioural disturbance, recognise early signs of aggression, de- escalation and individualised collaborative care plans and programmes of activity are to be promoted.

(i) Anticipated situations

- Where risk assessments identify that restrictive interventions may be needed their implementation should be planned in advance and recorded (CoP 26.38).
- An appropriate risk assessment - Detailed Risk Assessment and Management plan (DRAM) or alternative record of risk assessment and plans for management should therefore be completed as soon as possible to help guide interventions for all service users under the care of SHSC. The detail and extent of this planning will differ according to the context in which SHSC comes into contact with the service user. If there is felt to be a risk of violence or aggression, an interim risk management plan should be put in place to cover the immediate situation, whilst the more detailed plan is discussed and written.
- For service users in inpatient settings, a DRAM or alternative record of risk assessment and plans for management should be put in place during the admission process if one is not already in existence.
- For service users not in inpatient settings, local guidelines should be followed regarding when a DRAM needs to be completed.
- Where other agencies are also involved in the care/support of a service user, discussions with those agencies should take place at the earliest opportunity. This will be to establish how they will work together with SHSC around risk assessment and management and to determine clear lines of responsibility for doing this. This should preferably be done with the service user's consent. Where it is not possible to obtain consent (for example, before contact is made with the service user), the person does not have capacity to consent or consent is withheld, then the level of information sharing should be determined in line with SHSC's Confidentiality Code of Conduct.
- Where a risk of aggression or violent behaviour is discussed or identified as a possibility in the risk assessment, appropriate interventions and management strategies (and the service user's preferences regarding these) should be recorded in the service user's risk management plan. Such planning, where possible, should be carried out collaboratively and should identify service user's preferences. Due consideration must be given to service user requests and Advance Statements and careful consideration must be given to trigger factors and ways in which potentially violent situations can be avoided/defused. Service users' views about their trigger factors and early warning signs should be sought and documented.

- Consideration should be given to giving a copy of the care plan to the service user as standard practice (NG 10 2015). Where there are reasons not to give a copy of the care plan to the service user, then these should be clearly documented and the decision reviewed regularly.
- In completing the DRAM or alternative record of risk assessment and plans for management staff should consult related documents including Advance Statements (as well as any other relevant people) to improve knowledge regarding risk history and awareness of the service user's views on management of risk. The DRAM must be reviewed regularly and updated in terms of the service user's risks.
- Care should be taken to ensure that risk assessment is based upon as accurate information as possible and not upon stereotypes or reputations.
- Whilst a services user's history is important in assessing current risk staff should not assume that a history of behavioural disturbance means that the service use will necessarily behave in the same way in the future (CoP 26.9).
- Risk management plans should include details about the risks involved in any physical interventions and how these can be minimised. This process should be led by an appropriate staff member who has completed the four day Level 3 RESPECT course and who is therefore aware of the risk factors. Staff working with people with learning disabilities should use the Alternatives to Restraint processes in order to do this. Risk plans must be reviewed regularly and updated in line with the DRAM or alternative record of risk assessment and plans for management
- When a risk is anticipated, all staff involved in planned restraint must be respect trained to use any RESPECT techniques that may be required. Only staff trained to use particular techniques should be involved in the application of those techniques. Staff should follow procedures outlined in the Physical Health policy for monitoring the health of the person being restrained and should document their findings and actions as soon as possible after the incident using the Physical Health Monitoring form for Rapid Tranquillisation Seclusion and Restraint (Appendix G) .
- Where a **service user's health deteriorates**, or there are any concerns medical help should be sought immediately (via on-call medical staff or by contacting the ambulance service).
- Particular plans will need to be put in place around people with disabilities or health conditions, pregnant women and people with infectious diseases. When a service user who may be subject to physical intervention falls into one or more of these categories, then the RESPECT trainers should be contacted as soon as possible in order that they can provide support in devising safe and appropriate plans.
- Consideration should be given to the environment that an anticipated intervention takes place in for example the removal of objects not required or the amount of space required to undertake an intervention.
- In all situations, the aim must be to achieve a situation in which the probability of violent incidents (and resultant interventions) is reduced as far as possible.

(ii) Unanticipated situations

- On some occasions behavioural disturbance may not have been predicted by risk assessment. The use of physical intervention will be based on clinical judgement taking into account NICE guidance and available knowledge of the service user's circumstances (CoP 26.39).
- In unanticipated situations, there is no opportunity to plan. Therefore, staff will be making decisions about how to act in what can be very challenging and pressurised circumstances. The key is to follow the principles above in making sure that the response is proportionate to the situation and legally justifiable.

To support effective de-escalation and considering the safety of those present it may be necessary to support others to exit the situation.

If it is safe to do so, the first course of action should be for the situation to be de-escalated, staff should try to:

- Act calmly and confidently and continue to listen to the service user;
- Recognise the early signs of agitation, irritation, anger and aggression and if possible meet the service user's need which may successfully de-escalate the situation at this point;
- Understand the likely causes of aggression or violence, both generally and for each service user;
- Use techniques for distraction and calming, and ways to encourage relaxation or alternative ways to ventilate frustration or anger;
- Respond to a service user's anger in an appropriate, measured and reasonable way and avoid provocation;
- Recognise the importance of personal space;
- If physical interventions are required de-escalation attempts should continue throughout.
- However, there may be situations in which the only safe course of action is to use reasonable force for the protection of the worker and others. In an emergency, untrained staff may have to become involved in a physical intervention. The incident must be documented, an incident report completed and a senior clinical manager for that area be informed.
- Any registered nurse or appropriately trained staff member involved should monitor the health of the person subject to physical interventions. This will include use of the procedures outlined in the Physical Health policy. If a service user's health deteriorates, medical help should be sought immediately via on-call if available or by contacting the ambulance service. The Physical Health Monitoring form for Rapid Tranquilisation Seclusion and Restraint in App B will indicate if this is required.
- If, for whatever reason, any physical interventions employed with a service user deviate in any way from prescribed RESPECT techniques, then it is expected that this will be indicated and explained in full in all associated documentation on the e-incident system and on Insight ensuring that the RESPECT Team are alerted to this in Additional Staff to Notify. In such cases it is essential that staffs are open and honest as this allows the RESPECT trainers to analyse any such incident with a view to understanding what the difficulty was and how it may be circumvented should it arise in the future. It is through this process that the RESPECT trainers will identify any additional training issues.
- Staff not involved in the physical intervention must ensure that the environment is made safe for their colleagues by removing any clutter e.g. furniture which may impede the staff attempting to implement physical interventions to contain a violent situation. Note: If SHSC staff have been assaulted by a service user this may have an impact on their judgement, if possible should not be involved in that incident (i.e. if restraint is required).
- No action will be taken against a member of staff for the use of reasonable force if, after investigation, it is found that they have acted honestly, instinctively, within the spirit of this Policy, the spirit of the RESPECT training and best practice. This will include their actions being proportionate to the risk that was present and using no more than reasonable force to bring the situation under control.
- In both anticipated and unanticipated situations any physical interventions (restraint) must be for the shortest time possible.
- If, for whatever reason, there is a need to physically intervene (restrain) with a service user repeatedly or for a prolonged period, consideration should be given to administering PRN medication, rapid tranquillisation or to implementing seclusion; this is advisable as any form of physical intervention may potentially increase the risk of a service user experiencing compromised physical health e.g. positional asphyxia if repeatedly exposed to this risk within a short time period or if exposed to this risk for a prolonged period.

In both types of situation, consideration should be given to keeping other people in the environment safe and to maintaining the dignity of the person who is subject to the physical intervention. This is discussed in RESPECT training and may involve asking people to leave an area as safe/appropriate, or by keeping the incident as calm and low key as possible. Buildings should have their own plans about alerting people to incidents taking place and

managing the environment in those circumstances. In all instances where physical interventions have been implemented staff must complete an e-incident form stating this.

Where any level of risk is anticipated, due consideration should be given to the availability of the number of people who would be needed to manage a particular situation. The Lone Worker Policy should be adhered to, as should the Visitor Guidelines.

(iii) Police assistance

In very exceptional circumstances, in both anticipated and unanticipated situations, staff members may feel it necessary to call the Police. This is done via a 2222 call specifying the exact location and with a brief description of the situation. SYP will respond to situations where there is a threat to life or limb or a crime has been committed.

Should SYP attend to assist with the management of a service users the mental health professional continues to be responsible for the health and safety of the person. Health staff should be alert to the risk of respiratory or cardiac distress and continue to monitor the physical and psychological wellbeing.

South Yorkshire Police will not assist in the chemical restraint of service users. If the police are present and become involved in physical intervention and restraint of a service user, it remains the duty of health care staff to remain physically present and in direct observation of the patient at all times and should advise the police of any physical health concerns which can be observed for example change in pallor, sweating, waxy looking, respiratory rate/effort/noise and rating on AVPU.

South Yorkshire Police must not be relied upon to address shortfalls in service provision.

6.3 Using p.r.n. medication

When prescribing p.r.n. medication as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression (please refer to the SHSC Rapid Tranquilisation Policy): Prescribers should:

- not prescribe p.r.n. medication routinely or automatically on admission;
- Tailor p.r.n. medication to individual need and include discussion with the service user if possible;
- Ensure there is clarity about the rationale and circumstances in which p.r.n. medication may be used and that these are included in the care plan;
- Ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the British national formulary (BNF)when combined with the person's standard dose or their dose for rapid tranquillisation;
- Only exceed the BNF maximum daily dose (including p.r.n. dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented and carried out under the direction of a senior doctor
- Ensure that the interval between p.r.n. doses is specified.

(NICE Guidelines 10, 2015)

Staff administering medication to service users detained under the MHA must satisfy themselves that the prescription takes into account the requirements of Mental Health Act 1983 Part 4, ie that a T2 or T3 certificate is completed appropriately after 3 months of treatment, or the procedure for urgent treatment is followed.

It is unlawful to enforce medication on an adult who is capable of giving or withholding consent, unless s/he is detained under a section of the MHA to which Part 4 applies and the medication is for treatment of his/her mental disorder.

The provisions of the Mental Capacity Act 2005 must be followed for the medical treatment of service users who lack capacity and who are NOT detained under the MHA.

6.4 Young People under 18

In exceptional circumstances SHSC may have a young person receiving care within the adult Wards or with the Place of Safety.

Due regard should be taken of the young person's age, physical emotional and psychological maturity, size and physical vulnerability. Physical and Chemical interventions should be used with extreme caution to prevent harm physically and psychologically (CoP 26.52).

6.5 Procedure to follow if a weapon is involved

If staff are threatened by a service user with a weapon, they must calmly request that the service user places the weapon in a neutral area i.e. somewhere away from others, guidance on this issue can be accessed in the SHSC Security policy in appendix E: 'Offensive' Weapons.

6.6 Mechanical Restraint

Mechanical restraint is defined in the Mental Health Act Code of Practice as 'a form of restrictive intervention that [involves] the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control (CoP 26.75).

Mechanical restraint will not be used for the purpose of behavioural control in SHSC, however a very small number of service users may require the use of mechanical restraint to prevent 'self-injurious' behaviour such as falling from a chair or bed or to safely allow someone to travel in a car or bus.

In such instances the purpose of the mechanical restraint is not to control disturbed behaviour but is a risk-reduction intervention intended to maximise service user safety. The purpose of the mechanical restraint is to prevent injury e.g. to prevent falls where the service user is high at risk and vulnerable to fracture

Examples of mechanical restraint equipment that may be utilised for this purpose include safety straps in chairs, bed rails and safety helmets.

South Yorkshire Police (SYP) may on rare occasions bring service users in to SHSC care utilising handcuffs or leg restraints. For monitoring purposes this should be reported as mechanical restraint by South Yorkshire Police. In very rare and exceptional circumstances Taser or irritants such as pepper spray or CS gas may have been used. On every occasion an incident report will be made and an appropriate Clinical Manager informed, if this has happened on trust premises this is to be reported to the on call service manager.

Guidance on care of the service user in this situation is in Appendix K.

Service users who are being mechanically restrained by South Yorkshire Police should remain under continuous observation throughout the period of mechanical restraint (CoP 26.80) and be medically reviewed within one hour and at 4-hourly intervals thereafter, or more frequently at the request of nursing staff (CoP 26.82). These observations must be carried out by a competent medic/paramedic.

6.7 Legal and wider guidance context

Staff must ensure that, at all times, they are acting within the law. There is guidance and a number of number of laws and that are particularly relevant to situations involving violence and aggression. A brief, non-exhaustive, list of these is given below. When responding to (potential) violence and aggression, staff must consider the relevant pieces of legislation/guidance and seek appropriate advice and support if they are unclear about their responsibilities in relation to these:

(i) **The Mental Capacity Act (2005):** The Mental Capacity Act (2005) concerns people who lack the mental capacity to make decisions about aspects of their lives. In terms of physical intervention involving people who lack capacity, it states that any action intended to restrain a person who lacks capacity will not attract protection from liability, unless the following **two** conditions are met:

1. The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, **and**
2. The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.

All staff have a responsibility to be aware of the Deprivation of Liberty Safeguards and highlight to the manager responsible for the service if they feel that a person's care plan (including, but not limited to, the use of physical intervention(s)) amounts to a deprivation of their liberty. Managers should make relevant applications for authorisation under the Deprivation of Liberty Safeguards (see Mental Capacity Act 2005: Deprivation of Liberty Safeguards - Code of Practice, 2008) or via the Court of Protection. Any questions around this should be directed to the Sheffield Mental Capacity Act Hotline on 0114 205 3783.

(ii) The Mental Health Act 1983 (amended 2007)

"The Mental Health Act is largely concerned with the circumstances in which a person with a mental disorder can be detained for treatment for that disorder without his or her consent. It also sets out the processes that must be followed and the safeguards for patients to ensure that they are not inappropriately detained or treated without their consent. The main purpose of the legislation is to ensure that people with serious mental disorders which threaten their health or safety or the safety of the public can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others" (MHA 2007: An overview. Dept of Health, 2009).

There is no specific guidance to staff within the Act on the management of violent and/or aggressive behaviour. Chapter 26 of the Mental Health Act Code of practice 2015 gives specific guidance on management of service users presenting with particular problems. Staff working within the service should be familiar with the guidance it sets out.

(iii) The Human Rights Act (1998)

The Human Rights Act (1998) gives further effect to rights and freedoms guaranteed under the European Convention on Human Rights (ECHR) The use of physical interventions potentially infringes some of these rights, and must therefore be justified by a clear rationale. This should explain why other considerations are believed to override individual freedom of action. (RCN, 2008). Organisations have a duty to work in line with the Act and current interpretations. Of particular interest in this context are Article 2 (Right to Life), Article 3 (Prohibition of Torture (inhuman or Degrading Acts), Article 8 (Right to respect for Private and Family Life) and Article 14 (Prohibition of Discrimination).

(iv) Duty of Care

Duty of Care is "the legal obligation to safeguard others from harm while they are in your care, using your services, or exposed to your activities" (Collins English Dictionary). By law all staff (regardless of job role) have a duty of care towards their service users. Staff should act in ways that are consistent with the legalities of duty of care as set out by any codes of practice relevant to their profession and the Trust staff handbook. The Trust has a duty of care towards its employees and towards service users, which is fulfilled by the implementation of this policy.

(v) NICE Guidance (relating to inpatient psychiatric settings)
1.4.5 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.

1.4.6 Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance.

1.4.7 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.
- Also specified in CoP 26.36

(vi) Health and Safety Legislation
SHSC has a duty under health and safety legislation to have processes in place to risk assess, manage and report risks to their staff around violence and aggression (see www.hse.gov.uk).

6.8 Raising concerns - links to other systems

This policy operates in tandem with existing systems through which concerns can be addressed:
(i) Duty of Candour and Being Open Policy and Procedure: Communicating Patient Safety Incidents with Patients and their Carers. Candour and being open simply mean apologising and explaining what happened to service users and/or their carers who have been involved in a complaint or service user safety incident. A service user safety incident is defined as: 'any unintended or unexpected incident that could have or did lead to harm for one or more service users receiving NHS funded healthcare' (NPSA 2005).
(ii) SAFEGUARDING ADULTS/CHILDREN POLICIES AND PROCEDURES – Inappropriate use of physical interventions and some other responses to situations may be considered abusive. If a staff member (or anyone else) feels that an abusive incident has occurred, the appropriate Safeguarding procedures should be used. Links to the South Yorkshire procedures can be found below:
- Adults - http://www.sheffield.gov.uk/caresupport/policy/abuse/adultabusepolicy
- Children - http://sheffieldscb.proceduresonline.com/index.htm

(iii) DISCIPLINARY POLICY/CAPABILITY POLICY – These may be used when the conduct of a staff member is deemed to constitute a disciplinary or capability issue.

6.9 Working with other organisations

When SHSC staff are working in partnership with staff from other agencies to provide services to people, plans should be developed at a management level about the prevention and management of aggression and violence in that particular situation, in ways which allow staff to remain compliant with the Policy requirements of their own organisations. Incidents of incompatibility of policy should be raised with senior clinical managers.

6.10 Training
See Section 8.

6.11 Post incident procedures

In all situations anticipated and unanticipated, as part of the risk management plan, due consideration should be given to what will happen following a physical intervention incident. This should include procedures for staff, service users and members of the public.

Post-incident procedures should include monitoring of physical health, obtaining medical help where required (including if there has been any infection risk, for example from bodily fluids) and recording on the physical health monitoring form for Rapid Tranquilisation Seclusion and Restraint (Appendix G)

All SHSC staff can have access to Workplace Wellbeing as a source of support by self-referral

After all incidents that have involved physical intervention (anything amounting to more than a two person escort or release techniques), staff members should contact a doctor and request a physical review for the person as a matter of urgency including assessment for positional hypoxia. They should pass on information to the doctor about what has happened. For service users not on inpatient wards, the General Practitioner should be contacted. The level of priority given to this will be at the discretion of the doctor. If there are any particular concerns about the person's health, then immediate medical assessment should be sought (for example, through Accident and Emergency).

A post incident review must take place for all who have been involved in an incident. This should be led by a senior staff member in the service area. The purpose is to learn lessons from what has happened and to identify what went well and what did not go so well. These should be documented and shared with the staff team.

There should also be feedback to RESPECT trainers, for consideration about whether any outcomes should be incorporated into future training.

Good practice would be to have a further post incident review which is conducted by a senior member of staff who is not part of the affected team and by a service user who is also external to the team; such a post incident review should take place within 72 hours or as soon as possible after the incident.

Some service users may not be willing or able to participate in a post incident review, or it may not be appropriate to attempt on the grounds of risk. However, for those who are, consideration should be given to supporting them to write an advanced statement/directive about how they wish to be treated in the future; this may help in the prevention and management of further incidents. If they are able to do so, service users should be given the opportunity to record their thoughts about the incident in their notes with support from staff or Advocacy Services if required (Appendix H - Post Seclusion or Physical Intervention Review form.

All incidents need to be fully documented using the e-incident system and on insight. This will include documentation of the reasons behind any decision to use reasonable force. This will support a review of the reasons for the incident. If possible, this should be done in collaboration with the individual involved. The form must be submitted to the SHSC Risk Department.

If staff believe that they have been **physically assaulted at work**, then they must:

- Complete an incident form (IR1) and submit this to the risk department;
- Inform their line manager. The line manager should then contact the SHSC Local Security Management Specialist (LSMS) via the SHSC switchboard;
- They are also entitled to contact the police and request an incident number (this could also be done by a manager or relevant colleague).

The LSMS will guide the through the staff member through the rest of the process, including the process for seeking a witness statement from the Responsible Clinician (as appropriate),

This will be supported by the individual's line manager.

If a staff member believes that they have been **assaulted by a service user who is <u>not</u> under the care of SHSC** at that time (for example, if a staff member encounters a service user/former service-user in the street), then the staff member should seek support directly from the police.

Further information about procedures for when staff members feel that they been physically or non-physically assaulted can be obtained from the following documents:

- Tackling violence against staff : Explanatory notes for reporting procedures introduced by Secretary of State Directions in November 2003 (updated June 2009)
- A framework for reporting and dealing with non-physical assaults against NHS staff and professionals: Non-physical assault explanatory notes (November 2004).

If staff members are in any doubt as to the procedures to be followed (including whether or not to involve the Police), then they should contact the LSMS via the SHSC switchboard. They can also talk to their manager.

If staff believe that they have been non-physically assaulted at work, then they must:

- Complete an incident form (IR1) and submit this to the risk department;
- Inform their line manager. Who should contact the LSMS via the SHSC switchboard.

The LSMS can help with the decision about whether or not to report the incident to the Police. However, the staff member is at liberty to do this themselves and must not be discouraged from doing so. The LSMS will guide the through the staff member through the rest of the process

For both alleged physical and non-physical assaults, service users and members of the public may choose to involve the Police, should they wish to press charges after an incident.

When an incident has been reported to the Police, the multidisciplinary team must make a decision about whether and when it is clinically appropriate to tell the person about that (prior to any visit by the Police).

In some circumstances, the Trust may elect to withdraw treatment for service users where there has been evidence of wanton, deliberate aggression and violence. Consideration needs to be given to alternative options for treatment delivery, which may include different provider organisations. The Trust's Clinical Risk Manager must be involved in decisions to withdraw treatment, so that appropriate legal guidance and duty of care considerations are incorporated.

6.12 Support from RESPECT trainers

Each clinical area where staff receive mandatory Level 3 RESPECT course should have an allocated RESPECT trainer or Technical Assistant as a point of contact for advice and support. The allocated RESPECT trainer (or their nominated replacement if they were off work) will work with staff to care plan around specific situations in which there may be difficulties with using RESPECT techniques. Their role will be in a supportive capacity, rather than to take the lead around the management of a situation. The RESPECT team can be contacted regarding issues surrounding the management of behaviours that challenge and are actively encouraged to do so within training.

The Technical Assistants within each area where staff receive mandatory level 3 training will have been trained to a higher level than the other staff in that area. Technical Assistants will assist staff in maintaining their skills and techniques in terms of RESPECT physical interventions. Technical Assistants are not expected to lead and give direction on physical

interventions in every situation, this responsibility remains with the registered nursing staff on the shift.

For areas that do not have an allocated RESPECT trainer, the RESPECT professional lead or assistant professional lead should be contacted.

7. Dissemination, storage and archiving (Control)

A copy of the policy will be placed on the SHSC website and intranet by the Corporate Governance Team. The previous version will be removed and archived.

A communication will be sent to all SHSC employees informing them of the revised policy. Managers are responsible for ensuring that any hard copies of the previous versions are destroyed.

8. Training and other resource implications

All staff of SHSC will attend a RESPECT training course (and regular refreshers/updates) that is relevant to their job role and covers the skills and knowledge necessary for them to perform that role safely. This is set out in the SHSC Training Needs Analysis. Not every situation and eventuality can be covered on a course. In these situations, staff are expected to work in a way consistent with the spirit of the training they have received and seek extra support as necessary. The content of the training will not be repeated in this policy.

Staff must also attend other training deemed mandatory to their role. The training that is mandatory for each role will be decided locally (responsibility for this will be delegated by Service Directors), in line with the SHSC Mandatory Training Policy and Training Needs Analysis.

When considering training for a specific area, a local risk assessment should be carried out to ascertain the level of training suitable to that area, prevalent risks and responsibilities of staff in the area in question. This should be done by the Ward/Team/Department Manager.

All staff who will be involved in clinical care of service users will receive RESPECT Training as appropriate to their level of service user contact.

SHSC acknowledges the requirement for all staff trained in RESPECT to be trained in Basic Life Support or (as appropriate) Immediate Life Support and to be up to date in this training.

The identification of individual staff training needs is the responsibility of line managers, in line with the SHSC training needs analysis.

Training is in line with the five core standards as set out in Conflict resolution training: implementing the learning outcomes, NHS Protect (2013).

9. Audit, monitoring and review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Duties	Statement on Internal Control	Chief Exec through Exec Director of Operations/Trust Board through Audit and Assurance Committee	Annual	Board assurance process monitored through Audit and Assurance Committee	Director of Planning, Performance and Governance/ Audit and Assurance Committee	Director of Planning, Performance and Governance/ Audit and Assurance Committee
How the organisation carries out risk assessments for the prevention and management of violence and aggression	By using risk assessment and management processes (DRAM)	Lead clinician e.g. CPA Co-ordinator, Named Nurse	At least annually, more often if required	Through CPA or care planning process	Lead clinician e.g. CPA Co-ordinator, Named Nurse/CPA or care planning meeting	Lead clinician e.g. CPA Co-ordinator, Named Nurse/CPA or care planning meeting
Timescales for review of risk assessments	Through directorate and Trust governance processes	Trust Clinical Risk Group/ Directorate Clinical Risk leads reporting to Directorate Governance Groups Overview at Quality Assurance Committee	Quarterly	Clinical Risk Group reviews implementation of clinical risk training and use of DRAM.	Trust Clinical Risk Group/ Directorate Clinical Risk leads reporting to Directorate Governance Groups Overview at Quality Assurance Committee	Trust Clinical Risk Group/ Directorate Clinical Risk leads reporting to Directorate Governance Groups Overview at Quality Assurance Committee

How action plans are followed up	Through CPA or care plan review	Lead clinician e.g. CPA Co-ordinator, Named Nurse	At least annually, more often if required	Through CPA or care Planning process	Lead clinician e.g. CPA Co-ordinator, Named Nurse/CPA or care planning meeting	Lead clinician e.g. CPA Co-ordinator, Named Nurse/CPA or care planning meeting
Arrangements for making sure Lone workers are safe	Lone working policy implementation	Line manager	At induction for New staff and at least annually	On induction, Through supervision and annual PDR as appropriate	Line manager	Line manager
How the organisation trains staff in line with the TNA	RESPECT training at Appropriate level, Basic life Support training, ILS, Physical health eg EWS, Clinical Risk provided by SHSC Education, Training & Development Dept. Reports on staff Completing training sent to Directorate managers for monitoring	Line manager/team Governance group/ SHSC Training Committee	At least annually in PDR	Through supervision and annual PDR for individuals/ through team governance for teams/through Training Committee for training delivery and uptake	Line manager/team governance group/SHSC Training Committee	Line manager/team governance group/SHSC Training Committee

This policy will be reviewed by August 2019, or earlier where legislation dictates or practices change.

10. Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
Upload the revised policy onto intranet and Trust website and remove/ archive the old version.	Director of Corporate Governance	≤ 5 working days following ratification	
Issue a communication to front line staff and managers.	Director of Corporate Governance	≤ 5 working days following issue	Update for inclusion in the next issue of the Communications Digest following issue.
Ask the Education, Training and Development team to review the policy to update future training.	Director of Corporate Governance	≤ 5 working days following issue	

11. Links to other policies, standards and legislation (associated documents)

This policy links with and overlaps a number of other SHSC policies and good practice guidelines, which it should be read in conjunction with –

Capability Policy

Complaints Policy

Confidentiality code of conduct

Deprivation of Liberty Safeguards Policy

Disciplinary Policy

Education, Training and Development Policy

Good Practice Guidelines on the Prevention and Management of the Use of Restraint

Incident and Investigation Policies

Interpreting and Translating Policy

Lone Worker Policy

Management of Medicines Policy

Observation of Inpatients Policy

Personal Search Policy

Physical Health Care Policy

Rapid Tranquillisation Policy

Records Management Policy

Resuscitation Policy

Safeguarding Adults Policy

Safeguarding Children Policy

Seclusion Policy

Security Policy

Visitors Policy

12. Contact details

Title	***Name***	***Phone***	***Email***
RESPECT Professional Lead	Greg Hughes	Via switch	greg.hughes@shsc.nhs.uk
Senior Nurse, Quality Improvement	Kim Parker	01142663306	kim.parker@shsc.nhs.uk

13. References/further reading

A framework for reporting and dealing with non-physical assaults against NHS staff and professionals: Non-physical assault explanatory notes (November 2004)

A Positive and Proactive Workforce, DoH, (2014)

British Institute of Learning Disabilities (2010) Code of Practice for the Use and Reduction of
Restrictive Physical Interventions (3rd edition)

Clark, C.R., McInerney, B.A. & Brown, I. (2012). The prosecution of psychiatric inpatients: overcoming the barriers. Journal of Forensic Psychiatry and Psychology

Closing the gap: Priorities for essential change in mental health, DoH, (2014)

http://www.collinsdictionary.com/dictionary/english/duty-of-care (accessed 11/12/12)

Conflict resolution training: implementing the learning outcomes, NHS Protect (2013)

www.hse.org.uk

Human Rights Act 1998

Listening to experience, an independent inquiry into acute and crisis mental health, Mind (2013)

Mental Capacity Act 2005

Mental Capacity Act 2005 Code of Practice (2007)

Mental Health Act (1983, revised 2007)

Mental Health Act Code of Practice (2015)

Mental Health Act 2007 an overview Dept of Health 2009.
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_078743 accessed 14/03/13)

Mental health crisis care: physical restraint in crisis, a report on physical restraint in hospital settings in England, Mind, (2013)

Navigo (2011). Management of Violence and Aggression Policy

NHS Security Management Service (2003, updated 2009) - Tackling violence against staff: Explanatory notes for reporting procedures introduced by Secretary of State Directions in November 2003 (updated 2009)

NHS Security Management Service (2004) - A framework for reporting and dealing with non-physical assaults against NHS staff and professionals: Non-physical assault explanatory notes

NICE Guidelines - Violence and aggression: short-term management in mental health, health and
community settings. http://nice.org.uk/guidance/ng10

Offensive weapons NHS Security Management Service Guidance

Positive and Proactive Care: Reducing the need for restrictive interventions, DoH, (2014)

Prevention and Management of the use of Restraint: Framework for Good Practice (2011) – Sheffield City Council and NHS Sheffield

Prevention and Management of Violence where withdrawal of treatment is not an option (NHS Security Management Service Division)

Recognising Deteriorating Patients

Royal College of Nursing (2008) Let's talk about restraint – rights, risks and responsibilities

Service user experience in mental health: improving the experience of care for people using adult NHS mental health services (December 2011)

Tackling violence against staff : Explanatory notes for reporting procedures introduced by Secretary of State Directions in November 2003 (updated June 2009)

Tackling violence and antisocial behaviour in the NHS Joint Working Agreement between the Association of Chief Police Officers, the Crown Prosecution Service and NHS Protect

Appendix A – Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
1.0	Ratification and issue	October 2014	
2.0	Review / ratification / issue	Nov 2016	Early review undertaken to update the policy.

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
1.0	Oct 2014	Oct 2014	
2.0	Nov 2016	Nov 2016	Communications Digest Nov 2016 – all staff

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	No specific impact identified.	The policy encourages respectful responses to violence and aggression in a positive way in line with best practise.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015.
DISABILITY	No specific impact identified.	The policy encourages respectful responses to violence and aggression in a positive way in line with best practise.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015.
GENDER REASSIGNMENT	No specific impact identified.	The policy encourages respectful responses to violence and aggression in a positive way in line with best practise.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015.
PREGNANCY AND MATERNITY	No specific impact identified.	The policy encourages respectful responses to violence and aggression in a positive way in line with best practise.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015.
RACE	No specific impact identified.	The policy encourages respectful responses to violence and aggression in a positive way in line with best practise.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015.
RELIGION OR BELIEF	No specific impact identified.	The policy encourages respectful responses to violence and aggression in a positive way in line with best practise.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015.

SEX	No specific impact identified.	The policy encourages respectful responses to violence and aggression in a positive way in line with best practise.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015.
SEXUAL ORIENTATION	No specific impact identified.	The policy encourages respectful responses to violence and aggression in a positive way in line with best practise.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015.

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)
Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date) Rhodri Hannan (Assitant Service Director) 21st October 2016

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(Relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?

☒ **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. On completion of flow diagram – is further action needed?

☒ **No, no further action needed.**

☐ **Yes, go to question 3**

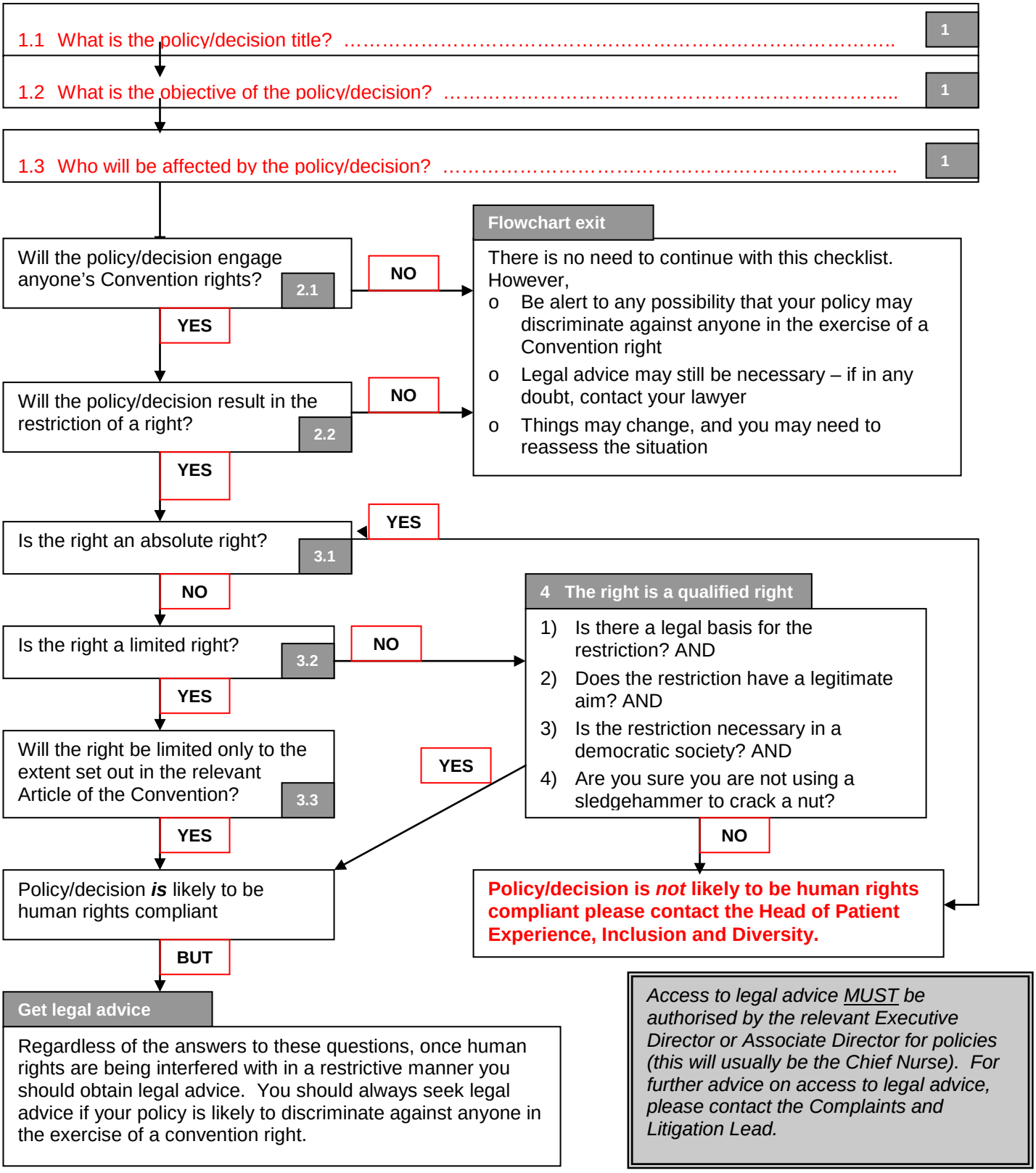
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix E – Development, Consultation and Verification

- Policy Authors: Greg Hughes and Kim Parker
- Guidance followed; Mental Health Act Code of Practice 2015 / Mental Capacity Act 2005. NICE Guideline 10 Violence and Aggression : short term management in mental health and community settings May 2015
- Groups and individuals consulted: SHSC Restrictive Interventions Project Group/ Mental Health Act Group/ Nurse Leaders/ South Yorkshire Police.
- Any changes made as a result of the consultation process: Consultation held between 30.06.2016 – 19.07.2016. 3 drafts produced by authors. No other comments received.
- Which governance group verified the document: Restrictive Intervention Project Group (RIPG) on 25 August 2016.

Appendix F –Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy template which can be downloaded on the intranet.

1. Cover sheet ✓

All policies must have a cover sheet which includes:

- The Trust name and logo ✓
- The title of the policy (in large font size as detailed in the template) ✓
- Executive or Associate Director lead for the policy ✓
- The policy author and lead ✓
- The implementation lead (to receive feedback on the implementation) ✓
- Document type ✓
- Document status ✓
- Date of initial draft policy ✓
- Date of consultation ✓
- Date of verification ✓
- Date of ratification ✓
- Date of issue ✓
- Ratifying body ✓
- Date for review ✓
- Target audience ✓
- Keywords ✓
- Policy version and advice on availability and storage ✓

2. Contents page ✓

3. Flowchart ✓

4. Introduction ✓

5. Scope ✓

6. Definitions ✓

7. Purpose ✓

8. Duties ✓

9. Process ✓

10. Dissemination, storage and archiving (control) ✓

11. Training and other resource implications ✓

12. Audit, monitoring and review ✓

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

13. Implementation plan ✓

14. Links to other policies (associated documents) ✓

15. Contact details ✓

16. References ✓

17. Version control and amendment log (Appendix A) ✓

18. Dissemination Record (Appendix B) ✓

19. Equality Impact Assessment Form (Appendix C) ✓

20. Human Rights Act Assessment Checklist (Appendix D) ✓

21. Policy development and consultation process (Appendix E) ✓

22. Policy Checklist (Appendix F) ✓

Appendix G

Rapid Tranquillisation, Seclusion and Post-Restraint Physical Health Monitoring Form

Service user's details

Forename :	
Surname :	
NHS no.:	Date of birth:
Gender:	Ethnicity:
Insight number:	Date of form:

Following administration of **Rapid Tranquilisation** medication
(IM Lorazepam, IM Haloperidol, IM Aripiprazole, IM Promethazine)
YOU MUST MONITOR AND RECORD

• Pulse • BP • Respiratory rate	• Temperature • Level of consciousness • Hydration

Either

- Every hour until no concern and at least twice.
- Every 15 minutes if above BNF limits.
- Every 15 minutes if used alcohol/substances, is asleep or sedated, has physical health concerns or experienced harm during physical intervention.
- Following **restraint for service users with a physical health** condition observations should be recorded as above initially until no concerns and continue 4-6 hourly for 24 hours.
- **DISCUSS ANY CONCERNS WITH MEDICAL STAFF.**

Medicines administered and date and time of administration.

X all that apply

Rapid Tranquilisation		Seclusion		Restraint	

Time								
Pulse (bpm)								
BP (mmHg)								
Respiration (rpm)								
Oxygen sats (% indicate air or O^2)								
Temp (°C)								
Level of consciousness (AVPU)								
Staff initials								
Hydration: When did the service user last have a drink? Record of fluids offered post Rapid Tranquillisation.								

IF UNABLE TO TAKE / SERVICE USER REFUSING PHYSICAL OBSERVATIONS PLEASE COMPLETE THE FOLLOWING AT THE SAME FREQUENCY AS IDENITIFED ABOVE.
USE AN ADDITTIONAL FORM IF REQUIRED.

WHERE YOU ARE UNABLE TO TAKE PHYSICAL OBSERVATIONS, you must use A, B, C, D, E and continue to attempt to take observations at the earliest opportunity.

Reason why:

Time:				
(A) Airway. Is the airway clear? Is the service user able to speak – if so their airway is clear? Is their breathing noisy – coming from the throat?				
(B) Breathing. Can you see the chest rising? Can you see if rising equally? Is breathing noisy – coming from the chest?				
(C) Circulation. Has the service user's colour changed – blue lips or fingertips?				
(D) Disability – level of consciousness. Use AVPU (**A**lert, responds to **V**oice, responds to **P**ain, **U**nresponsive).				
(E) Exposure, Examination ie. Any signs of bruising or rash				
Hydration: When did the service user last have a drink? Record of fluid offered post Rapid Tranquillisation				

DISCUSS ANY CONCERNSWITH MEDICAL STAFF

Appendix H

REDUCING RESTRICTIVE PRACTISE

Post Seclusion or Physical Intervention (Restraint) Review

Name	Ward		Insight No
Seclusion Review ☐		Restraint Review ☐	
Date and Time of Start and Termination		Date and Time of Restraint	
Date Of Post Seclusion Review		Date of Post Restraint Review	
Name and Designation		Name and Designation	
Area for Discussion			
Did someone tell you why you where secluded or restrained?			
Did you agree that seclusion or restraint was necessary?			
Did you feel anything could have been done to prevent the use of seclusion or restraint?			
Do you have an advance statement to help direct staff in your care?			

What would help prevent seclusion or restraint in the future?	
Did you feel that your privacy and dignity was maintained?	
Did staff talk to you and explain what was happening with • Your care and treatment? • Seclusion Reviews?	
Did you feel safe?	
Were your needs met whilst you were in seclusion? • Communication • Clothing and hygiene • Activities • Fresh air • Spiritual or Cultural • Food and Drink	
Any other information	
Completed by	

Appendix I

POST INCIDENT REVIEW FORM

This review should take place within 72 hours of the incident

Surname(s)	Forename(s)	Date of Incident	Date of Review

- What happened during the incident?

- What were the trigger factors?

- Each person's role in the incident and how they felt about the incident:

- Any concerns that need to be addressed further:

- Action Plan (if required):

Name of Team Manager: _____ Signature of Team Manager_____

Date of Completion: _____ Time of Completion: _____

(PTO if required)

Appendix J – Guidelines For The Care Of The Pregnant Service User In The Event That Physical Intervention Is Required For The Purpose Of Responding To Disturbed Behaviour

Admission Process

Careful consideration should be given when admitting a pregnant service user to an inpatient clinical area.

Every effort should be taken to manage any identified risks accordingly.

The current stage of pregnancy should be identified to clarify the current trimester and inform the management plan as early as possible if there is a risk of disturbed behaviour being exhibited from the service user.

Where possible, inpatient admission to an area which is attached to an Acute Trust with obstetric care should be the first option.

For those on the Care Programme Approach a CPA meeting should be undertaken as soon as possible following an admission (either as an inpatient or to community services) to consider psychiatric care in labour and post delivery.

The pregnancy planning meeting should include the service user, partner and those involved in the care from both mental health, obstetrics and other professions as necessary.

Those not on CPA and having a minimal level of care may still require a meeting, but it may be sufficient just to have liaison between relevant professionals.

The important thing is that the obstetricians have copies of psychiatric clinic letters where appropriate and they and the service user/partner have information about how to access psychiatric care in an emergency.

Single sex accommodation must be available to service users admitted to mixed sex units.

Male and female service users will not share sleeping accommodation, and will not share toilet and washing facilities. They will not have to pass through sleeping, toilet or washing areas of the opposite sex to access their own.

Recognising Pregnancy

All women of child bearing age should be asked if they are pregnant or planning a pregnancy.

The current stage of pregnancy should be identified to clarify the current trimester and inform the management plan as early as possible.

There are three stages of pregnancy:

First Trimester: (1st three months of pregnancy)
Second Trimester. (2nd three months of pregnancy)
Third Trimester. (Last three month of pregnancy)

It is essential that clinicians are aware which trimester a service user is in before proceeding with an intervention. Every effort should be made to establish this, but don't delay interaction. There are specific risks associated with the use of physical and pharmacological interventions which differ throughout the three trimesters and further advice should be sought.

Obstetric Care

If service users are prescribed medication then liaison should take place between obstetricians and paediatrician to discuss management of possible neonate withdrawal.

Arrangements for the service user to visit and familiarise themselves with staff and the surroundings within the obstetric department should be made.

Discussion between the obstetric staff and the service user should take place considering any chosen birth plan, breast feeding etc. and this should be incorporated into the service users care plan.

Responsibilities of all staff in relation to the physical and social wellbeing and safety of the mother and unborn baby

The earlier relevant agencies and professionals are aware of the mother's admission the more effective arrangements will be for both inpatient care and discharge planning.

All staff must be aware of the SHSC Safeguarding Children policy.

The midwife providing antenatal care must be contacted to inform her of the mother's admission and condition.

Ensure you consider risks to unborn babies e.g., maternal substance misuse, domestic violence, history of maternal abuse and discuss any concerns with the SHSC named person(s) for safeguarding children.

The Use of Physical Interventions with Pregnant Service Users

This section should be read in conjunction with the SHSC Policy on Aggression and Violence: Respectful Response and Reduction. This policy can be found on the SHSC intranet.

ALWAYS QUESTION if physical intervention is absolutely necessary? Consider alternatives e.g. increased observation status.

The use of physical intervention should always be a last resort and the least restrictive technique should always be used following an assessment of risk.

The use of verbal de-escalation techniques should be used throughout.

How to use physical interventions with a pregnant service user as safely as possible :

The use of physical intervention escort techniques using large sofas should always be the first choice. Care should be taken not to bend the woman too far forward and to avoid undue pressure to the abdomen as this will impair breathing / slow her heart rate especially during the later stage of the 2nd and the 3rd trimester (although this can be earlier with twins, triplets etc)

Where a sofa is not available a kneeling position can be adopted until de-escalation is successful.

If a restrictive supine position is felt to be required then the use of a bean bag or pillows to cushion the descent to the floor should be used to reduce the risk of any uterine and foetal damage.

During the latter stages of the 2nd and the 3rd trimester women who are held in a supine position can suffer from supine hypotension leading to a loss of consciousness due to supine inferior vena cava compression from the unborn child. To minimise the risk of this the woman's RIGHT hip needs to be elevated with the use of a wedge 2-3" high to improve venous return.

As soon as possible the woman is to be moved into a semi-recumbent escort position using pillows following a supine restrictive technique.(Laying back on pillows or a bean bag at 45°)

The woman is **not** to be stood up using escort techniques as there is a reduction in blood pressure when pregnant women stand up. Staff can assist the woman but this should be done at her pace!

It is essential that the woman's physical wellbeing is monitored at all times during the use of physical interventions and if any signs of distress are noted then the physical intervention should be terminated immediately and medical assistance sought.

Following a physical intervention the unborn child should be monitored by a midwife for any signs of distress or complications at the earliest opportunity.

Post incident – carry out a review with patient. Use information to inform risk assessment and plan for future prevention.

Complete an incident form as per the SHSC Incident Reporting Policy.

Complete a Physical Interventions Monitoring form as per the Violence and Aggression: Respectful Response and Reduction Policy.

Seclusion

Seclusion is not a recommended choice of management plan as levels of observations are decreased and for this reason should be avoided. However, in exceptional circumstances,

if seclusion is deemed to be absolutely necessary, then guidance can be found in the SHSC Seclusion policy.

Recording and Reporting

Document in service users notes detailing reason for interventions, de-escalation techniques used to avoid high-risk interventions. A physical interventions monitoring form must be completed in all instances of use of physical interventions.

Update service users Positive Behavioural Support Plan/DRAM/BRAM/risk management plan and notify all professionals accordingly.

Appendix K - Guidelines for Staff in the Event That Police Use a Taser or Irritant Spray on an Inpatient Whilst Responding to an Incident

Tasers are handheld, electronic incapacitation devices that are designed to fire two barbs at an individual. The device is aimed with the intention of embedding the barbs in the clothing or superficial skin on the torso and/or lower limb, but a barb may occasionally embed in an arm or hand. The current flowing into the body is sufficient to induce temporary disruption of voluntary muscle control and intense pain.

Removing the barbs

The removal of the barbs is the responsibility of the police. However, there may be occasion when assistance is needed from the Nursing staff to reassure the patient and gain their co-operation for the safe removal of the barbs.

Post Taser care of the patient

Staff will monitor and record their early warning score every 15 minutes for at least 1 hour post - Taser use, in line with the Physical Health Monitoring Form. The service user will be offered the opportunity to speak with staff about the incident which led Police assistance being required. (Staff are to refer to the patient debriefing guidance in the main policy).

NB: Staff need to be aware that the patient's pulse rate will be slightly raised post-Taser use, but should return to a normal rate within 30 minutes (dependant on other conditions which may be present).

Special consideration needs to be given to :

Pacemakers and other implanted electronic devices

The evidence concerning damage or disturbance to implanted devices (such as pacemakers) is limited and equivocal so staff need to be aware of the potential risk of damage.

Pregnancy

At present the risks to the foetus are thought to be very low but the evidence upon which this assessment is based is continually reviewed.

Irritant sprays

The effects of irritant spray on an individual can depend on where and how the spray has been used.

Factors that will influence the effects upon an individual are:

- If the spray has been used out of doors or in a confined space
- Hot and moist conditions - which make the spray more effective than cold dry conditions
- The accuracy of its delivery

The primary effects of the spray on an individual usually occur within 10-15 seconds but can take longer. However, there is variation between individuals and some are more susceptible to the effects of the spray than others, with up to 10% not being affected enough to be subdued.

The effects are temporary and reversible and usually last for between 15 minutes and one hour after exposure. They can last up to 45 minutes for the immediate environment.
The primary signs and symptoms of exposure to the spray include:

- Intense pain and redness in the eyes

- Excessive watering of the eye
- A burning sensation in the throat
- Constriction of the chest
- Choking, coughing, retching
- Excessive mucus production
- Irritation of the skin

Post exposure management and care

On admission or immediately after contamination (or as soon as practicable):-
Staff

If the person requires assistance to get undressed and washed, staff must wear protective clothing, ie Gloves, Plastic gown and Eye protection is advisable if liquid capacitant is still on the clothing
If staff feel the effects of the spray, they should remove themselves from the area immediately (if safe to do so) into fresh air.
If the contaminant is on the skin, wash with copious amounts of cold water. If there is a concern, consult a doctor.

Service User

- The contaminated person should be advised to rinse the face and eyes with copious amounts of cold water, or on the coldest setting available. For extensive contamination, or if the effects are felt on the body, the contaminated person should have a shower, on as cold a setting as possible
- **Hot water re-activates irritants used in the Spray**. If necessary, use a bowl of cool water for the most contaminated areas (probably the face, hair, neck etc.) then a shower.
- Ordinary soap may be used, but it is not essential.
- Skin irritation/blistering can occur up to 72 hours post exposure. Refer to a doctor for advice on treatment if this should happen.

The clothing

- All contaminated clothing is to be removed as soon as possible. Ideally all clothing to prevent further contamination and placed in a sealed plastic bag
- Hand clothing to carer on next visit (or person on discharge) with advice to open bag in well-ventilated area or outside preferably. Also give the carer/person a copy of the instructions on the next page
- Clothing should be hung out to ventilate for a couple of hours before putting through a normal wash cycle using ordinary detergents.
- Contaminated clothing should be washed separately to avoid cross contamination
- Clothing may need to be washed twice to fully remove the Irritant Spray particles.

Note: These instructions may be superseded by infection prevention and control procedures which may be required.

The Area

- The irritant Spray degrades naturally and requires no special procedures other than ventilate the area for 30 – 50 minutes.
- However, excessive use may leave a residual film of particles on surfaces. A simple wipe down with a wet or damp cloth will suffice. If a film is present, it will be potentially uncomfortable if the film is touched, then the eyes rubbed

Information Leaflet for Services Users

ADVICE NOTES FOR PEOPLE CONTAMINATED BY IRRITANT SPRAY ON THE DECONTAMINATION OF CLOTHING

You have been given a sealed bag of clothing.

THIS CLOTHING HAS BEEN CONTAMINATED BY AN
IRRITANT SPRAY AND NEEDS CAREFUL HANDLING
IN LINE WITH THE GUIDANCE BELOW.

The substances used in the irritant sprays are basically harmless, however care should be taken to prevent contamination.

Although the risks are very small, anyone who is prone to asthma should not be involved in managing the contaminated clothing until it has been washed once.

Follow these instructions;

1. OPEN THE BAG IN A WELL VENTILATED AREA, PREFERABLY OUTSIDE
2. USE GLOVES OR TONGS TO HANDLE THE CLOTHING
3. HANG CLOTHING OUTSIDE TO ALLOW IRRITANT SPRAY PARTICLES TO BLOW OFF THE CLOTHING NATURALLY (1-2 HOURS)
4. WASH IN A NORMAL CYCLE USING ORDINARY DETERGENTS. WASH SEPARATELY FROM OTHER CLOTHING FOR THE FIRST WASH
5. CLOTHING MAY NEED TWO WASH CYCLES TO FULLY REMOVE IRRITANT SPRAY PARTICLES

If you feel the effects of the spray, it has not been left outside long enough for the particles to dissipate. Leave the clothing outside, wash your hands and face in cold water. If you have any concerns consult a doctor.