Policy:

NP 030 Use of Force Policy – Prevention and Management of the Use of Force Safe and positive care

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Policy Owner	Director of Quality/Responsible person (Use of Force Act)
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Summary of policy
To provide guidance to statute, procedure, and best practice in relation to the prevention and Use of Force and managing situations that may lead to violence and aggression.
To ensure staff work within the legal frameworks related to the Use of Force, working within a human rights framework and ensure that all practice is trauma informed.

Target audience	All staff working within SHSC

Keywords	Use of Force, violence, aggression, distress, trauma informed practice, prevention, de-escalation, strategies, careplanning, support, information, responsible person, training

Storage & Version Control
Version V5 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (V4 25/01/2021). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
1.0	New draft policy created	10/2014	New policy commissioned by EDG on approval of a Case for Need
2.0	Review/ratification/issue	11/2016	Early review undertaken to update the policy
3.0	Review/ratification/issue	11/2019 – 06/2020	Full review completed as per schedule and to comply with new requirements in law and physical health monitoring
4.0	Review/ratification/issue	12/2020	Short review date of 4 months – next review date 30/04/2021
5.0	Review/ratification/issue	11/2021	Review of policy with additions and policy title change

Contents

1 Introduction

Sheffield Health and Social Care NHS Foundation Trust (SHSC) is committed to providing safe and positive care and ensuring the wellbeing of all its patients, service users, carers and staff. We will ensure our care is the least restrictive, the most positive and takes account of human rights, choice and engagement, and collaboration. We inspire to reduce our restrictive practices, which includes the Use of Force, to the least amount, and where we do use them ensure they are safe and positive, are done in collaboration with service users and their families/carers and are supported by best practice, a clinical model and sit within the framework of trauma informed care and human rights. We will ensure that a responsible person is identified to be accountable for the policy and practice within SHSC and that all training meets the requirements of the Restraint Reduction Network and the Use of Force Statutory Guidance (2021)

"*Every individual has the right to be treated with dignity and in a caring therapeutic environment which is free from abuse. The use of force (which refers to physical, mechanical or chemical restraint, or the isolation of a patient) can sometimes be necessary to secure the safety of patients and staff. The use of force always comes with risk and can be a traumatic and upsetting experience for patients when they are at their most vulnerable and in need of safe and compassionate care. The use of force can also be upsetting for those who witness it, such as other patients or visitors" (Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England and police forces in England and Wales)*

A Human rights-based approach to the use of force

The use of force must be lawful and compliant with the articles of the European Convention on Human Rights as incorporated into domestic law via the Human Rights Act 1998. The Trust will ensure that it has an established mechanism that enables patients to report any potential breaches of human rights.

"*Human rights are the fundamental freedoms and protections which everyone is entitled to. They cannot be taken away – but some rights can be restricted in specific circumstances for a legitimate reason, as long as that restriction is proportionate*".

The Articles of the Human Rights Act 1998 which are pertinent to the use of restraint in mental health settings are:

- **Article 2: Right to Life.**

  This obliges the Trust to protect anyone under its care from risk to that person's life, whether self-inflicted or by another, whether by act or omission. Article 2 imposes a procedural obligation on the Trust to conduct an investigation in circumstances including: where the person has attempted suicide while so detained and has sustained serious injury (or potentially serious injury); where the Trust owed a duty to take reasonable steps to protect the person's life because the person was under the Trusts control or care and the Trust knew (or ought to have known) there was a real and immediate risk to the person's life.

This can also include voluntary patients

- **Article 3: Prohibition of torture, inhuman or degrading treatment.**

  No restrictive intervention should be used unless it is absolutely necessary to do so in all the circumstances of the case. Action that is not proportionate or necessary may well breach a patient's rights under article 3.
  'Inhuman or degrading treatment' does not have to be deliberate and can be unintentional. To avoid this all the individual circumstances of the service users' case should be factored into any application of force.

- **Article 8: Respect for private and family life.**

  Restrictive intervention may breach a patient's article 8 rights if it has a sufficiently adverse effect on the patient's private life, including their moral and physical integrity.

- **Article 14: protects from discrimination.**

In addition to what is set out above as in the Mental Health Units (Use of Force Act (2018) statutory guidance:

- **Article 5** Restrictions that alone, or in combination, deprive a patient of their liberty without lawful authority will breach **article 5** of the ECHR (the right to liberty).

SHSC and its staff are legally obliged to respect patient's rights and take reasonable steps to protect those rights. There are legal frameworks including those under the Mental Health Act 1983 and the Mental Capacity Act 2005 that are designed to ensure that any use of force is applied only after a proper process has been followed. Such legal frameworks require any force used to be necessary and proportionate, and the least restrictive option.

2 SCOPE

The scope of this document concerns 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. It concerns Service Users, Carers, visitors and any member of the public who come into contact with SHSC services. It applies to the full range of SHSC services and includes both physical and non-physical violence and aggression:

• Physical violence and assault
• Self-harm
• Antisocial, offensive or disruptive behaviour
• Verbal abuse
• Threatening language or behaviour
• Harassment

• Damage to personal or Trust property

It is recognised that lone workers face increased risks of violence and aggression due to the circumstances in which they work, without the support of colleagues in an uncontrolled environment. Staff should refer to the Lone Working Policy https://jarvis.shsc.nhs.uk/search?keywords=lone+working+policy

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.

3 PURPOSE

The purpose of this policy is to set out the steps and interventions to prevent flashpoints and conflict that can lead to escalating situations of threat and harm to self or others and in turn can lead to restrictive practice and Use of Force.

To ensure that SHSC meets the legal and statutory requirements as set out in the Mental Health Units (Use of Force) Act 2018 and the Statutory Guidance 2021 which includes :

- Providing guidance on how situations can be dealt with in a way that minimises the risk to users of the service.
- Promotes safety of staff, Service user and all those who come into contact with SHSC services and staff.
- Identifies best practice
- Sets the standards across the Trust
- Ensures safeguards are in place to manage episodes of violence and aggression
- Reduces the use of restrictive practices within the Trust
- Safe use of restrictive practices and use of force as last resort

This policy reflects the requirements as set out by the Trust strategy (2021- 2024) to reduce restrictive practice and sets out our vision for meeting this challenge and how we will go about improving the care and experiences of the people who use our services. https://jarvis.shsc.nhs.uk/documents/least-restrictive-practice-strategy

SHSC will reduce its Use of Force by implementing and embedding the Least Restrictive Practice Strategy workplan supported by the Clinical and Social Care Strategy with its primary focus on prevention. Knowing services users, their strengths and needs and recognising trauma is key to this. De-escalation is a major factor necessary to prevention and reducing impact on service users and staff.

4 Definitions

Violence and aggression
Refers to a range of behaviours or actions that can result in physical / psychological 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.

‘**Physical assault**’ is defined by the Department of Health as:
"The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort."

‘**Non-physical assault**’ is defined by the Department of Health as:
"The use of inappropriate words or behaviour causing distress/or constituting harassment."[1]

Unacceptable behaviour

Unacceptable behaviour may include:

- Offensive or abusive language, verbal abuse and swearing which targets / marginalises people
- Loud and intrusive conversation
- Unwanted or abusive remarks
- Negative, malicious or stereotypical comments
- Invasion of personal space
- Brandishing of objects or weapons
- Physical assault
- Near misses i.e. unsuccessful physical assaults
- Threats or risk of serious injury to a member of staff, fellow service users or visitors
- Abusive telephone calls, emails and letters
- Bullying, victimisation or intimidation
- Stalking
- Alcohol or drug fuelled abuse
- Unreasonable behaviour and non-cooperation such as repeated disregard for NHS policy i.e.
    - Smoking on premises, or
    - Any of the above which is linked to destruction of or damage to property

NB – It is important to remember that such behaviour can be either in person, by telephone, letter or e-mail or other form of communication such as graffiti on NHS property.

Negligible use of force

This describes a use of force that is deemed as negligible, the final definition is still in coproduction; however the following examples are given :

- The use of touch support or assisted walking - guiding by one member of staff to provide redirection or support to prevent potential harm to a person or in support of undertaking an activity of daily living.
- meaning that the contact is so slight that the person can at any time over-ride or reject the direction of the guiding technique and exercise their autonomy.
- It is also essential that guiding through techniques such as touch support or assisted walking does not cause distress to the person.

The duty to keep a record of the use of force does not apply if the use of force is negligible.

If a member of staff's contact or touch with a patient goes beyond the minimum necessary in order to carry out daily therapeutic or caring activities then it is not a negligible use of force and must be recorded.

The use of force is not considered as negligible in the following circumstances if:
1. any form of chemical or mechanical restraint is used
2. the patient verbally or physically resists the contact of a member of staff
3. a patient complains about the use of force either during or following the use of force
4. someone else complains about the use of force
5. the use of force causes an injury to the patient or a member of staff
6. more than one member of staff carried out the use of force

Terms used in this policy

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

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

Breakaway techniques A set of physical skills to help separate or break away from an aggressor in a safe manner.

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

Chemical restraint refers to: 'the use of medication which is prescribed and administered (whether orally or by injection) for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness. Any incident recorded as chemical restraint must meet all the criteria of a restrictive intervention.

De-escalation The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression.

Incident An event or circumstance which could have resulted, or did result in, unnecessary damage, loss or harm to a service user, member of staff, visitor or member of the public under the care of the Trust or on Trust premises. For the purposes of violence and aggression incidents this is any event that involves the use of a restrictive intervention – physical interventions, rapid tranquillisation or seclusion (but not observation) – to manage violence or aggression.

Mechanical restraint is a form of restrictive intervention that refers to 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 (Code of Practice 26.75).

Mental Health Unit is described as a health service hospital or independent hospital in England (or part thereof) that provides treatment to in-patients for a mental disorder.

The types of in-patient service which would be considered within the definition of a mental health unit (this is not an exhaustive list) include:

- acute mental health wards for adults of working age and psychiatric intensive care units
- long-stay or rehabilitation mental health wards for working age adults
- forensic inpatient or secure wards (low/medium and high)
- child and adolescent mental health wards
- wards for older people with mental health problems
- wards for people with a learning disability or autism
- specialist mental health eating disorder services
- acute hospital wards where patients are “detained under the Mental Health Act 1983 for assessment and treatment of their mental disorder”

The following services are considered to be outside of the definition of a mental health unit (this is not an exhaustive list) and therefore not covered by the requirements of the Mental Health Units (Use of Force) Act 2018:

- accident and emergency departments of emergency departments
- section 135 and 136 suites
- outpatient departments or clinics

NB the principles of the Act will be applied

MHA Refers to **‘**Mental Health Act’

Observation A restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with a service user to ensure the service user's safety and the safety of others. There are different levels of observation, as defined in the Observation Policy. An intervention that aims to empower service users to actively participate in their care. Rather than 'having things done to' them, service users negotiate the level of engagement that will be most therapeutic.

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

PRN. (Pro Re Nata) When needed. In this guideline, p.r.n. refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression; it does not refer to p.r.n. medication used on its own for rapid tranquillisation during an episode of violence of aggression

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

RESPECT: RESPECT training is aimed at producing the safest, most effective and ethical solutions to preventing and managing behaviours that challenge.

Respect technique Refers to ‘Restrictive Physical Intervention’ in a manner compliant with what is taught in Respect Training

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

Seclusion Defined in accordance with the Mental Health Act 1983 Code of Practice: 'the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others'.

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.

5 Details of the policy

This policy explains how the prevention and management of violence and aggression, and the use of force should take place within the Trust to maintain safety, dignity and care of those subject to restrictive practice and Use of force.

Where Force is used this will be in line with the Use of Force Statutory guidance (2021) which covers the following requirements

1. Key definitions – identifying the types of force used and which areas are covered by the policy
2. Have an identified responsible person
3. Policy on use of force
4. Information on use of force – details of types and rights, what support is available and published
5. Training in appropriate use of force- trauma informed, person centered, human rights, role of activity, responsibility, careplanning, wishes, techniques, risks, impact, safety, RNN
6. Recording use of force
7. Investigation into injury or death from use of force

6 Duties

All staff working in Mental health settings will have due regard of this policy and its procedural arrangements

Both the ‘responsible person’ and staff working in mental health units ‘must have regard’ to the specific guidance related to the Use of Force Act (2018). It is important that, the responsible person ensures that they and other staff are familiar with its requirements, as departures from the guidance could give rise to legal challenge.

All staff have a responsibility to prevent non-physical and physical assaults, however, some professional groups and managers have specific responsibilities which are detailed within the Procedure. Monitoring of incidents of non-physical and physical assaults is essential for safety of everyone. Staff have a responsibility to ensure accurate and timely reporting of incidents.

Chief Executive is responsible for ensuring that the systems on which the Board relies to govern the organisation are effective.

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.

Responsible Person As directed by the Mental Health Units (Use of Force) Act 2018 SHSC must appoint a 'responsible person' whose role it is to ensure that the organisation complies with the requirements of the Act. The role of the responsible person is nominated as the **Director of Quality.**

- SHSC should ensure that whoever is appointed has the relevant skills and experience to undertake the responsibility of this role.
- SHSC should ensure the **responsible person** has the support of all senior management in performing their role and has the necessary resources available to them.
- The **responsible person** should attend appropriate training in the use of force to ensure they understand the strategies and techniques their staff are being trained in.
- It is important they are guided by the impact of trauma on their patients and the potentially re-traumatising impact of the use of force.
- Within SHSC the **responsible person** is appointed in relation to all the mental health units across the trust. This is to ensure a consistency of approach to the use of force across the organisation.
- The **responsible person** may delegate some of their functions under the Mental Health Units (Use of Force) Act 2018 to other suitably qualified members of staff within SHSC.
- The **responsible person** retains overall accountability for any delegated duties being carried out.
- SHSC will publish the name of the **responsible person**.

Least Restrictive Practice Oversight Group. The purpose of the group is:

- To oversee development, dissemination and implementation of the Trust-wide strategy on restrictive practice.
- To oversee the development, implementation and regular review of policies and procedures related to restrictive practices and de-escalation to support the delivery of the Trust's strategy on restrictive practice.
- To ensure the Trust discharges its duties in the use of restrictive practices in line with legislation as articulated within Human Rights, Mental Health Act, The Mental Capacity Act and The Mental Health Units (Use of Force) Act 2018.
- To oversee and critically reflect on the use restrictive practice across all care pathways within the Trust, including oversight of evaluation of embedding the clinical model application.
- To enable the voice of lived experience to influence the policy and development of practice within the Trust through appropriate representation
- To receive reports from the Operational Restrictive Practice Forum including analysis of restrictive practice data across the Trust, considering themes and ensuring shared learning from incidents.
- Ensure **data** is being used effectively at patient, team, and strategic level
- Create and communicate an environment and culture in which promotes appropriate and best practice use of restricted practice for positive patient care and staff safety.

- Receive assurance from the RESPECT team on provision and uptake of training aligned to national standards to ensure compliance of approved techniques in practice.
- To receive recommendations which identify emerging good practice both nationally and internationally and consider local implementation where appropriate, updating local policy and strategy as required.
- Ensure effective working across Trust services including interface with Estates and Information Technology to ensure consideration of restrictive practice within the environments in which patient receive care; including transport.
- Receive assurance on the use of medical devices within the organisation related to the use of restrictive practices.

Respect Instructors are responsible for delivering training (as appropriate to job role requirements) within SHSC. Trainers will meet all the requirements as set out by the Restraint Reduction Network (RRN) and are assessed on a yearly basis. They also support into clinical ward areas in support of the view to reducing restrictive practice.

The Respect Professional Lead for Training 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.

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 the use of force, aggression, violence or restrictive practice.
- Ensuring that there is a regular and comprehensive general risk assessment to ensure the safety of the environment
- 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.

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.

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).

All 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.

7 Procedure

7.1 Principles

The requirement is to reduce or prevent Use of Force as a means to manage an incident event or behaviour of a service user.

Primary strategies and secondary strategies must be employed in the first instance which take account of the individual circumstances of the service user and seek to identify strengths and needs.

If threat of harm to self or others is predicted, then advance careplanning and Positive Behaviour Support plans should be incorporated

Where threat or harm is unpredicted staff should take steps to minimise Use of force and harm. This will involve using a range of skills and techniques to diffuse situations that are creating distress and conflict and leading to the threat of harm.

Minimising the risk of harm (physical or psychological) of all involved and prevent traumatisation.

Action should be taken using the skills of de-escalation as appropriate to the situation. It is therefore essential that **all** staff have received appropriate training.

7.2 Lone Working

Refer to the **Lone Working Policy** and Local area risk assessment management plans and procedures.

7.3 Responding to verbal abuse over the telephone

Should a caller become abusive or demeaning in any way SHSC does not expect its staff to have to continue with that call.

The caller must be advised that this is not appropriate and that if the abuse continues, they will end the phone call. If the abuse, then does continue staff will inform the caller that the phone call is ending and terminate the call. The nature of the call should be recorded, and the matter discussed with the line manager or deputy for further action depending on the Trust involvement with the caller, mitigating circumstances and the level of risk. All actions must be fully documented as set out within this policy.

7.4 Advance Statements and Decisions

Advance statements and decisions might have an important role in management and prevention of aggression and violence. (NICE 2015)

Staff should check on admission with the service user and on Electronic Records if they have made an advanced decision in relation to restrictive interventions and whether a decision maker has been appointed to them.

More information on Advanced Statements and care plans can be found here

https://jarvis.shsc.nhs.uk/search?keywords=advanced+care+planning&audience=All&type=All&sort_by=search_api_relevance

7.5 Care Planning (inc advocacy and family)

Service users' families, carers and advocates should wherever practicable and subject to the service users wishes and their right to confidentiality be involved in the planning, reviewing and evaluating of all aspects of care and support. (DoH 2014). If a service user is unable or unwilling to participate staff should offer them the opportunity to review or revise the plans as soon as they are able.

Staff should use the Collaborative Care Planning section on the electronic record which also indicates service user involvement in the process of planning care.

7.6 Inpatient Areas – Mental Health units (135/136 health-based place of safety)

SHSC fosters the Respect ethos which is a values-based approach that focuses on preventative measures such as occupation, meaningful engagement, pro-active recognition of service users in distress, and de-escalation of potential aggression and the use of interventions which minimise the risk of its occurrence.

Meaningful activity will be encouraged within the use of 1:1 sessions identifying what the service user likes to do, what they need to do to assist in their recovery and what they want to achieve from their admission.

The manifestation of violence and aggression depends on a combination of intrinsic factors, such as personality characteristics and intense mental distress and other factors, such as the attitudes and behaviours of surrounding staff and service users, the physical setting and any restrictions that limit the service users' freedom.

SHSC's approach to managing and/or preventing violence from escalating is by using a graded set of interventions as taught within Respect Training.

1. proactive strategies (prediction, prevention, promoting meaningful engagement)
2. de-escalation techniques
3. disengagement techniques
4. restrictive interventions (increased observation levels, rapid tranquilisation, RESPECT holding techniques and seclusion)

Staff will systematically use level 1 first and only if this is unsuccessful should they proceed through the other levels. Restrictive interventions should only be used as a last resort and for the shortest time possible and where there is immediate risk to the service user or others.

Restrictive interventions will never be used to punish, inflict pain, suffering or humiliation or to establish dominance.

When managing violence and aggression staff will ensure that the service user's dignity and safety and the safety of others is paramount.

7.6.1 PROACTIVE APPROACH - PRIMARY PREVENTATIVE STRATEGIES

At SHSC we will adopt a Person Centred-Care approach - We will always seek to work in partnership with our service users and empower them by involving them where possible (within the limits of their mental health condition and capacity) in all decisions about their care and treatment, paying particular attention to their individual needs, preferences, choice and human rights.

We will ensure service user rights are upheld by making any adjustments to services required for those with protected characteristics as defined by the Equality Act, 2010. This will be recorded in the care plan.

7.6.2 DE-ESCALATION - SECONDARY STRATEGIES

Staff are trained in the use of de-escalation which includes:

• how to recognise the early signs of agitation, irritation, anger and aggression
• how to understand the likely causes of aggression or violence both generally and for the individual service user
• use techniques for distraction and calming and ways to encourage relaxation
• recognise the importance of personal space
• respond to a service users anger in an appropriate, measured and reasonable way and avoid provocation

(all the points above this should form part of the care plan and should be directed by the service user)

Good practice in de-escalation is that 1 staff member will take the lead. They should be the lead in communicating with the service user; they should assess the situation in terms of safety and use non-threatening communication to try to calm the situation. If possible you may want to ask the service user to speak with you in a quieter area of the unit.

Disengagement techniques

Sometimes the safest and most appropriate response will be to explain that you will leave the service user alone to give them some space, this must be risk assessed as being an appropriate response in each situation.

7.6.3 TERTIARY RESTRICTIVE INTERVENTIONS

Restrictive interventions should only be used if all other preventative strategies or de-escalation have been tried and failed and there is potential harm to the service user or others if no action is taken. This means that they are used as a last resort.

Service users, and where appropriate their families and carers, should be provided with information about the use of force and their rights in relation to any use of force which may be used by staff in a mental health unit.

During any restrictive intervention staff should continue to attempt de-escalation. The restrictive intervention should end as soon as it is not required.

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.
- take in to account protected characteristics

It is expected that staff undertaking planned physical interventions have been trained by attending and passing the appropriate level of accredited Respect Training. Individual team training requirements will be available via the team manager.

Incidents that occur very suddenly and without time to de-escalate or summon help may require immediate physical interventions. The use of such intervention is acceptable in law providing the amount of force is necessary and proportionate that is sufficient to stop the attacker and/or stop injury to yourself or others.

7.6.4 Safety requirements in the use of restrictive interventions

Use of Force Act 2018.

- people must not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen.
- there must be no planned or intentional restraint of a person in a prone or face down position on any surface, not just the floor.
- if exceptionally a person is restrained unintentionally in a prone or face down position, staff should either release their holds or reposition into a safer alternative as soon as possible.
- staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purpose of an immediate rescue in a life-threatening situation

SHSC Respect Training

- Hold only long bones e.g. Forearms, Upper arms and Legs.
- Monitor for signs of distress or injury and end the physical intervention as appropriate.

NICE guideline [NG10] Violence and aggression

- Do not routinely use manual restraint for more than 10 minutes.
- Consider rapid tranquillisation or seclusion as alternative to prolonged restraint (longer than 10 mins)
- One staff member should lead throughout the use of manual restraint. This person should ensure that other staff members are: able to protect and support the service user's head and neck, if needed able to check that the service user's airway and breathing are not compromised able to monitor vital signs supported throughout the process.
- Monitor the service user's physical and psychological health for as long as clinically necessary after using manual restraint.

SHSC utilises RESPECT techniques in regard to managing violence and aggression, RESPECT incorporates manual restraint techniques that fully comply with NICE and RRN STANDARDS in respect to managing violence and aggression.

7.6.5 Planned Restraints

Where restraint is has been identified as likely to occur within a planned intervention the person leading needs to assess the composition of the team and respond appropriately in considering gender and the persons own wishes as outlined in their care plan as far as is reasonably practicable in the circumstances.

Where staff are responding in an emergency the lead should consider the team composition so that staff can change in and out of holds following initial engagement.

One staff member will lead this intervention and will co-ordinate all staff. SHSC will only support a service user to the floor in the supine position where other, less intrusive strategies have failed to contain the situation. All staff engaging in this intervention must ensure they comply with the safety requirements outlined in 7.6.4

In addition staff must

- Communicate with the service user throughout, explaining continually what is happening and why.
- Only recognised physical interventions approved by the Trust should be used.
- Take extra care if the service user is pregnant, physically unwell, disabled or obese.
- Aim to preserve the service users dignity and safety, ensuring the service users head and neck is supported if needed.
- Monitor vital signs throughout the intervention.
- Ensure that the level of force applied during any manual restraint is justifiable, appropriate, reasonable, proportionate to the situation and applied for the shortest time possible
- If consent and co-operation for physical observations is not forthcoming from the service user, then it should be clearly documented in their records why certain checks could not be performed and what alternative actions have been taken.
- Staff not involved in the incident to remain with other service users, if other service users are present within the unit / department.
- Emergency resuscitation equipment should be available and staff should be trained in its use.

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.

Releasing a person from a physical intervention should take place at the earliest opportunity and staff should be guided by the lead person managing the incident. The

principles of ‘Gradient Support’ should be adopted by staff as per training. The service user should be informed of what is happening and why it is happening and what the expectations are from them when they are released. Staff should obtain agreement on immediate future actions, from the service user prior to release.

7.7 Types of restraint/Use of force

7.7.1 Prolonged Restraint

Where a Supine Restrictive Physical Intervention has been used in excess for 10 minutes then medical assistance must be sought through either the Responsible Clinician or On-Call rota for further advice.

The clinical team working with the service user should

- Consider rapid tranquillisation or seclusion as alternatives to prolonged use of physical interventions (longer than 10 minutes).
- Ensure robust physical health monitoring is in place to identify any potential cardiac or respiratory difficulties due to prolonged restraint
- Escalate concerns of the ongoing risk of physical restraint
- Complete an incident form

Post Incident: all incidents of prolonged restraint will be followed up by a manager through the use of incident reporting, they will

- see the service user as soon as possible;
- visit and talk to the service user about the incident and ascertain if he or she has any concerns or complaints and if so assist in putting them forward.
- Where appropriate inform family or advocacy to support the service user
- Consider psychological support to manage the trauma associated with the incident

The ward/on-call manager may delegate this task to a member of staff who has a good relationship with the service user.

The Respect Team can be contacted for advice when available.

7.7.2 Prone Restraint

SHSC no longer provides training in the use of prone techniques however recognises that at times service users can end up in a prone position for a number of reasons outside of staff control. Where this occurs it is essential that the service user is repositioned into a supine position as soon as practicable.

Any positioning in the prone position, even if for 5- 10 seconds must be reported via the Ulysses incident reporting system. The incident will then be reviewed to consider if further investigation is required.

7.7.3 Rapid tranquillisation (RT)

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

Rapid tranquillisation refers to the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression.

This policy should be used in conjunction with what is set out in the SHSC Rapid Tranquillisation Policy and Guidelines for Inpatient Wards.

7.7.4 Seclusion and Long Term Segregation

There may be times when an individual using Trust services and detained under the Mental Health Act may need to be moved from the communal ward environment and placed in seclusion or segregation away from others for the safety of themselves or others as a last resort.

In these instances staff should refer to the Trusts policy on The Use of Seclusion and Segregation (inc. Long Term).

7.7.5 Safety Pods™

Safety Pods have been introduced as an approach to support de-escalation thus preventing and managing aggression within the Trust using the least restrictive options. Currently the only Safety Pod which has been authorised for use is the Ultra-Shield Pod (For further advice / guidance please contact the Respect Team).

Training has been developed / incorporated into the Respect Training modules to meet the specific needs of introducing the Pods into clinical practice and staff must be trained in their use prior to using them.

Where the safety pod is used as part of a restrictive practice this is to be indicated within the e-incident reporting system.

The use of safety Pods maybe incorporated in the service user's person centred care management approach.

The SOP for **Safety Pods™** is included in appendix

7.7.6 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 in the form of handcuffs, soft cuffs or other devices to restrict and subdue an individuals movements is not permitted for SHSC clinical staff.

There may be times when a service user is brought to the 135/136 health based place of safety or a ward in handcuffs or other mechanical restraint aids by external

agencies including the police. In these circumstances staff must document their use via incident forms and compete a body map of any bruising relating to the use of mechanical restraint.

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. Post incident support is necessary.

Other uses of mechanical restraint

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
- Safely allow someone to travel in a car or bus (the use of seat-belts, where provided, is required by law)

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 bed rails and safety helmets. The use of bed rails must be managed aligned to the Bed Rail Policy. Safety helmets must only be utilised when prescribed and fitted by professional clinical staff and documented for use in the care plan.

The use of mechanical restraint, including using a sheet or mattress to re-locate a patient is permitted to facilitate safe exit from a building or area in a fire evacuation, in line with appropriate moving and handling techniques.

7.8 WEAPONS

Offensive weapons are defined in the Prevention of Crime Act 1953: as any article made or adapted for use for causing injury to the person, or intended by the person having it with him for such use by him or by some other person.

Where staff are threatened with a weapon, attempts should not be made to physically disarm the individual. Ask the service user to put the weapon down but on no account ask for the weapon to be handed to yourself.

Those present should attempt to keep the situation contained and call the police for assistance. They must also maximise withdrawal of others and themselves from the situation where possible.

7.9 Practice Issues and Potential Use of Physical Interventions

Physical Interventions can be used in order to undertake different forms of treatment where there is legal authority to treat the individual without consent. It should not be used unless there is such legal authority. (e.g. prevention of Self-Harm, Personal

Care, Vaccines, Medication, Medical investigations etc.). advice on the appropriate legal frameworks can be sought from the mental health legislation team.

7.9.1 Clinical Holding

Clinical holding is a restrictive intervention and therefore MUST be reported on the Trust incident system every time a restraint classified as clinical holding is utilised.

- A definition of Clinical Holding as taken from the Mental Capacity Act is 'The use of restrictive physical interventions that enable staff to effectively assess or deliver clinical care and treatment to individuals who are unable to comply.'
- Clinical holding may be defined as the proactive holding of part of the body to allow a procedure to be carried out, e.g. holding an arm while blood is being taken in order to prevent reflex withdrawal and consequent unnecessary pain, distress or injury to the patient, staff or accompanying persons.
- Clinical Holding interventions are planned interventions and therefore must be care planned accordingly.
- Clinical Holding should not routinely require a full National Early Warning Score (NEWS 2) to be completed, unless there is a clinical need.

7.10 Physical Health Care for the Service User Following Restrictive Interventions

Once the Supportive Interventions has ceased, a series of **physical observations** should be carried out and recorded. The following should be monitored;

- Pulse rate
- Respiration rate
- Blood pressure
- Temperature
- Oxygen saturation via pulse oximeter
- Fluid and food intake and output
- Level of alertness and consciousness

Staff should also look out for

- Verbal complaints of pain and discomfort
- Non-verbal clues to pain or discomfort (especially if verbal communication is identified as difficult)

Physical monitoring is especially important:

- Following a prolonged or violent struggle
- If the service user has been subject to enforced medication or rapid tranquillisation
- If the service user is suspected to be under the influence of alcohol or illicit substances
- If the service user has a known physical condition which may inhibit cardiopulmonary function e.g. asthma, obesity

Where it is not possible to get consent for obtaining vital signs though heightened distress, unwillingness or physical barriers staff should document what they can observe from a distance and document why they were unable to obtain vital signs.

7.11 Observations

There may be times when enhanced levels of observation are required for the short-term management of behavioural disturbance or during periods of distress to prevent suicide or serious self-harm. (CoP 26.30).

Staff should balance the potentially distressing effect on the individual of increased levels of observation, particularly if these are proposed for many hours or days, against the identified risk of self-injury or behavioural disturbance. (CoP 26.34)

Staff should refer to the policy on Observation of In Patients - Routine and Enhanced Observations of Patients.

7.12 Immediate Post Incident Debrief

After using restrictive interventions and the risk of harm has been contained the senior nurse and doctor should conduct a post incident debrief. Debrief cannot prevent reactions from occurring but can provide a framework for the individual to contain them and provide opportunities to take further action to resolve distress. It aims to prevent the development of further adverse reactions and minimise the occurrence of unnecessary psychological and emotional suffering.

De-brief should also be offered to other people who may have witnessed the incident. All involved should feel supported and be given an opportunity to talk about and work through their experience.

The debrief should identify if any individual has been particularly upset by events and the senior member of staff should meet with them to explore their need for further support. The debrief should also identify the factors that led to the event and any factors that can be addressed quickly to reduce the likelihood of a further incident.

7.13 Support for Service User Following Restrictive interventions and Use of Force

Service user's experiences of staff dealing with aggression and violence can have a traumatic effect on their wellbeing and future recovery, therefore following an incident; the service user must be offered post incident support.

Staff should plan the process of re-integration **with** the service user into the ward area carefully, taking into account the individual needs and risks posed, so previous and current experiences of such events are considered to facilitate a value based approach to post incident support. Where a service user does not have the capacity to engage in

this process, staff are to ensure they are aware of the recovery phase which can be documented in the Collaborative Care Plan and use these strategies.

This process should allow for opportunities to revisit any identified concerns or issues, so the level of support is continuous and relates to on-going care and presenting needs. The steps would include:

- The Service User Post Incident Review form on insight should be completed in collaboration with the service user.

- All incidents are reviewed to offer immediate support so as to understand the impact of events and where possible proactive support is developed. This should be developed through on-going assessment, joint support plans, considering the impact of previous experience.

Where practical to do so, support plans or the development of support plans are jointly reviewed to reflect presenting needs, this may include:

- Considering the facts and how they were seen by all parties: does the service user understand why restrictive practices were used and is there an opportunity to give context, emerging thoughts and feelings relating to such events
- How does the service user feel now, after the event?
- Does the service user feel that restrictive practices were necessary / proportionate?
- what is the outcome and plan to manage / resolve and support?: It is important to document actions, immediate plans and how differences / ongoing protection may be reconciled
- How can we minimise the need for any further episodes of restrictive practices in the future?
- Being proactive: One to one review and basic support
- A review of support plans
- Aim to facilitate additional support based on need – this must include the view of the service user and where appropriate and consent given: relatives carers, spiritual care, external advisers.
- Offer agreed follow-up and review, so events are not stand alone, but a review and joint plan of continuous needs

Ensure that all details of post incident support process are fully recorded on Insight as part of the daily running record. This should include what or how on-going support / follow-up will look like. The Collaborative Care Plan should be updated to reflect this.

Following the use of restrictive practices it is essential that the clinical staff re-establish the therapeutic relationship with the service user.

Service users who are assaulted have the right to make a complaint to the Police. Staff should support service users in this process. The manager of the area should be informed if Police are contacted.

7.14 Staff Support following Incidents

Post-incident support is essential and part of good management practice. It aims limit wherever possible the effects of exposure to distressing workplace events which can be traumatising or re-traumatising for staff as well. Responding appropriately to the needs of our staff who have been through distressing experiences is important and the Trust will aim to make sure that everyone who has been involved in an incident can feel supported and be given an opportunity to talk about and work through their experience. Initially this support should be offered through the clinical management structure.

A review of whether members of staff require medical treatment, sick leave or temporary relief from duty must be carried out by the Line Manager, or Deputy and appropriate arrangements made as detailed in the Promoting Attendance Policy. A review and assessment of working practices and security measures must be carried out and appropriate changes made. Where changes are required, but cannot be implemented, these must be reported to Line Managers immediately.

When a member of staff has been involved in an incident, the Line Manager should ensure the member of staff has the contact details of the appropriate staff counselling service. The Line Manager should discuss the issue of prosecution and refer to the trust Security Policy.
If the member of staff requires sick leave, the Line Manager should establish how frequently the member of staff would like to be contacted. Staff may feel very isolated if they are away from work, and unable to discuss the events.

Managers should ensure RIDDOR is followed if appropriate, managers should also check how the staff are feeling when they return to work, and at intervals following the incident

Where staff require further support staff or managers should review the Support section on the intranet referring to each section as needed. Access to Workplace Wellbeing and IAPT is available through this section of the intranet.

7.15 SHSC staff use of restraint/Use of Force in other hospital settings (non SHSC)

This policy is applicable only within the defined mental health units governed by SHSC. This includes Service users who are under the care of SHSC Psychiatric Liaison in STH premises or service users who are admitted to Sheffield teaching hospital.

Any consideration of the use of force outwith SHSC mental health units MUST be discussed with the Medical Director and/or Exec Director of Nursing, Professions and Operations and/or Director of Quality. Out of hours this enquiry should go via the Director on call.

The overriding principle is that there is no legal framework for SHSC staff to restrain individuals in premises outwith SHSC aligned to the Use of Force Act.

7.16 Unacceptable Behaviour

All Unacceptable Behaviour by staff, service users, visitors, relatives or carers will be taken seriously and must be reported in line with the Security policy and Incident Management Policy and also where appropriate to the police.

All behaviour has a function (sensory, pain, distress, seeking care/unmet need, escaping/avoiding an event/place/person). It is important the functions of the behaviour are considered and responded to in a timely manner.

A range of measures can be taken by the Trust (depending on the severity of the situation) to assist in the management of unacceptable behaviour by seeking to reduce the risks:

- Clinical risk assessment and review of service provision.
- Subsequent Action
- Informal / formal notification letters
- Withdrawing Treatment
- Human Resources Procedures where issues relate to staff members

7.17 Withdrawing treatment

SHSC supports a zero tolerance of violence and aggression framework and will support clinical teams and staff in consideration of the withdrawal of treatment for service users where there has been evidence of deliberate aggression and violence not owing to their mental health.

The withholding of treatment from the NHS will always be a last resort but it is an option available to managers and staff working in the NHS.

In any case being considered for treatment withdrawal an appropriate risk assessment must be formulated that details the reasons why the withdrawal of treatment is being considered, the best option and alternatives to treatment are offered, options must also include different provider organisations.

This must be documented and SHSC's Medical Director and Director of Nursing, Professions and Operations must also be involved in these considerations so that the appropriate legal guidance and duty of care considerations are incorporated.

This also will ensure that SHSC is supporting teams in this difficult area

7.18 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 service user 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.

7.19 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 refer to the medicines policies on the intranet.

7.18 Use of transport (secure and non-secure)
To be read in conjunction with Conveyance and Assistance policy

South Yorkshire Police (SYP) or contracted secure transport services may on rare occasions bring service users in to SHSC care utilising handcuffs or leg restraints. 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.

7.19 Advocacy

Advocacy must be offered to all service users at the point of admission. Where a service user declines but is subsequently subject to a restrictive intervention, this should be offered again as a supportive mechanism.

7.20 Safeguarding

All incidents are reviewed daily in the trustwide incident huddle which includes safeguarding practitioners. Where staff are concerned that the use of a restrictive practice constitutes a safeguarding concern they should “tick” the safeguarding box on the incident form.

Staff can contact the SHSC safeguarding team during working hours for advice and support related to any aspects of clinical care.

7.21 Involvement of families and carers

Involving others can be key to good careplanning and prevention. Whilst it is acknowledged that some service users do not wish their families or cares to be involved the team caring for the service suer should take all steps to understand the relationship and involve where appropriate to do so.

7.22 Information on use of force

Service users, families and carers will be provided with information about the use of force and their rights in relation to any force which may have been used by staff. This will include what help and support is available to them should they need it.

7.23 Incident Reporting

For all Internal Reporting Requirements please refer to the **Incident Management Policy and Procedure**

Statutory Guidance on what is to be included in incident reports where the Use of Force has been applied:

- the reason for the use of force
- the place, date and duration of the use of force
- the type, or types of force used on the patient
- whether the type or types of force used on the patient formed part of the patient's care plan
- name of the patient on whom force was used
- a description of how force was used
- the patient's consistent identifier
- the name and job title of any member of staff who used force on the patient
- the reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient
- the patient's mental disorder (if known)
- the relevant characteristics of the patient (if known)
- whether the patient has a learning disability or autistic spectrum disorder
- a description of the outcome of the use of force
- whether the patient died or suffered any serious injury as a result of the use of force
- any efforts made to avoid the need for use of force on the patient
- whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan

The Training Needs Analysis in Appendix details the types of holds and breakaway techniques used within SHSC.

7.24 Complaints

Any complaint made against staff as a result of a violent incident including what the service feels was an inappropriate use of force or where too much force was applied will be investigated through the appropriate SHSC's procedure including complaints, safeguarding or performance procedures.

Service Users and Carers should be supported through this process.

Staff are also encouraged to consult their own professional association or Trade Union for advice.

7.25 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.
(ii) SAFEGUARDING ADULTS/CHILDREN POLICIES AND PROCEDURES
(iii) DISCIPLINARY POLICY/CAPABILITY POLICY

7.26 Respect Training

'RESPECT' Training is a training package designed to prevent, de-escalate and manage challenging situations. A person-centred approach based on support does not control.

RESPECT training meets the NHSE contractual standards for such training and these are assessed on an annual basis aligned ot the Use of Force Act. More information on the standards can be found here: The Restraint Reduction Network

It is the role of the Respect Professional Lead for Training to ensure that standards are met and adhered to.

Support from the 'RESPECT' Instructors is available in work bases areas in between training sessions to enhance the skills and confidence of staff. If no instructors are immediately available, then they can be contacted through switch or by emailing RespectLevel3Trainers@shsc.nhs.uk.

Staff are expected to complete training as outlined in SHSC's Training Needs Analysis – identified individually on the Electronic staff Record (ESR)

Where staff who have attended the relevant training and have been 'referred' or 'failed' to achieve the required learning objectives then the line manager must complete an occupational risk assessment and liaise with human resources regarding the appropriateness of continuing to work within the area.

All staff are responsible for maintaining their required level of training identified within the ESR for their need including refresher training.

All bank staff should have received the relevant Trust training for the area they are required to work in as discussed above before being employed in those areas. Where this is not the case then the bureau / agency should manage the situation as above.

8 Development, Consultation and Approval

Consultation on the Use of Force took place between March 2021 and November 2021 by undertaking a number of sessions Trust wide and team based, with service users and staff.

The Use of Force Act statutory guidance (2021) has been incorporated into this policy

The Reducing Restrictive Practice operational group has contributed to the review

9 Audit, Monitoring and Review

Incidences of violence and aggression and the Use of Force are reported and reviewed by Risk department and local area managers. Incidents are monitored, discussed and reviewed by the Trust Risk Safety Huddle. Incidents are reviewed by the Respect Professional Lead for Training when requested.

SHSC provides periodic analysis of incidents to both the Least Restrictive Practice Oversight Group, SHSC Board and clinical/service areas.

Trust, Directorate and team dashboards are available in order to support learning, identify themes and any areas for address or improvement.

Such reports should follow guidelines from the Mental Health Units (Use of Force) Act 2018 statutory guidance to include:

- when force is used, does it meet the justification threshold of imminent or immediate risk of harm to self or others
- is there a reduction in the average duration when force is used
- was the level of force proportionate in all cases
- is there an overall reduction in the use of physical restraint
- is there a reduction in the use of prone and supine restraint
- is there a reduction in the number of complaints from patients and families or carers following the use of force
- is there a reduction in the number of injuries to patients and staff following the use of force?

An audit programme is available to support audit and review of the standards related to restrictive practice and the Use of force, specifically to seclusion, restraint and rapid tranquilisation. Audits will be performed after each event and reports are available to establish if standards are being met.

SHSC have a responsibility to consider the detail behind the data to evaluate if our wider approaches to minimising the use of force are effective. Success should not be measured on a reduction in the number of reported incidents alone.

This data and its analysis will be vital in informing the SHSC's plan to reduce the use of restrictive interventions.

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
Monitor use of force and relevant standards related to Statutory guidance	Incident reporting Dashboards Thematic analysis Complaint and concerns Audit	Patient safety team Business support team Nurse Consultant Least Restrictive Practice oversight group	On event for use of restraint, seclusion and RT Quarterly for incident data and complaints	Mental Health Legislation Committee	Reducing Restrictive Practice Operational group	Least Restrictive Practice oversight group

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change.
Review date: April 2022

10 Implementation Plan

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and remove old version	*Chief Nurse*	*01/12/2021*	
Make teams aware of revised policy	*Team manager* Comms Lead	*31/12/2021*	
Integrate policy into Relevant RESPECT training	*Professional lead for RESPECT*	*31/01/2022*	
Develop sessions to share policy requirements across the Trust via existing forums and establishing teams session (e.g. QIF, SUNRISE etc)	*Professional lead for RESPECT and Nurse Consultant for Restrictive Practice*	*31/01/2022*	

11 Dissemination, Storage and Archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0, 2.0. 3.0	Versions no longer available			
4.0	January 2021			
5.0	December 2021	December 2021	December 2021	

12 Training and Other Resource Implications

The revised policy will be included as an update within the relevant RESPECT training.

Presentations across the Trust will take place to enable understanding of the requirements of the policy and its standards.

Training has commenced on the use of the audit tool related to the Perfect ward audit – specific to seclusion, restrain and rapid tranquilisation.

Other training plans (personal safety, trauma informed practice and care, human rights, autism, clinical risk management and medicines management) is being progressed linked to the Clinical and Social Care strategy, the risk management strategy and the Least restrictive Practice strategy.

Ward and team managers and lead will be expected to deliver local sessions on the revised policy and its requirements to enable discussion and increase understanding

13 Links to Other Policies, Standards (Associated Documents)

The policy is set out to meet the requirements from; The Mental Health Units (Use of Force) Act 2018 as set out in the Mental Health Units (Use of Force) Act 2018 statutory guidance for NHS organisations in England and police forces in England and Wales (2021) and fully supports the recommendations of Violence prevention and reduction standard (2020), Positive and Proactive Care: reducing the need for restrictive interventions (2014), Restraint Reduction Network (RRN) Training Standards (2019), NICE - Violence and aggression: short-term management in mental health, health and community settings (2015), Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings (2016).

The Trust also recognises it has an obligation under the Health and Safety at Work etc. Act (1974) and the Management of Health and Safety at Work Regulations (1999), for the health, safety and welfare at work of its staff.

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
Conveyance policy
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

14 Contact Details

Title	***Name***	***Phone***	***Email***
Director of Quality and Responsible person	Salli Midgley	01142711136	Salli.midgley@shsc.nhs.uk
Professional Lead for RESPECT	Greg Hughes	01142716802	Greg.hughes@shsc.nhs.uk
Health and Safety Manager	Samantha Crosby	01142718260	Samantha.crosby@shsc.nhs.uk
Nurse Consultant for Restrictive Practice	Lorena Cain	01142718331	Lorena.cain@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date:	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - 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 and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	**Does any aspect of this policy 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. It covers all adults within SHSC**		
Disability	**No. It covers all adults within SHSC**		
Gender Reassignment	**No. It covers all adults within SHSC**		
Pregnancy and Maternity	**No. It covers all adults within SHSC**		

Race	**No. It covers all adults within SHSC**		
Religion or Belief	**No. It covers all adults within SHSC**		
Sex	**No. It covers all adults within SHSC**		
Sexual Orientation	**No. It covers all adults within SHSC**		
Marriage or Civil Partnership	**No. It covers all adults within SHSC**		

Please delete as appropriate: no changes made.

Impact Assessment Completed by: Lorena Cain
Name /Date 22/11/2021

This policy can be applied to all service users and staff within SHSC, recognising that there are some people with protected characteristics and that care delivery is required to be person centred, culturally appropriate and equal and diverse. Access to specialism in key areas is available and work is being progressed, related to the Least Restrictive Practice strategy, in relation to the use of force with people from BAME.

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	yes
2.	Is the local Policy Champion member sighted on the development/review of the policy?	yes
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A Review of policy
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	Yes – via least restrictive consultation
5.	Has the policy been discussed and agreed by the local governance groups?	yes
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	yes
	Template Compliance	
7.	Has the version control/storage section been updated?	yes
8.	Is the policy title clear and unambiguous?	yes
9.	Is the policy in Arial font 12?	yes
10.	Have page numbers been inserted?	yes
11.	Has the policy been quality checked for spelling errors, links, accuracy?	yes
	Policy Content	
12.	Is the purpose of the policy clear?	yes
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	yes
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	yes
15.	Where appropriate, does the policy contain a list of definitions of terms used?	yes
16.	Does the policy include any references to other associated policies and key documents?	yes
17.	Has the EIA Form been completed (Appendix 1)?	yes
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	yes
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	yes
20.	Is there a plan to i. review ii. audit compliance with the document?	yes
21.	Is the review date identified, and is it appropriate and justifiable?	yes

Appendix C

Additional clinical guidance

Showing respect for diversity generally includes the following:

- creating and sustaining inclusive environments where every patient feels valued, listened to and supported.
- recruiting and supporting diverse staff groups which reflect the local community.
- positively challenging practices and behaviour which have the potential to cause patients or staff to feel degraded and/or excluded.
- an outline of the law covering all the protected characteristics under the Equality Act 2010; this should recognise the distinct experience of abuse, discrimination and inequality experienced by groups with different protected characteristics.
- how to demonstrate respect for individual beliefs, values, cultures and lifestyles and appreciating the differences.

Avoiding unlawful discrimination, harassment and victimisation includes the following:

As with 'Showing respect for diversity generally' an outline of the law covering all the protected characteristics under the Equality Act 2010; this should recognise the distinct experience of discrimination, harassment and victimisation experienced by groups with different protected characteristics. This should cover in particular:

- direct discrimination (for example on the basis of disability, race, age, or sex).
- indirect discrimination.
- reasonable adjustments, and how they are relevant to use of force (for example environmental changes).
- The Public Sector Equality Duty
- how use of force monitoring and data can identify themes and issues which affects those involved (patients, staff and managers) and in turn, how this should be acted upon.
- the important role of independent advocates in helping patients to challenge the inappropriate use of force

The use of techniques for avoiding or reducing the use of force includes the following:

- understanding the challenges and constraints experienced living in mental health units (for example the impact of living under blanket restrictions, sensory issues, missing family and friends, being away from familiar surroundings, or feeling unsafe)
- recognising the high levels of trauma amongst patients in mental health units, particularly among women and girls, people with autism or a learning disability, and people from black and ethnic and minority backgrounds
- creating positive physical environments
- person-centred care, including preventative approaches such as Safewards and where applicable Positive Behaviour Support
- conflict avoidance and resolution (within inter-personal relationships and groups)
- staff clinical supervision, reflective practice, and development and mentoring

- understanding of the difference between coercion or threatening to use force and de-escalation so that staff understand that trying to gain compliance through coercion or threats is not ethical or in line with the least restrictive approach (see the section on training to understand the effect of a threat to use force and coercion)

The risks associated with the use of force includes the following:

- preparing care plans which identify individual risks associated with the use of force, and how these risks are minimised (including by not using force)
- physical, psychological and emotional effects on those subject to the use of force
- physical, psychological and emotional effects of witnessing the use of force
- physical, psychological and emotional effects on staff applying the use of force
- the risk of deaths and serious injuries caused by, or connected to, the use of force
- medical emergency procedures – to include vital signs monitoring and response, and raising the alarm if concerned about a patient's health
- roles and responsibilities during an incident – in the exceptional event of the police being called to assist staff in the management of a patient, it is important that everyone is aware of the role of the police and the healthcare staff in managing the incident properly and safely, and the procedures to be followed

The impact of trauma (whether historic or otherwise) on a patient's mental and physical health includes the following:

- the impact of sexual, physical and emotional abuse on survivors' experience of the use of force
- coping with loss, fear and anxiety
- strategies for building self-esteem and regaining a sense of control
- modelling non-violent, healthy relationships
- understand the meaning of 'trauma' and how it can impact on people's experience of use of force
- how the use of force can trigger a trauma memory
- understanding that the use of force can be traumatic for patients experiencing it and the staff applying it
- considering how the sex of the person applying the use of force could trigger trauma memories for certain patients, particularly women and girls who are disproportionately likely to have experienced violence and abuse from male perpetrators
- recognition of potential symptoms of trauma and how behavioural symptoms can be linked to trauma
- an understanding of trauma through a developmental perspective that applies to all ages not just children

The impact of any use of force on a patient's mental and physical health includes the following:

- the impact of use of force in further traumatising or re-traumatising patients whose mental ill health may already have been exacerbated by forms of trauma
- ensuring use of force is never applied as a punishment or as a means of causing pain, suffering or humiliation

- the impact of the sex of the person applying the use of force to the patient and the sex of the patient subject to the use of force
- the impact of the use of force in relation to the age of the patient
- the impact of the use of force in relation to the person's health condition or impairment

The impact of any use of force on a patient's development includes the following:

- risk of unmet or misunderstood needs being conceived as wilful, challenging behaviour (leading to coercive and punishment-based interventions)
- preventing institutionalisation and preparing patients for family life and relationships within the community

How to ensure the safety of patients and the public includes the following:

- the process by which patients and their families or carers are informed of the approaches and techniques which may be used
- the process by which patients and their families or carers are involved in agreeing their own care plan and arrangements to take active steps to prevent and pre-empt distress and conflict arising
- the impact of the use of force on staff's mental and physical health whether this is caused by a patient's physical aggression or by observing the use of force and how this is mitigated within the organisation
- the role of observers in any use of force incidents
- the role of independent advocates in assisting patients and their families or carers in agreeing plans and raising concerns about the use of force
- Duty of Candour in regulation 20 of the 2014 Regulations in respect of the use of force

The principal legal or ethical issues associated with the use of force includes the following principles (from Positive and Safe Care 2014):

- the use of force must never be used to punish or be for the sole intention of inflicting pain, suffering or humiliation
- there must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken
- the nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm
- any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need
- any restriction must be imposed for no longer than absolutely necessary
- what is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent
- use of force must only ever be used as a last resort
- the involvement of people who use services, carers and independent advocates is essential when reviewing plans for the use of force
- understanding of human rights and discrimination legislation and how this interacts with other mental health, and health and social care legislation

and should also cover the following:

- the (very limited) circumstances in which the use of force is appropriate and what are the reasons for its use or not; The legal framework for use of force but, in particular circumstances justifying the use of force *Mental Capacity Act 2005*
- the rights of service users and staff to be in a safe environment

Trauma informed care and practice

Trauma, both personal or caused by the system, whether historical or current is an area of care and practice for us to address as part of improving safe and positive care and reducing restrictive practices. We will strive to be increasingly trauma aware and sensitive to the impact of actual, potential, and vicarious trauma on the lives of everyone who encounters services, including those who work within it. This will involve the integration of trauma informed care into all of our training and specific training in teams to support this.

Therapeutic environments and activity and dedicated space for calming, soothing and de-escalation

A therapeutic environment provides the best opportunity for recovery and wellbeing.

Meaningful Activity is essential to this, and a key component in reducing restrictive practice, a purposeful admission, enhancing health and wellbeing and making the stay of service users more positive.

Activity, and the way it is delivered provides, (amongst other things):

- A meaningful conduit for therapeutic engagement and developing therapeutic relationships
- Can be used to cope with symptoms and the challenges that living on an inpatient ward can bring
- Promotes maintenance and development of individuals skills, roles and routines. The ward is a place where people can discover or rediscover skills and values that can be taken forward into the community
- Offer people an opportunity to take an active role in promoting their own recovery and mental wellbeing
- Can alleviate boredom and supports the model of recovery and wellbeing

A programme of activities will be available throughout the day and week and be a key component of the service users care and treatment: It will be seen as routine and as essential as medication.

Activity will be embedded in the ward culture, owned by all and be routinely and consistently offered as part of the therapeutic model of care.

To support this there needs to be

- Identified spaces and rooms both on and off the ward (in and outdoors) that 1:1 and group activities can take place
- A range of resources and equipment: leisure, creative, educational etc.

Staff knowledge, skills and training

Staff education and training are essential to promoting and supporting calm, safe and respectful environments where the use of force is kept to a minimum. It is essential that staff are properly trained to provide safe, trauma informed, person centred care, where people are treated with dignity and respect and their views and feelings are understood and their specific needs are met. Training provided will support an overall human right- based approach, which is focussed on the minimisation of the use of force and ensures any use of force is rights respecting. Training will focus on creating a positive environment for care which pre-empts, takes active steps to avoid, or de-escalate distress and conflict. Staff will be skilled and knowledgeable to know when they can and should use appropriate and proportional force, as well as be able to recognise what is inappropriate or excessive use force. Training will be co-designed and delivered with those with live experience.
The training is certified with NAVIGO as part of the Restraint Reduction Network and is also supported by the Safewards implementation programme.

Collaboration and care planning

Service users and their families/carers (where relevant) will be involved in the planning, development and delivery of care and treatment. This will show respect for service users past and present wishes and feelings. Response to distress will be included, as part of knowing the person, and will form part of the care plan. Crisis response plans and Positive Behaviour support plans will also be part of this.
Where force has been used or is predicted to need to be used, the care plan will set out ways of supporting future prevention as well as post situation follow up and care.

Safewards

The clinical model of safe wards is to be implemented and embedded across all inpatient services as a way of improving safety and harmony between staff and services users by working together on the interventions, which support the reduction of flashpoints and conflict and support the non-use of force**.**

The Safewards Model depicts six domains of originating factors: the staff team, the physical environment, outside hospital, the patient community, patient characteristics and the regulatory framework. These domains give risk to flashpoints, which have the capacity to trigger conflict and/or containment. Staff interventions can modify these processes by reducing the conflict-originating factors, preventing flashpoints from arising, cutting the link between flashpoint and conflict, choosing not to use containment, and ensuring that containment use does not lead to further conflict. The trust is adopting the implementation of the interventions from Safewards in a structured, supported way. The interventions are included within the Respect training and are as follows:

- Clear Mutual Expectations
- Soft Words
- Talk Down
- Positive Words
- Bad News Mitigation
- Know Each Other
- Mutual Help Meeting

- Calm Down Methods
- Reassurance
- Discharge Messages

These interventions also reflect the process of approaching managing behaviours of concern through primary, secondary and tertiary strategies.

Appendix D
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°)

Support can be sought from the Resuscitation and Physical Health Team. If any concern or rapid deterioration/cardiac arrest BLS to be carried out as appropriate. The wedge or pillows are to be replaced by manual displacement of the gravid uterus to the left side. If a pregnant woman is admitted please inform the Resuscitation and Physical Health Team as soon as possible to facilitate specialist resuscitation training.

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.

Appendix E
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

Appendix F
Safety Pod Standard operating procedure

Template - STANDARD OPERATI