Prevention and Management of Violence and Aggression and Rapid Tranquilisation Policy and Guidance

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<td>Author</td>
<td>PSTS Training Manager / Senior Practitioner and Chief Pharmacist</td>
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<td>Copyright</td>
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## Prevention and Management of Violence and Aggression and Rapid Tranquilisation Policy and Guidance

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Care Quality Commission: Monitoring the Mental Health Act in 2012/13
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NHS Protect (2013) Meeting needs and reducing distress: Guidance on the prevention and management of clinically related challenging behaviour in NHS settings


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RELATED POLICIES/PROCEDURES/PROTOCOLS/FORMS/LEAFLETS

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1 INTRODUCTION

1.1 The Kent and Medway NHS and Social Care Partnership Trust attaches the greatest importance to the personal safety and security of employees, patients, visitors, carers and other persons carrying out authorised tasks for and on the behalf of the Trust. The Trust accepts its legal and moral responsibility to eradicate or reduce risks to staff, patients, visitors, carers and other persons so far, as is reasonably practicable.

1.2 The NHS (SMS) a Professional Approach to Managing Security in the NHS was launched in December 2003 (NHS Protect 2003). This outlines the service’s overall aims and objectives and sets out the NHS Security Management Service’s approach to security management issues.

1.3 The Trust recognises the risk of violence towards its staff, patients, visitors and carers and aims to ensure, through the provisions of this policy, as safe and secure environment as is reasonably practicable. This policy should be read in conjunction with the Safeguarding Vulnerable Adults policy.

1.4 The Trust will accept vicarious liability provided that employees adhere to the Trust’s policy and procedural guidelines. In addition, the Trust will reserve the right to exclude persistently violent patients, visitors and carers to support the prosecution of those acting violently or abusively towards its staff, equipment or premises.

1.5 This policy will cover all aspects of Promoting Safer and Therapeutic Services (PSTS):

1.6 The Trust will learn from Best Practice and is committed to reducing/eliminating prone/face down restraint.

2 PURPOSE

2.1 This document outlines the Trust approach to minimise the risks to staff that could potentially arise through violent or aggressive behaviour. It also summarises the actions that could and should be taken by staff if and when they find themselves in a potentially violent situation.

3 DEFINITION OF VIOLENCE

3.1 Non-physical assault – “The use of inappropriate words or behaviour causing distress and/or constituting harassment”. (NHS Protect June 2012)

3.2 Physical assault – “The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort (NHS Protect June 2012)

3.3 The following list provides examples of behaviours that are deemed by the Trust to be unacceptable. Violators (Staff, patients, visitors and carers) who exhibit extreme and or persistent inappropriate behaviours will face sanctions proportionate to their actions; this may include disciplinary procedures, withdrawal of treatment and prosecutions.

3.4 Staffs, patients, carers, visitors of the Trust have the right to work and be cared for in a safe and supportive environment. The Trust will not tolerate (See also Employment and Procedures Manual):

3.4.1 Verbally abusive and aggressive language including racial and sexual harassment

3.4.2 Verbal and non-verbal threats of violence
3.4.3 Disruptive behaviour that prevents staff from carrying out their duties, this can be active or passive e.g. withdrawing co-operation and communication
3.4.4 Emotional and or psychological intimidation
3.4.5 Destructive behaviour toward Trust property including fire setting, wilful damage and theft
3.4.6 Self-injurious behaviour
3.4.7 Misuse / abuse of alcohol, drugs and or other substances on site
3.4.8 Drug dealing on site
3.4.9 Stalking
3.4.10 Attempted / actual physical assault
3.4.11 Aggravated physical violence
3.4.12 Threats of violence involving a weapon and attempted / actual weapon assault
3.4.13 Offensive sexual gestures, inappropriate touching, attempted rape and rape
3.4.14 Any behaviour toward a member of staff that threatens or undermines their own personal safety and security is threatened
3.4.15 Bullying and Harassment
3.4.16 Detaining staff against their will.

4 EMPLOYERS DUTIES

4.1 Employer’s duties with respect to the management of work related incidents of violence and aggression are determined by National Health and Safety legislation, and by the common-law duty of care in the UK.

4.2 The Trust Board
4.2.1 The Trust is committed to providing an environment which minimises risk and promotes the health, safety and well being of all those who enter or use its premises whether as staff, patients, visitors and carers. It has overall responsibility to:
   a) Ensure that appropriate training (PSTS) is in place and effective throughout the Trust.
   b) Work to ensure full compliance with all appropriate legislative and statutory requirements.
   c) Ensure risk management becomes an integral part of the management processes and financial planning within the Trust.
   d) Ensure that strategies, structures and processes are constantly reviewed and evaluated to ensure the continuing health, safety and well being of staff, patients, visitors and carers.

4.2.2 They have delegated responsibility for monitoring and review through the Integrated Audit and Risk Committee.

4.2.3 A memorandum of understanding has been developed with the Association of Chief Police Officers (ACPO). The Trust will provide information to Kent County Constabulary through the Local Security Management Specialist (LSMS) where appropriate.
4.3 Executive Director of Nursing and Governance

4.3.1 Takes the lead for delivering clinical governance and ensuring that PSTS follows the Department of Health and Security Management’s Services (S.M.S.) Guideline’s and acts as effective risk management tool for all staff.

4.3.2 Executive boards must approve the increased behavioural support planning and restrictive intervention reduction programmes to be taught to their staff.

4.4 Integrated Audit and Risk Committee

4.4.1 Have responsibility and the authority to act on behalf of the trust board.

4.4.2 Ensure that a risk training strategy is in place an annual review is undertaken.

4.4.3 Receive reports from trust wide health and safety group.

4.4.4 Responsible for providing assurance to the trust board.

4.4.5 Report to the board twice yearly.

4.5 Trust Wide Health Safety Reporting Group

4.5.1 Ensure compliance with Health and Safety law, including (RIDDOR) 2010 specifically include those serious injuries sustained by staff as a result of violence.

4.5.2 Have responsibility and the authority to oversee and receive reports from The Violence, Restraint and Seclusion Monitoring group.

4.5.3 Ensure that there are suitable arrangements in place within directorates/care groups to meet their training in PSTS requirements and demonstrate compliance with C.Q.C 5 Key Standards.

4.6 Violence, Restraint and Seclusion Monitoring Group.

4.6.1 Will undertake regular and systematic audit of all activities clinical and non-clinical to identify, and where possible eliminate or minimise risk.

4.6.2 This Group will have a senior representative from PSTS, Corporate Nursing, Health and Safety, Care Groups and Safeguarding.

4.6.3 The Group will consider themes and trends and ensure these are taken to the Learning from Experience Group and picked up in supervision if needed in the Care Groups.

4.7 Chief Pharmacist Duties

4.7.1 Ensures that Trust policy is based on current NICE guidelines and standards in relation to rapid tranquilisation

4.7.2 Defines the levels of training required by staff across the Trust

4.7.3 Ensures that a system of clinical audit of rapid tranquillisation is carried out to monitor compliance with this policy

4.7.4 Provides professional advice to the Trust wide Patient Safety Group through membership and attendance at meetings.

4.7.5 Ensures this policy is reviewed and updated in response to changes in recommended Guidelines.

4.8 Complaints Manager
4.8.1 Ensures that the PSTS Training Manager/ Senior Practitioner is involved in reviewing complaints regarding the use of physical intervention skills, seclusion or any issues of conflict management.

4.8.2 Feeds back outcomes from complaints to ensure lessons can be learnt.

4.9 **Head of Learning and Development**

4.9.1 Ensure staff induction and training programmes take full account of all hazards and risks, clinical and non-clinical, likely to be encountered in the workplace and provide safe systems of work based upon evidence-based practice where available.

4.9.2 Reviews corporate, directorate and care group mandatory and statutory training requirements, and reports on compliance.

4.9.3 Provides sufficient courses to train all staff in PSTS as stated in training matrix.

4.10 **PSTS, Manager /Senior Practitioner.**

4.10.1 Ensures that training is fit for purpose and available to all staff.

4.10.2 Designs and delivers packages tailor-made for services or challenging individuals via team teaches.

4.10.3 Works with Risk Manager to review incidents regarding (aggression, violence, seclusions and S.I, s)

4.10.4 Monitors and audits P.S.T.S skills (Trust wide).

4.10.5 Develops safe systems of working and best practice.

4.10.6 Provides Clinical Support to wards and provides the link between clinical area’s and training teams.

4.10.7 Assists in complaints process on issues of physical interventions.

4.10.8 Provides advice to Trust on lessons to be learnt from incidents.

4.10.9 Provides a monthly report to care groups and bi-monthly reports to the Trustwide Health and Safety Group.

4.10.10 Will follow up with Service Managers incomplete reporting forms to ensure complete learning is picked up.

5 **EMPLOYEES DUTIES**

5.1 All staff have a responsibility and are expected to attend relevant theoretical and practical training and development opportunities in order to gain the necessary competencies associated with the professional management of a violent or potentially violent incident in accordance with Trust policy and other locally determined procedures.

5.2 Those registered nurses who are involved in administration of rapid tranquillisation must undertake Immediate Life Support training yearly.

5.3 All other nursing staff who are trained in physical interventions must under take Basic Life Support training yearly.

5.4 All employees will identify potential / actual risks within their own work area and bring these to the attention of their designated manager at the earliest opportunity.
5.5 All staff must be aware of the systems and procedures in place for summoning assistance when required.

5.6 All employees will report all incidents / near misses of violence and aggression in accordance with Trust policy and procedures, to their Line Manager and complete the necessary documentation at the earliest opportunity, whether directly or indirectly involved in an untoward incident or as a witness to a violent or potentially violent incident, in accordance with the Trust’s Incident/Accident/Near Miss Reporting Policy.

5.7 Ensure there is available Information for patients, visitors and carers with regard to the Trust’s position on violence.

6 REDUCING THE RISK

6.1 The Trust is committed to providing an environment which minimises risk and promotes the health, safety and well being of all those who enter or use its premises whether as staff, patients, visitors or carers. To this end the Trust will:

6.1.1 Work to ensure full compliance with all appropriate legislative and statutory requirements.

6.1.2 Ensure a proactive Risk Assessment (Risk Assessment form on RiO) is carried out in relation to all PSTS matters

6.1.3 Undertake regular and systematic audit of all activities clinical and non-clinical to identify, and where possible eliminate or minimise risk.

6.1.4 Enable and ensure all staff are competent and safe to practice and are aware of their personal responsibility for the management, reporting and recording of clinical and non-clinical risk.

6.1.5 Ensure support and information systems are in place to assist the Implementation of all aspects of risk management.

6.1.6 Ensure that strategies, structures and processes are constantly reviewed and evaluated to ensure the continuing health, safety and well being of staff, patients, visitors and carers.

7 ENVIRONMENT AND SECURITY

7.1 Appropriate measures commensurate with the risk assessment will be taken to adapt the working environment to reduce and or manage identified risks of violence toward staff, patients, visitors, carers and others.

8 COMMUNICATION AND RECORD KEEPING

8.1 All staff must be aware of the systems and procedures in place for summoning assistance when required.

8.2 All incidents of aggression and violence must be reported via the Datix electronic system within 24 hours of occurrence.

8.2.1 Non-physical and Physical assaults

8.2.2 Use of Personal Safety

8.2.3 Use of Physical Interventions

8.2.4 Use of de-escalation

8.2.5 Use of Rapid tranquillisation
8.2.6 Use of Long Term Segregation (see Long Term Segregation / Seclusion Policy for documentation)

8.2.7 Use of Seclusion (see Long Term Segregation / Seclusion Policy for documentation)

8.3 It is the responsibility of all staff to report and record actual or potential incidents using the appropriate reporting documentation. Following incident investigations it is the responsibility of Managers to report to the individual(s) and or staff groups concerned their findings and recommendations to prevent further incidents from arising.

8.4 Information for patients, visitors and carers with regard to the Trust’s position on violence is available

9 LONE WORKING

9.1 Definition:

9.1.1 Lone working is defined as - Staff who work by themselves in areas without direct supervision and away from Trust staff or other persons who would be able to provide immediate assistance if required. This includes staff working in the community as well as in isolated parts of any non-domestic building or premises used as a workplace by Trust staff.

9.1.2 All staff have a responsibility to ensure they comply with their local lone working protocol which should be created in line with the Trust Lone Working Policy, available from


9.2 Register of staff details

9.2.1 Managers are responsible for maintaining an up-to-date register of the details of staff who work alone.

9.2.2 Staffs who work alone should provide limited personal information (9.2.4) to assist in any search. This information should be kept in a secure place at the team base and updated by staff following any change.

9.2.3 The risk assessment should identify the systems for recording staff details, including where these are stored and accessed in the event of staff being unaccounted for.

9.2.4 As a minimum, staff details should include:

| a) Name | d) Next of kin name, address, contact number. |
| b) Recent photograph | e) Emergency contact (if different to next of kin) |
| c) Mobile phone number | f) Car details (registration, make, model and colour) |

10 DE-ESCALATING A VIOLENT SITUATION

10.1 De-escalation primarily concerns the actions staff undertake to manage potentially untoward situations.

10.2 The aim of de-escalation is to defuse the situation and avoid the need for physical intervention. The purpose of de-escalation is to:

| Alter the course of the aggression cycle | Re-direct the patient to a calmer state |
Reduce their level of anxiety / arousal | Restore control to the health care environment
Avoid violent responses and the need for physical intervention
Staff should not at any time during the interaction exceed their personal capabilities or professional responsibilities or place unrealistic expectations on the potential aggressor; this could cause the situation to rapidly deteriorate

10.3 In approaching the situation staff will need to demonstrate through their verbal and non-verbal behaviours that they are:

<table>
<thead>
<tr>
<th>Calm</th>
<th>Caring</th>
<th>Open and non-judgemental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled</td>
<td>Non-threatening</td>
<td></td>
</tr>
</tbody>
</table>

10.4 De-escalation should be carried out in the follow locations:

<table>
<thead>
<tr>
<th>De-escalation Room</th>
<th>Quiet Room</th>
<th>Lounge/Sitting area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Area (last option)</td>
<td>Dining area</td>
<td>Any low stimulus room</td>
</tr>
</tbody>
</table>

10.4.1 De-escalation in principle is only effective under certain circumstances where the level of risk is relatively low.

10.4.2 Where the motivational circumstances and the presenting behaviours of the potential attacker(s) indicate increased risk, then staff will need to seek immediate help and assistance as opposed to trying to engage the patient in de-escalation strategies.

10.4.3 Staff must at all times adhere to planned responses in order to ensure that potentially violent episodes are properly managed. Any ad hoc actions taken by staff must comply with local / Trust policy and procedures.

10.4.4 All incidents involving staff action should be reported and recorded on the PSTS section on the Datix electronic reporting system as soon, as is practically possible after the event, but no later than 24 hours.

10.5 The De-escalation Process

Staff must:

10.5.1 Be aware of personal space and keep a safe distance.
10.5.2 Remain calm and in control of their own level of arousal.
10.5.3 Adopt non-confrontational verbal and non-verbal behaviours – Keep own personal threat level low.
10.5.4 Remain open and non-judgemental – be cautious of demonstrating negative feelings through unguarded comments or facial expressions.
10.5.5 Assess the potential aggressor’s verbal and non verbal behaviour.
10.5.6 Determine their grasp on reality, psychosis / substance abuse.
10.5.7 Assess the degree of dangerousness (potential harm) associated with their behaviour and their willingness / ability to co-operate.
10.5.8 Consider the impact staff presence is having upon the situation.
10.5.9 Conduct an environmental assessment, exit routes, door locking mechanisms, lighting, floor surface, potential barriers, proximity to unsafe areas i.e. tops of stairs, large glass areas, corners of a room, etc. Avoid all vulnerable areas do not compromise personal safety.
10.6 Adopt non-confrontational behaviours, seek and maintain non-threatening eye contact – observe and listen - give them your full attention.

10.6.1 Encourage them to talk and ask questions, ensure honest responses are given, do not make promises that you or others cannot deliver on, use non-provocative language avoiding jargon.

10.6.2 Throughout your interactions continually monitor and assess the patient’s behaviour, how are they responding is their behaviour becoming less or more aggressive.

10.6.3 Clarify the problem, search for an acceptable solution; agree a course of action and act.

10.6.4 Report and record the incident in detail, document the antecedents and the behaviours exhibited by the potential aggressor and the de-escalation process you undertook and the outcome of your intervention.

11 PHYSICAL INTERVENTIONS

11.1 Physical restraint refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person. (Mental health Act 1983, Code of Practice s.26.69)

11.2 The Trust recognises that staff, who are likely to find themselves in aggressive or violent situations, where intervention might be necessary, must attend an appropriate course run by qualified instructors.

11.3 Patients (either detained or informal), visitors or others may behave in such a way as to disturb others around them and their behaviour may present a risk to themselves or others. These problems may occur anywhere and it is important to distinguish

11.3.1 The needs of the patient, visitors and others who pose an immediate threat to themselves or others around them and where Physical interventions are used must be to:

a) take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and

b) end or reduce significantly the danger to the patient or others. (Mental Health Act 1983 s.26.36)

11.4 The Trust seeks to highlight the legal and statutory requirements that Trust employees must observe when managing difficult patients or members of the public. This Policy should be read in conjunction with the policies guidance and references above.

11.5 The most important legal principle underpinning the valid use of Physical Interventions is that of ‘least restrictive alternative’ (Mental Health Act 1983) or ‘least necessary use of force’ (Criminal Law Act 1967) must be used.

11.6 The principles of understanding cultural sensitivity and awareness underpins the principles of this policy and procedures therein (see appendix B)

11.7 Non-resistive physical interventions, which do not involve the use of force, may the DoH suggests, include such measures as assisting a person walking.

11.8 A restrictive physical intervention is defined as involving the use of force to control a person’s behaviour and can be employed using bodily contact, mechanical devices or changes to the persons environment (Mental Health Act 1983 Code of Practice s.26) (The idea is that there may be some kind of resistance exercised by the person to whom the force is applied.)
11.9 All such interventions may constitute the offences of assault, assault and battery, or false imprisonment.

11.10 In more serious cases it may constitute the offences of inflicting grievous bodily harm (GBH), causing harm with intent, and where death occurs manslaughter.

11.11 A duty of care exists when duties and responsibilities are imposed upon professionals or paid carers. In general terms, this means taking reasonable care to avoid acts or omissions that are likely to cause harm to another person. Judgement about what is or is not a ‘reasonable’ course of action may be made with reference to the following:

11.11.1 The conduct of other practitioners with similar skills and responsibilities
11.11.2 An appropriate body of expert opinion
11.11.3 What is reasonable in the circumstances
11.11.4 The foreseeable risks associated with a course of action

11.11.5 KMPT is aiming to reduce the number of restrictive interventions (i.e. Restraint, Seclusion and Rapid Tranquilisation) alongside significant reductions in the use of prone restraint

a) Full account should be taken of the individual’s age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment, which may confer additional risks to the individual’s health, safety and well being in the face of exposure to physical restraint.

b) A member of staff should monitor the individual’s airway and physical condition to minimise the potential of harm or injury. Observation, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/discolouration), should be conducted and recorded.

c) People should 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.

d) There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor. (Prone is any position that the person’s chest is in contact with a solid surface)

e) If exceptionally a person is restrained unintentionally in the prone/face down position (i.e. they over power the team due body mass, strength or skills) staff should reposition into a safer alternative as soon as possible (i.e. immediate turn).

f) Where unplanned or unintentional incidents of any restrictive practice occur there should always be recording and debrief to ensure learning and continuous safety improvements.

ghere maybe the odd occurrence where it maybe the patients preference due to some past trauma, if this is the case it must be documented in the notes, care plan and behaviour therapy put in place to deal with the past trauma and to move away from this preference.

h) Restraint of a pregnant patient on the floor (Prone/Supine) should be avoided as it can compromise the well being of the mother and baby.

i) Staff must not deliberately use techniques where a person is allowed to fall unsupported, other than where there is a need to escape from a life-threatening situation.
11.12 Whilst deployment of personal safety techniques generally occur in a one to one situation or with a member of staff rescuing some one else, physical intervention must be employed using a team approach.

11.12.1 A minimum of one team per site must be available (which must be noted in the designated nurse in-charge folder).

11.12.2 A physical intervention team consists of three members of staff a team leader and two support members.

12 MECHANICAL RESTRAINT (HAND/SOFT CUFFS)

12.1 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. (Section 26.75, Mental Health Act Code of Practice 2015)

12.1.1 Mechanical restraint should only be used exceptionally, where other forms of restriction cannot be safely employed. It should be used in line with the principle of least restrictive option and should not be an unplanned response to an emergency situation. Mechanical restraint should never be used instead of adequate staffing.

12.1.2 As mechanical restraint (hand/soft cuffs) is a form of restrictive practice. All relevant paperwork must be completed this includes (appendix b of the forensic services hand cuff procedure) and Datix.

Mental Health Act Code of Practice 1983

12.2 Section 41(3)(c)(i) of the Mental Health Act Code of Practice 1983 (2008) requires a responsible clinician to obtain consent from the Secretary of State before granting Section 17 leave to a restricted patient detained under section 37/41 and 47/49. No such patient may leave the hospital or unit named on the authority of detention without such consent.

12.2.1 Staff applying soft/handcuffs devices must have undergone a appropriate training:
- In their application of use.
- Maintenance of the equipment.
- All successful staff names will be kept on the learning and development training data base.

12.2.2 All training will be delivered internal by the recognised train the trainer who must be updated annually by a recognised and accredited tutor/company.

12.2.3 All staff attending their mandatory use of handcuffs training must firstly be in date with their PMVA training prior to attendance. Use of soft/handcuffs must only be applied if staff have successfully completed that aspect of training.

12.2.4 Mechanical restraint which involves tying an individual (using tape or a part of the individual’s garments) to some part of a building or its fixtures should never be used.

Human Rights Act (Article 2 Right to life)

12.3 Under article 2 and 3 the following needs to be taken into consideration if handcuffs/soft cuffs are to be authorised for use by the KMPT and applied by its staff.


- Article 2 provides for us the positive obligation for public authorities to promote the right to life giving high value to everyone’s right to life.
- It also promotes the positive obligation to preserve life. This means that if there is a risk to life and something can be done to eliminate or reduce that risk to life then that absolutely should be done.

**Article 3 Prohibition of Torture**

12.4 **Torture**: Deliberate inhumane treatment causing very serious and cruel suffering.

- **Inhumane Treatment**: Treatment that causes intense physical and mental suffering.
- **Degrading Treatment**: treatment that arouses in the person a feeling of fear, anguish and inferiority capable of humiliating and debasing the person and possible breaking his/her physical or moral resistance.

- It could be considered that the application handcuffs/soft cuffs in certain situations could be considered degrading and inhumane for example a person detained under the mental health act that are being taken for medical or dental treatment outside of the secure establishment.
- We need to balance between Article 3 and 2 the intention of the restriction and the degradation/humiliation imposed by it i.e. the “positive benefit” taking into account prevailing foreseeable risk factors.
- In short undertaking a risk assessment to justify its use, which is backed up by clear policy and protocol?

12.4.1 Application of pain please refer to section 18 of this policy, Section 78-83 of the Department of Health Positive and Proactive Care and (See Appendix H Forensic Protocol)

12.5 **Article 5 – Liberty & Security of Person**

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law

2. Everyone who is arrested or detained shall be informed promptly, in a language which he understands, of the reasons for his detention and of any charge against

12.6 **Article 8 – The Right to Respect for Private and Family Life, Home & Correspondence**

This article is very broad and holds a wide range of implications. Public authorities may only interfere with someone’s private life where they have legal authority to do so, the interference is necessary in a democratic society for one of the aims stated in the article and is proportionate to that aim. For example to maintain the safety of others.

**Forensic services:**

12.7 There may be occasions where restraint (including handcuffs/soft cuffs) is used for security purposes for transferring restricted patients in a secure setting for the following reasons:

- To transfer to other wards.
- For treatment off site e.g. hospital, dentist etc.
- Escort to courts.
- To bring back an absconded/ AWOL patient
12.7.1 Handcuffs/soft cuffs will only be used with compliance from the individual they are to be applied to. Following Kent & Medway Partnership Trusts Forensic Protocol (appendix H) if/when the individual were to become non-compliant and/or behaviour escalates staff are to terminate the escort, re-seek compliance and when exhausted but the need for the escort remains paramount, the service is to contact the police to assist the escort.

12.7.2 Any events of planned leave that may require the use of 'secure escorting arrangements' must be risked assessed and documented prior to staff facilitating the escort. Such escorts may be for: (list should not be exhaustive)

- Medical treatments – non emergency
- Dental treatment
- Attending a funeral
- Attending Court

12.7.3 Any escort that requires the use of handcuffs must be legally justified and documented in the service user’s RIO notes prior to the commencement of the escort.

12.7.4 In exceptional circumstances, where the patient appears unconscious, immobile or life is at risk due to physical injury/illness it may be unwarranted to apply handcuffs due to the nature of health, however the Duty Manager may decide that staff carry the handcuffs in case that the individual is feigning the illness in order to be removed from the secure setting.

12.7.5 When staff are faced with unplanned and/or emergency leave is required for any person who may be subjected to a restriction order, The service must make contact with the Ministry of Justice as soon as practicably possible, ideally beforehand, if not then the Ministry of Justice must be also provided with a reason why this could not be sought for prior to the leave being granted.

12.7.6 The Ministry of Justice must always be updated with the risk management process for the leave of an individual leaving the secure service to the return of the individual.

**Older Adults:**

12.8 Mechanical restraint also includes the following:

- Cots sides on beds. (The use of these needs to be risked assessed and should include the patient (if possible) and their next of kin in the decision making)
- Lap belts on wheel chairs. (These should only be used for the transportation of patient from A to B and not for any other reason).
- Lap belts on hoists free standing. (Must be used as per training and manufactures guidelines)
- Lap belts on bath hoists fixed ((Must be used as per training and manufactures guidelines or lowering in and out of the bath). Unless risk assessment states otherwise i.e. risk of sliding of seat.
- Arm Splints. (These are generally used to limit self-injurious frequent and intense behaviour of the patient)

13 **CULTURAL ISSUES IN RELATION TO PHYSICAL INTERVENTIONS**
13.1 Recognition of sensitivities based on Equality Protected Characteristics of age, disability, gender reassignment, sex, sexual orientation, marriage & civil partnership, religion and belief and race. In addition to recognition of sensitivities relating to socio-economic status, language, geography and occupation.

13.2 There have been numerous reports highlighting inadequate provision of mental health services for ethnic minority groups, including:

13.2.1 Suffolk and Cambridgeshire SHA (2003) Independent Report into the death of David Bennett. This report looked into the death of an African Caribbean during restraint and stated that there was ‘institutionalised racism in the NHS’.

13.3 Guidance from the Dept. of Health in 2003 –Inside Outside – Improving Mental Health Services for Black and Ethnic Minority Communities states that ethnic minority groups are more likely to:

13.3.1 Be disproportionately represented in special hospitals, medium secure units and psychiatric in-patient units.

13.3.2 Experience far more detentions under the Mental Health Act 1983 and are forcibly restrained more often.

13.3.3 More likely to be prescribed anti-psychotic medication.

13.4 The Race Relations (Amendment) Act 2000 requires;

“All public authorities to actively promote race equality, including eliminating unlawful racial discrimination”, therefore as much information should be gathered about the patient’s cultural beliefs as possible, this information can be found within our own trust policies and from research but should primarily be sought from the patient and their family and carers.

13.5 It is important to communicate with patients and others to gain insight and understanding to their way of life.

14 SUMMARY

14.1 Preservation of life outweighs all other factors.

14.2 We must be prepared to justify our actions and our omissions.

14.3 If in doubt- find out by listening to patients and their carers.

15 THE USE OF MEDICATION IN THE MANAGEMENT OF VIOLENCE AND AGGRESSION

This policy has been updated in accordance with NICE guideline 10: Violence and aggression: short term management in mental health, health and community settings. Published May 2015.

15.1 Involving service users in decision-making

15.1.1 Involve service users in all decisions about their care and treatment, and develop care and risk management plans jointly with them. If a service user is unable or unwilling to participate, offer them the opportunity to review and revise the plans as soon as they are able or willing and, if they agree, involve their carer.
15.1.2 Check whether service users have made advance decisions or advance statements about the use of restrictive interventions, and whether a decision-maker has been appointed for them, as soon as possible (for example, during admission to an inpatient psychiatric unit) and take this information into account when making decisions about care.

15.1.3 If a service user has not made any advance decisions or statements about the use of restrictive interventions, encourage them to do so as soon as possible (for example, during admission to an inpatient psychiatric unit). Ensure that service users understand the main side-effect profiles of the medications recommended in this guideline for rapid tranquilisation so that they can make an informed choice.

15.2 Using oral PRN (pro re nata) medication

PRN in this policy refers to the use of oral medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression. It does not refer to PRN medication used on its own for rapid tranquilisation during an episode of violence or aggression (this is described in section 15.3).

15.2.1 If a patient is admitted outside of normal working hours the clerking doctor may prescribe oral lorazepam or promethazine PRN ONLY IF CLINICALLY INDICATED until the patient can be reviewed by a multi-disciplinary team (15.2.2)

15.2.2 A multi-disciplinary team that includes a psychiatrist should develop and document an individualised pharmacological strategy for using routine and PRN medication to calm, relax, tranquilise or sedate service users who are at risk of violence and aggression as soon as possible after admission to an inpatient psychiatric unit.

15.2.3 If a specialist pharmacist was not present in the multi-disciplinary team meeting then their agreement with the strategy or further discussion should take place as soon as possible.

N.B 15.2.1 – 15.2.3 Are a variation on NICE NG10 to allow for the safety of staff and clients admitted outside of normal working hours.

15.2.4 The multi-disciplinary team should review the pharmacological strategy and the use of oral PRN medication at least once a week and more frequently if events are escalating and restrictive interventions are being planned or used. The review should be recorded and include:

a) Clarification of target symptoms
b) The likely timescale for response to medication
c) The total daily dose of medication, prescribed and administered, including regular and PRN medication that is being used for tranquilisation / sedation
d) The number of and reason for any missed doses of regular medication
e) Therapeutic response
f) The emergence of unwanted effects.

15.2.5 When prescribing oral PRN medication as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression:

a) Do not prescribe PRN medication routinely or automatically on admission unless this is outside of working hours and clinically indicated. Such a prescription must be reviewed ASAP by a multi-disciplinary team
b) Tailor PRN medication to individual need and include discussion with the service user if possible
c) Ensure there is clarity about the rationale and circumstances in which PRN medication may be used and that these are included in the care plan

d) Ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the BNF when combined with the person’s standard dose or their dose for rapid tranquillisation

e) Only exceed BNF maximum daily dose (including PRN dose, the regular dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented, and carried out under the direction of a senior doctor

f) Ensure the interval between PRN doses is specified

15.2.6 The multidisciplinary team should review PRN medication at least once a week and, if PRN medication is to be continued, the rationale for its continuation should be included in the review. If PRN medication has not been used since the last review, consider stopping it.

15.3 **Rapid Tranquillisation**

15.3.1 Rapid Tranquillisation for the purposes of this policy (and as defined in NICE CG10) refers to the administration of sedative medication by injection if oral medication is not possible or appropriate and urgent sedation with medication is needed.

15.3.2 Rapid tranquillisation is to be used when disturbed or violent behaviour by an individual in an inpatient setting poses a serious risk to that individual, other service users and staff. The aim is to achieve a state of calm sufficient to minimise the risk posed to the service user or to others.

15.3.3 Rapid Tranquillisation should only be considered when all other techniques of calming or managing the patient have failed to reduce the level of risk, or when the extreme nature of the incident requires a rapid response.

15.3.4 Although a number of effective agents are available for sedation, there is no evidence showing clear superiority for any one agent. Therefore individualised treatment needs to be emphasised, taking into account the service user’s view, pre-existing physical health problems, previous response to medications including adverse effects, the potential for interactions with other medications, and the total daily dose of medications prescribed and administered.

15.3.5 Intramuscular lorazepam is recommended for service users who have not taken antipsychotic medication before because it is an effective intervention that is likely to be acceptable to the majority of service users. Prescribing the initial dose of rapid tranquillisation as a single dose will ensure that any subsequent treatment options can be individualised, taking account of both response and any emergent adverse effects of the initial treatment choice.

15.3.6 Medication for Rapid Tranquillisation must be used with caution because of the following risks:

a) Loss of consciousness instead of tranquillisation

b) Sedation with loss of alertness

c) Loss of airway

d) Cardiovascular and respiratory collapse

e) Interaction with medicines already prescribed, or illicit substances taken

f) Possible damage to patient-staff relationships
g) Underlying coincidental physical disorders

15.3.7 There are specific risks with different classes of medication. Risks may be compounded if used in combination.
   a) Benzodiazepines: Loss of consciousness, respiratory depression or arrest;
   b) Cardiovascular collapse when receiving both clozapine and benzodiazepine.
   c) Antipsychotics: loss of consciousness, cardiovascular/respiratory complications and collapse; seizures; akathisia; dystonia; dyskinesia; neuroleptic malignant syndrome; excessive sedation.
   d) Antihistamines: excessive sedation; painful injection; additional antimuscarinic effects.

15.3.8 When prescribing medication for use in rapid tranquillisation, write the initial prescription as a single dose, and do not repeat it until the effect of the initial dose has been reviewed. The reason for prescribing must be documented in the patient’s notes
   a) Do not prescribe intra-muscular rapid tranquillisation medication routinely or automatically on admission unless this is outside of working hours and clinically indicated. Such a prescription must be reviewed asap by a multi-disciplinary team
   b) Tailor i.m. Rapid tranquillisation medication to individual need and include discussion with the service user if possible
   c) Ensure there is clarity about the rationale and circumstances in which rapid tranquillisation medication may be used and that these are included in the nursing care plan

15.3.9 Use either intramuscular lorazepam on its own or intramuscular olanzapine on its own or intramuscular haloperidol combined with intramuscular promethazine for rapid tranquillisation in adults. **It is important that olanzapine is only prescribed with Consultant authorisation.** When deciding which medication to use, take into account:
   a) The service users preferences or advance statements
   b) Any contra-indications, warnings or precautions necessary. Patients with any co-existing physical illness, including poor liver, renal or cardiac function, should have drug and dose adjusted accordingly. Care should be exercised in patients with a history of or risk factors for, seizures.
   c) Care should be exercised in patients who are or may be pregnant, or who are breast feeding. Where possible advice must be sought from the pharmacist in advance of a potential incident. As the frequency of rapid tranquillisation of this client group is quite low this should always be actively considered so that in the eventuality of an emergency situation there is enough information on which to base prescribing decisions.
   d) Possible intoxication
   e) Previous response to these medications, including adverse effects
   f) Potential for interactions with other medications
   g) The total daily dose of medications prescribed and administered

15.3.10 If there is insufficient information to guide the choice of medication for rapid tranquillisation, or the service user has not taken antipsychotic medication before, use intramuscular lorazepam.
15.3.11 If there is evidence of cardiovascular disease, including prolonged QT interval, or no ECG has been carried out, avoid intramuscular haloperidol combined with promethazine and use intramuscular lorazepam or olanzapine instead.

15.3.12 If there is partial response to intramuscular lorazepam, consider a further dose.

15.3.13 If there is no response to intramuscular lorazepam, consider intramuscular haloperidol combined with intramuscular promethazine or intramuscular olanzapine on its own.

15.3.14 If there is a partial response to intramuscular haloperidol combined with intramuscular promethazine, or olanzapine on its own, consider a further dose.

15.3.15 If there is no response to intramuscular haloperidol combined with intramuscular promethazine (or olanzapine) consider intramuscular lorazepam if this hasn’t been used already during this episode. If intramuscular lorazepam has already been used, arrange an urgent team meeting to carry out a review and seek a second opinion if needed. Do not combine haloperidol and olanzapine in the same rapid tranquillisation episode.

15.3.16 After rapid tranquillisation, monitor side effects and the service user’s pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. Monitor every 15 minutes if the BNF maximum dose has been exceeded or the service user:

   a) Appears to be asleep or sedated
   b) Has taken illicit drugs or alcohol
   c) Has a pre-existing physical health problem
   d) Has experienced any harm as a result of any restrictive intervention

15.3.17 Resuscitation equipment must be available within 3 minutes in all healthcare settings where Rapid Tranquillisation might be used. This equipment should include:

   a) Automatic external defibrillator
   b) Bag Valve Mask
   c) Oxygen
   d) Suction
   e) Pulse Oximeters
   f) (a) (d) and (e) to be checked daily and records kept.

15.4 Alternative treatment options

15.4.1 These recommendations do not preclude the use of alternative treatment options. However, the use of alternative treatments should be tailored to the individual in line with the recommendations for rapid tranquillisation and the rationale for using a medication that is not recommended above must be clearly documented in the patient’s notes, with agreement from a multi-disciplinary team, prior to a prescription being written.

15.5 Rapid tranquillisation during seclusion

15.5.1 If rapid tranquillisation is needed while a service user is secluded, undertake with caution, following the above recommendations and

   a) Be aware of and prepared to address any complications associated with rapid tranquillisation
b) Ensure the service user is observed within eyesight by a trained staff member

c) Undertake a risk assessment and consider ending the seclusion when rapid tranquillisation has taken effect.

15.6 **Immediate Post incident debrief**

15.6.1 Following an incident involving the use of rapid tranquillisation, once the risks of harm have been contained, it is good practice for an immediate post-incident review should take place where practical, including a doctor and a nurse, to identify factors that can be addressed to reduce the likelihood of a further incident and amend risk and care plans accordingly.

15.6.2 Ensure that the service user involved has the opportunity to discuss the incident in a supportive environment with a member of staff or advocate. If the service user takes up the offer, this should be recorded in the clinical record.

15.7 **Formal Post incident review**

Where possible and practical, it is good practice for a formal external post-incident review should take place within 72 hours after an incident involving rapid tranquillisation. The group undertaking the review should ensure that the review:

15.7.1 Is led by a service user and includes staff from outside the ward where the incident took place, all of whom are trained to undertake investigations that aim to help staff learn and improve rather than assign blame

15.7.2 Uses information recorded in the immediate post-incident debrief and the service user’s notes related to the incident

15.7.3 Includes interviews with staff, the service user involved and any witnesses

15.7.4 Evaluates the physical and emotional impact on everyone involved, helps service users and staff to identify what led to the incident and what could have been done differently

15.7.5 Determines whether alternatives to rapid tranquillisation were discussed

15.7.6 Recommends change to philosophy, policies, care environment, treatment approaches, education and training, if appropriate

15.7.7 The group undertaking the review should provide a report to the ward where the incident took place.

16 **THE USE OF PAIN IN MANAGEMENT OF ACTUAL VIOLENCE**

16.1 Pain based techniques serve no therapeutic value and must only be used in extreme circumstances to ensure safety of self/others (NICE 2005).

16.2 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.

16.3 The patient’s freedom should be contained or limited for no longer than is necessary. Unless there are cogent reasons for doing so, staff must not cause deliberate pain to a patient in an
attempt to force compliance with their instructions (for example, to mitigate an immediate risk to life).

16.4 The P.S.T.S (Promoting Safer and Therapeutic Services) team will, throughout training and practice, provide clear guidance to students of exceptional circumstances where the use of pain may be acceptable and circumstances where it is unacceptable.

17 MONITORING OF PHYSICAL INTERVENTION/ RAPID TRANQUILISATION

Following any physical intervention or rapid tranquilisation the monitoring forms MUST be completed via Datix electronic reporting system. Failure to report can leave the staff and or patients, visitors and carers at risk.

17.1 Staff and Patient Support

17.1.1 Following an incident of violence appropriate after-care will be provided for affected staff and patients, visitors and carers through the immediate line management who will involve other personnel as appropriate.

17.1.2 It is important to consider informing next of kin, family member or carer of staff or patient who have been involved in the incident before any press involvement.

17.1.3 Staff should work with the Patient to review and amend their Positive Behaviour Support Care Plans

17.2 Immediate Support

17.2.1 Ensure all staff and patients are safe. Arrange physical care is given as required. Ensure all staff and patients have the opportunity to talk through their experiences. Provision should be given for further and ongoing support.

17.2.2 Arrange for Incident Debriefing to take place (48-72 hours after incident)

17.3 Follow Up

17.3.1 Appropriate support must be offered to all those who have been directly or indirectly affected by the incident.

17.3.2 Access to support is available for staff see staff handbook

17.3.3 It may be necessary to access other professionals to provide on going support to patients visitors and carers including the Safeguarding team

17.4 Additional Action to be taken following an Incident

17.4.1 To notify the Police that a violent incident/ crime has occurred.
   a) For a level 4 or 5 (SI reportable) i.e. broken bones, skin and/or blood) call 999
   b) For level 3 or below report through the 101.

17.4.2 The Local Security Manager Specialists (LSMS's) should be informed of the incident by the member of staff affected by the incident, the ward manager or nurse in charge.

17.4.3 That the Incident is reported through the Datix system.

17.4.4 Ensure witness statements are taken within 48 hours.

17.4.5 The nurse in charge at the time must make and document an assessment:
   a) Of the patient's capacity at the time of the incident.
   b) Complete a Police Capacity Assessment Form.
c) A current and updated risk assessment for the police.

d) He or she should then arrange for assessment of the patient/patient by a consultant within 24-48 hours.

17.4.6 An Advocate may need to be appointed to act on behalf of the assaulted victim (to act on their behalf and to keep them informed of proceedings)

17.4.7 The situation should be discussed with the wider multi-disciplinary team in relation to safeguarding and DoLS any appropriate assessments made, please refer to the Safeguarding Vulnerable adult’s policy.

17.5 **Remember:**

17.5.1 Other staff and patients, carers and visitors may experience a reaction to the incident. They may require support and guidance in addition to training to help them manage future situations effectively. Involving all staff in any review of departmental risk assessments and safety procedures soon after the incident and periodically thereafter will help to allay any anxieties staff groups may feel in relation to particular incidents.

17.5.2 The Trust will support police prosecution of individuals committing any acts of violence against staff and patients, visitors and carers.

17.5.3 The Trust will support private prosecution of individuals where appropriate and subject to favourable legal advice.

17.5.4 The member of staff and/or patient assaulted must make a statement to the police if they wish a prosecution to be pursued with any chance of success.

17.5.5 Additional support and advice can be obtained through the Trust's Legal Department.

17.6 **Clients observation (as soon as possible following interventions)**

17.6.1 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 airways and breathing are not compromised
- able to monitor vital signs
- supported throughout the process

17.6.1.1 Monitor the service user’s physical health and psychological health for as long as clinically necessary after using manual restraint.

17.6.2 If Rapid Tranquilisation has been used monitor side effects and the service user’s pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. Monitor every 15 minutes if the BNF maximum dose has been exceeded or the service user:

- a) Appears to be asleep or sedated
- b) Has taken illicit drugs or alcohol
- c) Has a pre-existing physical health problem
- d) Has experienced any harm as a result of any restrictive intervention

This needs to be documented via MEWS if any issues with readings follow MEWS guidelines.
18 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

18.1 The Trust provides compulsory training in accordance with National and Local policy and guidelines (See Trust Learning and Development Training Prospectus for details of courses).

18.2 Set out below is the training needs analysis for all staff groups identifying which members of staff require training and the level they require.

The aim of the training is to:
Ensure all staff are aware of their duties/roles and responsibilities to enable them to implement the policy.

<table>
<thead>
<tr>
<th>PACKAGE</th>
<th>WHO AIMED AT</th>
<th>CONTENT’S</th>
<th>DURATION/VENUE</th>
<th>UPDATE'S</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Inpatient Services</td>
<td>Forensic/learning Disabilities Younger/ Older Adults/ Re-hab Units-on Trust Sites</td>
<td>Theory Personal Safety Physical Interventions</td>
<td>5 DAYS (Gym)</td>
<td>Yearly 3 Days</td>
</tr>
<tr>
<td>B Inpatient Services</td>
<td>(Stand alone)Older Adult Wards:- Jasmine Ward; Littlestone Lodge; Ruby Ward &amp; Frank Lloyd Unit</td>
<td>Theory Personal Safety Physical Interventions</td>
<td>2 DAYS (Gym)</td>
<td>Yearly 2 Days</td>
</tr>
<tr>
<td>B Patient Contact</td>
<td>Community Teams Doctor’s Domestic/Porter’s/Kitchen Physiologist’s Occupational Therapists Ward Clerk/Receptionists Any person on an inpatient site (according to Risk Assessment) Re-hab Units - off site*</td>
<td>Theory Personal; Safety</td>
<td>1 Day (Gym/Team Teach)</td>
<td>Yearly ½ Day</td>
</tr>
<tr>
<td>C Non-Patient Contact</td>
<td>All Other Staff</td>
<td>Theory</td>
<td>e-Learning or ½ Day (Class room or Team Teach)</td>
<td>Every 3 years</td>
</tr>
</tbody>
</table>

* Rehabilitation Services based on hospital sites will complete physical interventions.

<table>
<thead>
<tr>
<th>PACKAGE</th>
<th>WHO AIMED AT</th>
<th>CONTENT’S</th>
<th>DURATION/VENUE</th>
<th>UPDATE'S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Tranquilisation</td>
<td>Doctor’s Registered Nurses</td>
<td>• Introduction</td>
<td>e-Learning</td>
<td>Yearly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rapid tranquilisation adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rapid tranquilisation older adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Types of medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Risk of medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Physical Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Remedial Measures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
19 STAKEHOLDER, CARER AND USER INVOLVEMENT

19.1 Key Individuals:

Promoting Safer Therapeutic Services Training Manager/ Senior Practitioner

19.2 Groups:

| a) Promoting Safer Therapeutic Services Team | b) Promoting Safer Therapeutic Services Group |
| c) Trust Wide Health and Safety Group | d) Risk Management Domain Group |
| e) KMPT and CFSMS information Sharing Group | f) Local Faith Groups |
| g) Violence, Restraint, Seclusion Monitoring Group |

19.3 Disciplines:

| a) All staff through consultation with representatives | b) Via Clinical Governance Group |

19.4 Carers/Users and Associated groups:

| a) Via consultation and monitoring group | b) Via Clinical Governance Group |

Stakeholders will be informed of any changes via consultation, monitoring Group and Health and Safety Group.

20 EQUALITY IMPACT ASSESSMENT

20.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions and to assess the impact of its policies/strategies on protected groups. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT, the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

21 HUMAN RIGHTS

21.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with.

22 KEY PERFORMANCE INDICATORS

22.1 Reduce the number of aggressive and violent incidences to staff, carers, services users and visitors.

22.2 Reduce staff sickness caused by assault or injury.
22.3 To ensure all staff are trained in how to deal with aggressive and violent Incidents.

22.4 That the Trust has a clear understanding of its role and responsibilities.

22.5 That staff have a clear understanding of their role and responsibilities.

22.6 That all Trust staff will have a clear understanding of support as it relates to staff, carers, services users and visitors.

22.7 To reduce the use of prone restraint to those situations where it is the patients own choice of position due to past trauma or situations where the patient over powers the team accurate and complete recording of all incidents

### 23 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

<table>
<thead>
<tr>
<th>What will be monitored</th>
<th>How will it be monitored</th>
<th>Who will monitor</th>
<th>Frequency</th>
<th>Evidence to demonstrate monitoring</th>
<th>Action to be taken in event of non compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of the policy and ability of staff to apply it in practice.</td>
<td>Observation of trends and review of incidents - data to service managers every 4 weeks to enable them to produce reports every 8 weeks to VRS group</td>
<td>Violence, restraint and seclusion monitoring Group</td>
<td>Bi-monthly meetings and reporting to Trustwide H&amp;S group H&amp;S group to report to IARC quarterly. Board to sign off annually.</td>
<td>Minutes and reports from VRS group, Trust wide H&amp;S group, IARC and board</td>
<td>A lead member of the clinical team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders through the PSTS training team. Audits will be undertaken by the PSTS Manager and identify if any patients were subject to DOLS or any safeguarding alerts have been raised.</td>
</tr>
<tr>
<td>Processes and duties for undertaking prevention &amp; management of violence and aggression risk assessments are adhered to.</td>
<td>Review of PSTS incidents via Datix</td>
<td>PSTS Manager and PSTS Senior Instructors VAS VRS???</td>
<td>1. Bi-monthly 2. Bimonthly 3. Monthly</td>
<td>Reports to Violence and restraint monitoring group 2. Reports to Trust wide H&amp;S group 3. Monthly reports to care groups.. 4. Annual reports to commissioners made publically available.</td>
<td>Required changes to practice will be identified and actioned within a specific time frame. A lead member of the clinical team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders through the PSTS training team.</td>
</tr>
<tr>
<td>Risk assessments are shared to protect staff and patients from violence and aggression</td>
<td>Review of PSTS monitoring forms</td>
<td>PSTS Manager</td>
<td>Monthly</td>
<td>Reports to care groups</td>
<td>A lead member of the clinical team will work with the PSTS training team to share learning with relevant stakeholders.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Appropriate Staff attend PSTS training and Rapid Tranquilisation</td>
<td>Training stats</td>
<td>Learning &amp; Development team PSTS Manager</td>
<td>8 weekly</td>
<td>Training reports to care groups</td>
<td>Line managers will ensure that staff attend next available training course.</td>
</tr>
<tr>
<td>Processes and duties on prescribing guidelines for rapid tranquillisation and documenting observations carried out after rapid tranquillisation are adhered to</td>
<td>Review of PSTS monitoring forms</td>
<td>Senior Pharmacist</td>
<td>Annual</td>
<td>1. Report to Violence and restraint monitoring group</td>
<td>Required changes to practice will be identified and reported to the VRS group. A lead member of the clinical team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders</td>
</tr>
</tbody>
</table>

### 24 EXCEPTIONS

24.1 Forensic Services and those areas where specialist mattresses are used can restrain on a bed or mattress. All other areas must restrain on the floor to minimise the potential risks.
APPENDIX A  EQUALITY ASSESSMENT

The Equality Impact Assessment for this policy can be found on the Equality and Diversity pages of the Trust intranet.
## APPENDIX B  ABBREVIATIONS AND DEFINITIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACPO</td>
<td>Association of Chief Police Officers.</td>
</tr>
<tr>
<td>AED</td>
<td>Automatic External Defibrillator</td>
</tr>
<tr>
<td>BNF</td>
<td>British National Formulary</td>
</tr>
<tr>
<td>CFSMS</td>
<td>Counter Fraud Security Management Services.</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>HSWA</td>
<td>Health and Safety at Work Act</td>
</tr>
<tr>
<td>KMPT</td>
<td>Kent and Medway Partnership Trust</td>
</tr>
<tr>
<td>LSMS</td>
<td>Local Security Management Specialist</td>
</tr>
<tr>
<td>MHSWR</td>
<td>Management of Health and Safety at Work Regulations.</td>
</tr>
<tr>
<td>NIMHE</td>
<td>National Institute for Mental Health in England</td>
</tr>
<tr>
<td>NMS</td>
<td>Neuroleptic Malignant Syndrome</td>
</tr>
<tr>
<td>PSTS</td>
<td>Promoting Safer and Therapeutic Services</td>
</tr>
<tr>
<td>RIDDOR</td>
<td>Reporting of Injuries, Disease and Dangerous Occurrences Regulations.</td>
</tr>
<tr>
<td>RT</td>
<td>Rapid Tranquillisation</td>
</tr>
<tr>
<td>SMS</td>
<td>Security Management Services.</td>
</tr>
<tr>
<td>SPC</td>
<td>Summary of Product Characteristics</td>
</tr>
<tr>
<td>VAS</td>
<td>Violence, Restraint, Seclusion Monitoring Group</td>
</tr>
<tr>
<td>PBS</td>
<td>Positive behaviour Support</td>
</tr>
</tbody>
</table>
APPENDIX C  THE USE OF PHYSICAL INTERVENTIONS TO MEET THE NEEDS
OF PATIENTS PERSONAL HYGIENE NEEDS

<table>
<thead>
<tr>
<th>WARD OR UNIT NAME:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF PATIENT:</td>
<td></td>
</tr>
<tr>
<td>STATUS:</td>
<td></td>
</tr>
<tr>
<td>CAPACITY ASSESSMENT DATE:</td>
<td></td>
</tr>
</tbody>
</table>

In order to meet the personal hygiene needs of the above named patient, and to ensure the safety of both the individual and the staff. It will at times be necessary for up to three members of the nursing team to intervene using the following technique(s)

<table>
<thead>
<tr>
<th>Guidance</th>
<th>Hold 1 (Elbow/Wrist)</th>
<th>Hold 2 (Figure Four)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hold 3 (Thumb to Thumb)</td>
<td>Arm Wrap</td>
<td>Seated</td>
</tr>
</tbody>
</table>

At all times, the patients dignity and privacy will be respected, and any treatment will be given in the patients best interest as stated in the Capacity Act 2007 (Section 6) as dated above.

Such action will only be deployed as a last resort following the failure of other interventions such as gentle persuasion and the promotion of self independence.

Full details of the approach to be used and the number of nursing staff required to carry out the intervention is not only listed above but will be incorporated into the patient’s care-plan. Also an entry will be made in the daily nursing notes documenting the level of intervention required.

<table>
<thead>
<tr>
<th>CONSULTANT’S SIGNATURE:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>WARD MANAGER’S SIGNATURE:</td>
<td></td>
</tr>
<tr>
<td>NEXT of KIN’S SIGNATURE:</td>
<td></td>
</tr>
</tbody>
</table>

N.B Use of any hold above hold 1, requires completion of prevention and Management of aggression and violence risk assessment form (appendix C)
Continuous risk reassessment and use of de-escalation techniques

INTERVENTIONS FOR CONTINUED MANAGEMENT
Consider, in addition to above, one or more of the following:

<table>
<thead>
<tr>
<th>Rapid Tranquillization (RT)</th>
<th>Seclusion</th>
<th>Physical Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use to avoid prolonged physical intervention</td>
<td>Used to avoid prolonged physical intervention</td>
<td>Better if patient responds quickly</td>
</tr>
<tr>
<td>Medication is required to calm a psychotic or non-psychotic behaviourally disturbed patient</td>
<td></td>
<td>Can be used to facilitate administration of RT and/or to enable RT to take effect</td>
</tr>
</tbody>
</table>

CONTRA-INDICATED AS AN INTERVENTION

<table>
<thead>
<tr>
<th>When patient has taken previous medication</th>
<th>Should be terminated when rapid tranquillization, if given, has taken effect</th>
<th>Prolonged physical intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should be terminated when rapid tranquillization, if given, has taken effect</td>
<td>When other interventions not yet explored</td>
<td></td>
</tr>
</tbody>
</table>

POST-INCIDENT REVIEW
APPENDIX D2 RAPID TRANQUILLISATION IN AN ACUTELY DISTURBED ADULT

Do baseline measurements of Temperature, Pulse, BP, and Respiratory Rate where possible

Lorazepam 1-2mg (Elderly 0.5-1mg) IM.
Mix 1:1 with water for injections prior to use
Ensure flumazenil available in case of benzodiazepine-induced respiratory depression

Promethazine 50mg (Elderly 25mg) IM + Haloperidol 5mg (Elderly 2.5mg) IM
Ensure IM Procyclidine available
If evidence of cardiovascular disease or if no recent normal ECG has been carried out, do not give haloperidol

Olanzapine 5- 10mg (Elderly 2.5 - 5mg) IM
Ensure IM Procyclidine available
Olanzapine should only be prescribed with Consultant authorisation

If partial response: repeat after 30-60 minutes
If no response after 60 minutes: promethazine + haloperidol OR olanzapine

If partial response: repeat after 2 hours
If no response after 60 minutes: lorazepam

Monitor side effects and Temperature, Pulse, BP, Respiratory Rate, level of hydration and level of consciousness at least every hour until no further concerns about physical health status.

Monitor every 15 minutes if BNF maximum dose exceeded, or if service user

- Appears asleep or sedated
- Has taken illicit drugs or alcohol
- Has pre-existing physical health problem
- Has experienced harm as result of restrictive intervention

Use pulse oximetry if patient asleep or unconscious
APPENDIX D3  GUIDELINES FOR THE USE OF CLOPIXOL ACUPHASE

Clopixol Acuphase (zuclopentixol acetate) is NOT recommended for Rapid Tranquillisation due to its long onset and duration of action. It may be considered as an option when:

- patient will be disturbed/violent over an extended time period
- past history of good/timely response
- past history of repeated parenteral administration
- cited in an advance directive

**Acuphase should NEVER be administered:**

- In an attempt to “hasten” the antipsychotic effect of other antipsychotic therapy
- At the same time as other parenteral antipsychotics or benzodiazepines (may lead to over sedation which is difficult to reverse)
- As a test dose for zuclopentixol decanoate depot injection
- To a patient who is physically resistant (risk of intravasation and oil embolus)

**Acuphase should never be used for, or in, the following:**

- Patients who accept oral medication
- Patients who are neuroleptic naïve
- Patients who are sensitive to EPSE
- Patients who are unconscious
- Patients who are pregnant
- Patients with hepatic or renal impairment
- Patients with cardiac disease

**Onset and duration of action**

Sedative effects usually begin to be seen after 2 hours. The effects may last for up to 72 hours.  
**Note: Acuphase has no place in rapid tranquillisation; its action is not rapid.**

**Dose**

Acuphase should be given in a dose of 50-150mg, up to a maximum of 400mg over a 2-week period. This maximum duration ensures that a treatment plan is put in place. It does not indicate that there are known harmful effects from a more prolonged administration, although such use should be very exceptional. There is no such thing as a course of Acuphase. The patient should be assessed before each administration.

**Injections should be spaced at least 24 hours apart**

The Maudsley Prescribing Guidelines 9th Edition
APPENDIX E  REMEDIAL MEASURES IN RAPID TRANQUILLISATION

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>REMEDIAL MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute dystonia</strong> (including oculogyric</td>
<td><strong>Procyclidine 5-10mg IM</strong></td>
</tr>
<tr>
<td>crisis)</td>
<td></td>
</tr>
<tr>
<td><strong>Reduced respiratory rate</strong> (&lt;10/min) or</td>
<td><strong>Give oxygen, raise legs, ensure patient is not lying face down</strong></td>
</tr>
<tr>
<td>oxygen saturation (&lt;90%)</td>
<td><strong>Give flumazenil if benzodiazepine-induced respiratory depression suspected</strong></td>
</tr>
<tr>
<td></td>
<td><strong>If induced by any other sedative agent transfer to a medical bed and ventilate</strong></td>
</tr>
<tr>
<td></td>
<td>immediately</td>
</tr>
<tr>
<td><strong>Irregular or slow (&lt;50/min) pulse</strong></td>
<td><strong>Refer to specialist medical care immediately</strong></td>
</tr>
<tr>
<td><strong>Fall in blood pressure</strong> (&gt;30mmHg</td>
<td><strong>Have patient lie flat, tilt bed towards head. Monitor closely</strong></td>
</tr>
<tr>
<td>orthostatic drop or &lt;50mmHg diastolic)</td>
<td></td>
</tr>
<tr>
<td><strong>Increased temperature</strong></td>
<td><strong>Withhold antipsychotics (risk of NMS and perhaps arrhythmia) Check creatinine</strong></td>
</tr>
<tr>
<td></td>
<td><strong>kinase urgently</strong></td>
</tr>
</tbody>
</table>
## GUIDELINES FOR THE USE OF FLUMAZENIL

<table>
<thead>
<tr>
<th><strong>Indications for use</strong></th>
<th>If, after the administration of lorazepam (or other benzodiazepine) respiratory rate falls below 10/minute</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contraindications</strong></td>
<td>Patients with epilepsy who have been receiving long-term benzodiazepines</td>
</tr>
<tr>
<td><strong>Caution</strong></td>
<td>Dose should be carefully titrated in hepatic impairment</td>
</tr>
<tr>
<td><strong>Dose and route of administration</strong></td>
<td>Initial: 200 microgram intravenously over 15 seconds – if required level of consciousness not achieved after 60 seconds, then subsequent dose: 100 microgram over 10 seconds</td>
</tr>
<tr>
<td><strong>Time before dose can be repeated</strong></td>
<td>60 seconds</td>
</tr>
<tr>
<td><strong>Maximum dose</strong></td>
<td>1 mg in 24 hours (one initial dose and eight subsequent doses)</td>
</tr>
<tr>
<td><strong>Side effects</strong></td>
<td>Patients may become agitated, anxious or fearful on awakening. Seizures may occur in regular benzodiazepine users</td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td>Side effects usually subside</td>
</tr>
<tr>
<td><strong>What to monitor</strong></td>
<td>Respiratory rate continuously until rate returns to baseline level. Flumazenil has a short half-life and respiratory function may recover and then deteriorate again. <strong>If respiratory rate does not return to normal or patient is not alert after initial doses given, assume that sedation is due to some other cause</strong></td>
</tr>
</tbody>
</table>
1. INTRODUCTION

1.1 De-escalation will provide the patient with an opportunity to calm themselves either with or without staff assistance, however staff should continue observe and be available if required.

1.2 De-escalation rooms will provide a low stimulus environment in which staff and patient can interact away from other patients.

1.3 Use of de-escalation rooms will, under normal circumstances, be by mutual agreement between the patient and the staff and should not be confused or used within the seclusion process.

2. ENVIRONMENTAL RECOMMENDATIONS

2.1 The de-escalation space should be planned as a single purpose area; it may be close to or connected to the seclusion suite.

Spaces used for de-escalation should be:

- Minimally furnished with either robust furniture that cannot be lifted and thrown, or lightweight furniture (for example foam) that would not cause injury or damage if thrown
- Soothing in decor with muted and restful colours
- Quiet, without a telephone or television

-Extracted from the Department of Health Environmental Recommendations for De-escalation areas.

3. SCOPE

3.1 This protocol is to be implemented on wards within Kent and Medway NHS social care partnership Trust - that have access to a de-escalation room.

4. INDIVIDUAL PROFESSIONAL RESPONSIBILITIES AND DUTIES

4.1 The Chief Executive holds overall accountability for the implementation and adherence to this protocol.

4.2 Service managers and ward managers are responsible for ensuring that staff on the wards are aware of this protocol.

4.3 The Promoting of Safer Therapeutic Services Training team will include de-escalation in their training programmes, elements of theory are also included in Trust e-learning however the best way for staff to learn who to de-escalate a situation is by observing good practice and practicing under the supervision of someone more experienced. It is therefore the responsibility of managers and mentors to cover this through clinical supervision and role modelling and for individuals to be receptive to feedback on their handling of situations.
5. INTERVENTION

5.1 All patients, whether detained or informal, may make use of de-escalation facilities.

5.2 The following list is not exhaustive and the multi disciplinary team should use their discretion when suggesting using the de-escalation room:

- Severe over stimulation
- High risk of self harm/ suicide
- Sexually disinhibited behaviour
- High risk to others of violence/ aggression
- Specific threats to particular patients or members of MDT
- Initial assessment when admitted to the ward
- Behaviour likely to be detrimental to the well being to others e.g. persistent bullying, racism, stealing, etc.
- Extreme vulnerability

5.3 A nurse should remain with the patient at all times unless to do so would increase the risks to patient or staff member.

5.4 Patients should never be locked in a de-escalation room as this would constitute de-facto detention or false imprisonment, unless under extreme circumstances, such as if there is a weapon involved, in which case it would be justified.

5.5 On occasions the de-escalation room may be used for physical restraint, if this happens a PSTS form should be completed.

6. RECORDING OF DE-ESCALATION

When de-escalation is used the care plan, risk assessment and progress note must be updated to reflect this and should state what interactions were effective and what were not to engage the individual and what plans have been put into place to get the person back into the main ward environment.

APPENDIX H  FORENSIC SERVICES HAND CUFF PROCEDURE
# FORENSIC SERVICES

## HAND CUFF PROCEDURE

<table>
<thead>
<tr>
<th>Policy Author:</th>
<th>Forensic Policy Review Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Director:</td>
<td>Associate Medical Director</td>
</tr>
<tr>
<td>Date of Implementation:</td>
<td>November 2014</td>
</tr>
<tr>
<td>Date of Review:</td>
<td>November 2015</td>
</tr>
</tbody>
</table>
1.0 **INTRODUCTION**

1.1 The use of handcuffs in health care settings is a contentious and sensitive aspect in clinical practice. In some circumstances, however, in order to protect patients, staff and the general public it may be necessary to use hand cuffs to manage a patient’s high risk of violence to themselves, or to others and for managing their absconding risk whilst they are being escorted outside the perimeters of the Forensic Service. The purpose of using hand cuffs is to allow staff to maintain control, to prevent violence to others or self harm and to keep the patient in secure custody. Kent and Medway Social Care Partnership Trust has agreed that staff within the Forensic Service may use hand cuffs in certain circumstances, and in strict accordance with these procedural guidelines.

1.2 This document relates to the use of hand cuffs within the Forensic Services only. This relates only to High Risk Escort patients who are being taken outside of the secure perimeter for essential purposes such as hospital visits, court appearances or prison transfers. Hand cuffs will only be used during internal transfers under exceptional circumstances, if judged necessary by the nurse in charge, in discussion with the Responsible Clinician.

1.3 All escorted leave for high risk escort patients (defined as below) should include the use of handcuffs. If there is a clear argument for not using them then this will need to be discussed in the MDT, clearly documented on RIO. Out of hours in an emergency, the default position is for hand cuffs to be used and this should be reported to the on-call Senior Manager and Responsible Clinician.

1.4 A high risk patient escort is defined as one of the following:

- Any transferred prisoner (section 47 & 48) who does not have regular external leave agreed by the Ministry of Justice.

- A patient considered by the MDT to a) present a high risk of absconding or b) to present a high risk of harm to self or others in the process of transfer.

- Any patient whose mental state has deteriorated rapidly and significantly.

1.5 An MDT decision needs to be made for each patient about whether, in the case of an emergency, they are a “high risk escort” as defined above and therefore, that hand cuffs should be used. This should be recorded in the Alerts section of RIO.

1.6 All High Risk Escorts must involve a minimum of 3 staff (plus driver), all with up to date PMVA training and at least one approved hand cuff user.

2.0 **RATIONALE**

2.1 Compulsory detention and restriction of liberty is permitted by *Section 3 of the Mental Health Act 1983*, and judged to be necessary for the protection of the health and safety of the patient and/or the health and safety of others.

2.2 Further, force as is “*reasonable in the circumstances*” may be used to prevent the commission of a crime, pursuant to Section 3 (1) of the Criminal Law Act 1967. **Staff should be aware that unreasonable force used, not commensurate to the circumstances, may be deemed unlawful and give rise to criminal conviction of assault.**
2.3 In addition to the above, Section 137 of the Mental Health Act 1983 provides that “person(s) restricting liberty or detaining, in accordance with Section 3 of the Criminal Law Act, has the same powers, authorities, protection and privilege as a constable, for the purpose of taking a person into custody, conveying or detaining them.” For the purpose of this policy, powers conferred in Section 137 may include the use of hand cuffs.

2.4 When using this form of restraint, the Mental Health Act 1983 Code of Practice, DH Positive & Proactive Care, NICE Guidelines NG10/NG11 (2015) should be followed, in that a person should be restrained for no longer than necessary. There should be a continued risk assessment undertaken, which takes into consideration the physical environment and condition of the patient.

2.5 To ensure the use of hand cuffs complies with patient’s safeguards contained in the European Convention on Human Rights (ECHR), namely Article 5(1), a physical assessment should take place promptly when the person conveyed arrives at a place of safety. Further, a continued review of the appropriateness of the use of hand cuffs is required. The review of appropriateness ensures the restriction of the liberty and autonomy of a person is justified. The use must be proportionate to the risk; the reasons for such interference must be relevant and sufficient.

2.6 If these safeguards are not complied with, litigation may result as the Trust would have failed to ensure adequate and protective safeguards are in place, to protect human rights of those restricted.
3.0 PROCEDURE FOR USE OF HANDCUFFS

3.1 If there is a clear argument for not using handcuffs with a high risk escort, this must be clearly documented on RiO and communicated, as outlined in section 1.3.

3.2 The decision to implement the use of handcuffs must be discussed and agreed at the patient’s MDT in an appropriate setting (i.e. care plan review meeting). The decision must involve the patient’s Responsible Clinician or nominated deputy. A detailed management plan must be developed and recorded as a RiO care plan. The management plan must take into account the following points:

a) Nature of escort – planned/emergency  
b) Need for escort – can the procedure/event take place on the unit?  
c) Duration of escort  
d) Patient’s current physical state, particularly conditions or circumstances which could be relevant to use of handcuffs, e.g. muscular-skeletal injuries, cuts.  
e) Current mental state of the patient  
f) Risk to public, staff or patient. To include risk of violence and aggression for the duration of the escort.  
g) Is the patient assessed to be compliant or non-compliant? Most important factor is past/recent history of absconding  
h) Legal status  
i) Leave status  
j) Use of secure van (must be used)  
k) Use of ambulance. An emergency transfer requiring the use of a Paramedic ambulance may still require the use of handcuffs. However, it is accepted that the risk of escape is overshadowed by the risk of a life threatening condition. Handcuffs will not be used if this hinders any procedures to be undertaken by the paramedic staff.  
l) Destination – environment, exits, availability of waiting room, ability to accommodate patient and escorts, security i.e. lockable doors etc.  
m) Any circumstances in which a patient’s handcuffs need to be removed and reapplied while they are outside of Secure Services e.g. certain treatments/therapies.  

n) Factors such as the make-up of the 3 person escorting team; their skills, size, training (all PMVA trained and at least 1 approved handcuff user), ethnicity and gender mix along with physical comparison to the service user, as well as knowledge of and relationship to the patient. Wherever possible, substantive staff from across the Forensic Service should escort.  
o) A risk assessment of the area to which the patient is to be escorted and any action needed to reduce the risk of absconding. (This may need to take place immediately on arrival in some cases, but should happen before the escort leaves the ward).
Risk of an accomplice assisting the patient to abscond may be reduced by limiting
knowledge of the escort date/time route etc, but staff will require clear guidelines
on the procedure should this occur.

The escorting staff requirements and their individual specific roles and
responsibilities.

The communication arrangements between base and destination throughout the
journey.

The transport arrangements for outward and return journeys, including the type of
vehicle, loading arrangements, seating arrangements, unloading arrangements.

The route to destination.

The arrival point and arrangements to be received by other establishment/agency.

Whether the use of hand cuffs is planned or not, the decision about who is in the escort
team needs to be made by the nurse in charge of the area the patient is coming from.
They need to document on RiO decisions made in terms of ensuring wherever possible
substantive staff completes the escort. Out of hours they must escalate this transfer to
the on call manager.

The availability and use of hand cuffs within the Forensic Service should not be
discussed in the presence of patients or visitors. However, the MDT should always
communicate a decision to use hand cuffs to the patient concerned prior to the escorted
journey. The MDT should inform the patient of the reasons for hand cuffs being used;
the procedures involved and obtain the patient’s views. This does not include obtaining
the patient’s consent. MDTs should be mindful of the potential risks involved in giving
some patients prior knowledge of an escorted journey and/or the use of hand cuffs when
making a decision about when to inform. In emergency situations, the on-call doctor and
the senior nurse on shift in charge will discuss this issue with the patient following
discussion with the patient’s on-call consultant.

The hand cuffs will be applied at the point of departure of the patient, and they must be
removed immediately upon return. All journeys where patients are hand cuffed should
depart and arrive via the secure ambulance bay, which offers a discrete route and
suitable location for hand cuffs to be applied and removed prior to leaving and on re-
entering the building. It may be required for hand cuffs to be applied prior to leaving the
ward if the risk is deemed high enough, this should not be the norm.

Before an approved hand cuff user applies the hand cuffs the patient must be clearly
informed about the procedure, the justification, as well as their rights following articles
prescribed from the ECHR and under detention (Including the right to make a complaint
etc.)

Where the service user refuses to have hand cuffs applied, an immediate risk
assessment of the situation will be undertaken and the following options considered:

- Termination of escort
- Request police assistance

The application and removal of hand cuffs is the highest risk point for assaultative
behaviour and sufficient staff should be available at this point to ensure the safety of all
concerned. A clinician may request for the removal of the restraints due to an immediate or imminent risk to the client, impeding essential treatment (unless risk of absconding is high) or where the client is experiencing pain and discomfort. The response needs to be acted as quickly but as safely as possible. If the request to remove the handcuffs is due to an immediate risk to the health of the client then this must be done urgently without delay to ensure staffs fulfil the individual's Right to Life (Art 2 Sec 6 ECHR).

If any staffs are in doubt regarding the risk of absconding, staff must share their risk assessment with other clinicians where appropriate and all must be seeking to find a resolution to the matter.

3.8.1 Where the request cannot be resolved, the escorting staff must:

- Inform the hospital staff and duty manager that the handcuffs must remain in place
- Await for the Duty Managers decision to whether the handcuffs can be removed.

The decision of the Duty manager must be based only on the information that has been documented in the individuals risk assessment, any changes to those circumstances and the advice from the hospital clinician.

The duty manager must speak to the clinician personally prior to any removal of any restraint. In exceptional circumstances, where the Duty manager disapproves the advice presented the on-call Home Office Senior Manager must be notified as soon as practically possible.

3.9 Handcuffs may be carried by the escorting staff, where an assessment indicates a possible use as a contingency plan for specific and pre-determined situations e.g. where it is possible that a court decision will significantly increase a patient’s risk of violence and/or absconding. In this case, it is essential that a record of the assessment and detailed contingency plan is available within the patient’s progress notes and known and planned by the escorting staff prior to the journey commencing.

3.9.1 At times, depending on services, some courts may request that the individual is to be handcuffed with their hands behind their back. Escorting staff do have the right, and must, refuse this application as to act within all governing policies, procedures, national guidance and training. Where escorting staff find resistance from any court the Duty Manager must be contacted immediately.

3.10 At all times the handcuffs must be used in such a manner as to cause the least possible discomfort to the patient and in compliance with the training given. Handcuffs must be applied with a comfortable but secure fit and any application of handcuffs must not contravene Art 3 ECHR.

3.11 The tightness of the cuffs must be checked by the nurse in charge of the escort, staff applying the handcuffs. They should be secured above the wrist bone and tight enough so as they cannot be slipped over this bone. Also the patient’s wrist movement and blood flow/capillary checks must be checked regularly throughout their use. The staff responsible for this should be identified prior to the escort taking place.

3.12 Patients must never be cuffed to any furniture, fixtures and/or fittings as per mental health act code of practice
3.13 The nurse in charge of the escort must ensure that the hand cuffs are checked at frequent irregular intervals, to ensure that the patient has not tampered with them or attempted to ‘slip’ them.

3.14 The use of hand cuffs is not a substitute for the exercise of vigilance by escorting staff. Indeed there is a greater need to continually monitor the physical and mental state of patients to minimise injury to any party.

3.15 Escort straps must be applied if the patient requires the use of the toilet while on the escort.

3.16 Once the patient is in a secure environment i.e. police station holding areas or court cells, the decision to remove the cuffs can be made. This will be made by the nurse in charge of the escort. This course of action will have been agreed in the team brief before leaving the secure environment.

4.0 RISKS ASSOCIATED WITH THE USE OF HAND CUFFS

It is essential that escorting staff are aware of the following

4.1 A person’s ability to protect themselves during a fall is compromised by not allowing free movement of the arms.

4.2 Over-tightening or manipulation of the hand cuffs can cause discomfort and potentially hand tissue, nerve and bone injuries. This can be recognised as a disproportionate amount of force and staff may be in breach of Art 3 ECHR

5.0 EQUIPMENT SPECIFICATION, STORAGE AND ISSUE

5.1 The type of cuffs approved and provided for use by within the Forensic Services is the “soft cuffs” and “rigid hand cuffs”. Only these cuffs are authorised for use when escorting patients from the Forensic Service to specific destinations.

5.2 The Trust does not permit staff to use any other form of mechanical restraint or restrictive device at any time, within or outside Trust premises.

5.3 The cuffs/keys will be stored within Reception and reconciled three times daily by Reception staff.

5.4 An up-to-date list of ‘approved hand cuff users’, see 6.0 for details (Staff Training) will be stored with the equipment. This will be kept up to date by the Security Liaison Manager. Any equipment removed from the cupboard must be signed out when they are issued and signed back in when they are returned.

5.5 Reception will check the contents of the secure storage cupboard.

5.6 The Receptionist will issue 1 pair of cuffs to an “approved hand cuff user” for situations where a risk assessment and detailed care plan indicate the authorised and appropriate use of hand cuffs on a patient during an escorted journey away from the secure environment.

5.7 Upon return, the ‘approved hand cuff user’ will return the cuffs to the receptionist.
6.0 STAFF TRAINING

6.1 An education and training programme is available for staff working within the Forensic Service to attend via learning and development booking.

6.2 The recognised member of staff must have, firstly, successfully completed KMPT’s Physical Intervention Training/yearly update and must be in date; secondly the member of staff must have also successfully completed KMPT’s handcuff training. If any element from staffs CPD is missing handcuffs must not be issued nor should they be applied. The member of staff will not be recognised, by their employer, as an ‘approved handcuff user’.

Any member of staff that does not fulfil this category will be removed from the recognised list and will not be reapplied until certification can be provided to their line manager and/or senior.

6.3 Handcuffs will only be applied and removed by ‘an approved handcuff user’. A record of staff (‘approved handcuff user’) will be held by The learning and development data base and Security Manager.

7.0 INFECTION CONTROL AND MAINTENANCE

7.1 All staff must be conversant to Kent & Medway Partnership Trust’s Decontamination Policy, with regards to infection control when either managing bodily fluid spills and/or cleaning of equipment (see appendix F Moving & Handling).

7.2 The equipment must be cleaned after every use or weekly if not used and this must be documented on a check list that holds a signature of the person that has completed the task. Ideally this process will be carried out in accordance with the general checks of the handcuffs.

7.3 One only exception with soft cuffs being not to use any detergent and certainly do not attempt to tumble dry the piece of equipment.

7.4 Maintenance of any rigid cuffs will involve ensuring that the single-bar can pass through the ratchet with ease and that the use of bike maintenance lubricant to metal parts only is sufficient not WD40.

7.5 Soft cuffs/emergency response cuffs require a detailed check to ensure that all stitching is in-tact and that the compression strap/Velcro is clear of fluff and other material. The plastic buckle must be checked to ensure that it is free of any jagged areas that could cause harm to the client.
APPENDIX A

The Law in Relation to use of HAND/EMERGENCY RESPONSE CUFFS (SOFT CUFFS)

Mental Health Act Code of Practice 1983

- Section 41(3)(c)(i) of the Mental Health Act Code of Practice 1983 requires a responsible clinician to obtain consent from the Secretary of State before granting Section 17 leave to a restricted patient. No such patient may leave the hospital or unit named on the authority of detention without such consent.

- When secure transfers are undertaken, Section 137 states ‘Provisions as to custody, conveyance and detention’ is also relevant. The members of staff who undertake a secure transfer may use reasonable force in order to stop a patient/client/service user from escaping legal custody.

- With regards to patients detained under section 37/41 and sentenced prisoners transferred under sections 47/49 the following detail(s) will be required: …..Arrangements for transporting the patient to court, including physical security e.g. number of escorts/secure van/necessity for handcuffs.

Common Law:

- The use of handcuffs/soft cuffs (and other restraint equipment) is normally governed under the Common Law as a “common law use of force option”. Under common law any person may use force to protect their private right.
- As such a hand cuff/soft cuff (or other restraint device) is considered a “temporary restraining measure” to prevent harm to self or others or to prevent the escape of a person lawfully detained.

Section 3(1) of the criminal law act 1967:

- Section 3(1) of the criminal law act 1967 deals generally with the right of all law abiding citizens to use reasonable force.
- Therefore the use of hand cuff/soft cuff (or other restraint equipment) would be lawfully excused provided that their use was “reasonable in the circumstances”.
- With regard to deprivation of liberty this would have to be balanced against the harm that could possibly be occurring if such equipment was not used.

Health & Safety at Work Act (Etc.) 1974

- All employers have a Legal Duty to ensure the Health, Safety & Welfare at work of their employees
- All offences under the act are criminal offences

Section 2 – Duties to Employees
“It shall be the duty of every employer to ensure so far as is reasonably practicable the health and safety and welfare of all their employees”

2a. safe plant and systems of work
2b. safe use, handling, storage and transport
2c. information, instruction, supervision & training
2d. safe workplaces Inc., access and egress
2e. safe environment

Section 3 – Duties to others

“It shall be the duty of every employer to conduct his undertaking in such a way as to ensure so far as is reasonably practicable that persons not in his employment are not exposed to risks to their health and safety.”

Section 7 – Duties to self & others

“It shall be the duty of every employee while at work to take reasonable care for the health and safety of himself and of others who may be affected by his acts or omissions.”

The management of Health & Safety at Work Regulations 1999 – Regulation 3 (1):
Risk Assessment

Every employer shall make suitable and sufficient assessment of –

a) The risk to the health and safety of his employees to which they are exposed whilst they are at work; and
b) The risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking.

The Manual Handling Operations Regulations 1992:

24. The regulations apply to the manual handling of loads, i.e. by human effort, as opposed to mechanical handling by crane, lift, trucks etc. The human effort may be applied directly to the load, or indirectly by hauling on a rope or pulling on a lever. Introducing mechanical assistance, for example a sack truck or a powered hoist, may reduce but not eliminate manual handling since human effort is still required to move, steady or position the load.

25. Manual handling includes both transporting of a load and supporting of a load in a static posture. The load may be moved or supported by the hands of any other part of the body, for example, the shoulder. Manual handling also includes the intentional dropping of a load and the throwing of a load, whether into container or from one person to another.

31. The extent of the employer’s duty to avoid manual handling or reduce the risk of injury is determined by reference to what is reasonably practicable. This duty can be satisfied if the employer can show that the cost of any further preventive steps would be grooingly disproportionate to the further benefit from their introduction.
When considering what is reasonably practicable, additional potentially relevant factors may be:

a) The seriousness of the need for the lifting operation: and
b) A public authority’s duties to the public and to the particular member of the public who has called for the authority’s help.

33. Taking these factors into account, the level of risk which an employer may ask an employee to accept may, in appropriate circumstances, be higher when considering the health and safety of those in danger, although this does not mean that employees can be exposed to unacceptable risk of injury.

**PUWER 1998 – Provision and Use of Work Equipment Regulations**

Puwer 1998 require that equipment provided for use at work is:

1. Suitable for the intended use
2. Safe for use, maintained in a safe condition and, in certain circumstances, inspected to ensure this remains the case
3. Used only by people who have received adequate information, instruction and training; and
4. Accompanied by suitable safety measures, e.g. protective devices, markings, warnings etc.

**Human Rights Act (Article 2 Right to life)**

Under article 2 and 3 the following needs to be taken into consideration if handcuffs/soft cuffs are to be authorised for use by the KMPT and applied by its staff.

- Article 2 provides for us the positive obligation for public authorities to promote the right to life giving high value to everyone’s right to life.
- It also promotes the positive obligation to preserve life. This means that if there is a risk to life and something can be done to eliminate or reduce that risk to life then that absolutely should be done.
- One of the main risks to life during restraint is death due to positional asphyxiation, which can be brought about by many factors including a prolonged struggle, prone restraint, supine restraint, health conditions or pressure being applied to torso/neck.
- If the risk of harm/death can be eliminated or reduced by the application of handcuffs/soft cuffs then the authorization of their use can be justified under human rights legislation.

**Article 3 Prohibition of Torture**

**Torture:** Deliberate inhumane treatment causing very serious and cruel suffering.
**Inhumane Treatment:** Treatment that causes intense physical and mental suffering.
**Degrading Treatment:** treatment that arouses in the person a feeling of fear, anguish and inferiority capable of humiliating and debasing the person and possible breaking his/her physical or moral resistance.
• It could be considered that the application handcuffs/soft cuffs in certain situations could be considered degrading and inhumane for example a person detained under the mental health act that are being taken for medical or dental treatment outside of the secure establishment.
• We need to balance between Article 3 and 2 the intention of the restriction and the degradation/humiliation imposed by it i.e. the “positive benefit” taking into account prevailing foreseeable risk factors.
• In short undertaking a risk assessment to justify its use, which is backed up by clear policy and protocol?

Application of pain please refer to section 18 of this policy, Section 78-83 of the Department of Health Positive and Proactive Care and (See Appendix --- Forensic Protocol)

Article 5 – Liberty & Security of Person

3. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law (C): The lawful arrest or detention of a person for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so; (E): The lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;

4. Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.

5. Everyone arrested or detained in accordance with the provisions in paragraph 1(c) of this article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear by trial.

6. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is lawful.

7. Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation.

Article 8 – The Right to Respect for Private & Family Life, Home & Correspondence

This article is very broad and holds a wide range of implications. Public authorities may only interfere with someone’s private life where they have legal authority to do so; the interference is necessary in a democratic society for one of the aims stated in the article and is proportionate to that aim.
It is important to note that the rights and freedoms expressed in Art. 8 may be limited where necessary to achieve an important objective such as protecting public health and safety.

1. Everyone has the right to respect for his private and family life, his home and his correspondence

2. There shall be no interference by a public authority with the exercise of his right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others
# Hand Cuffs Withdrawal and Risk Assessment Form

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Section:</th>
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<table>
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<tr>
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<tr>
<th>Nature of Escort: i.e. court</th>
<th>RiO Number:</th>
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<tr>
<th>Current Leave Status:</th>
<th>Destination:</th>
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</table>

**Risk assessment of destination/ Things to consider:**

- Patients current physical state, (particularly conditions relevant to handcuff use, e.g. muscular-skeletal injuries):
- Current Mental State:

**Current Risk assessment**

- Past/recent history of absconding:
- Risk to public, staff or self:

**Circumstances in which handcuffs may be removed & reapplied while outside of secure services:**
- Staff escort names

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<thead>
<tr>
<th>Date:</th>
<th>Completed by (Print &amp; Sign)</th>
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This document must always be emailed to the Forensic Service Manager, Forensic Lead Nurse, Forensic Security Manager, Responsible Clinician, Service Director, and Director of Operations.

Out of hours, as well as the above, this document must be emailed to the on call Manager and on call Service Director.
### Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
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<tr>
<td>1. Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
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</tr>
<tr>
<td>• Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Age</td>
<td>Yes</td>
<td>Overtightening or manipulation of hand cuffs can cause discomfort and potentially hand tissue or nerve/bone injuries, which older people may be more vulnerable to</td>
</tr>
<tr>
<td>• Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>Yes</td>
<td>People requiring mobility aids may not be able to use hand cuffs. People with visual impairments may be hypersensitive to touch</td>
</tr>
<tr>
<td>2. Is there any evidence that some groups are affected differently?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3. If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>Yes</td>
<td>Risk assessments should be carried out on an individual basis. See section 3.2</td>
</tr>
<tr>
<td>4. Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
<td>Decision may be made that hand cuffs are not necessary</td>
</tr>
<tr>
<td>5. If so can the impact be avoided?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>6. What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>An individualised care plan can be drawn up to manage risk without the use of hand cuffs. Different types of handcuffs?</td>
<td></td>
</tr>
<tr>
<td>7. Can we reduce the impact by taking different action?</td>
<td>Yes</td>
<td>See above</td>
</tr>
</tbody>
</table>