Keele UNIVERSITY TEACHING TRUST

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Our Ref: LW/lmw/FOI.198.23
Date: 19th July 2023

Laurie Wrench
Deputy Director of Governance
North Staffordshire Combined Healthcare NHS Trust
Lawton House
Bellringer Road
Trentham
ST4 8HH

Tel 01782 275030

Dear

Freedom of Information Act Request
I am writing in response to your e-mail of the 29th June 2023**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:
Request 1.
Please could you list all your 'mental health units' as defined above, including those that provide treatment for psychiatric or behavioural problems linked to psychiatric disorders (e.g. depression, bipolar, schizophrenia, eating disorders), dementia, learning disabilities or autism.
You can find a list of the Trust services on https://www.combined.nhs.uk/our-services/

Request 2.
Please provider copies of the 'restraint policies' prepared by each of these units in accordance with s3 of the Mental Health (Use of Force) Act 2018. If you are not sure what I mean by this, the government guidance is here.

Please see Appendices 1-6 attached.

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

L. Wrench.

Laurie Wrench
Deputy Director of Governance

Document level: Trust
Code: R01
Issue number: 2

Policy on the Use and Reduction of Restrictive Practice

Lead executive	Director of Nursing and Quality
Authors details	Reducing Restrictive Practices Lead

Type of document	Policy
Target audience	Clinical Staff
Document purpose	Information and guidance

Approving meeting	Quality Committee Trust Board	Meeting date	6th May 2021 13th May 2021
Implementation date	18th June 2021	Review date	31st May 2024

Trust documents to be read in conjunction with	
	Rapid Tranquilisation policy
	Seclusion and Long term segregation policy

Document change history		Version	Date
What is different?	Changes to team name. (e.g. Reducing Restrictive Practices Team) Changes to job titles (e.g. QILN and site manager) Change to time of review for restraint episodes	1	1/05/21
Appendices / electronic forms			
What is the impact of change?			

Training requirements	Inform clinical staff of change to timeframe for review by QILN/Site manager from 2 hours to 30 mins

Document consultation	
Directorates	Adult and urgent care, specialist directorate
Corporate services	Reducing Restrictive practices Group
External agencies	

Financial resource implications	None

External references

1. **Department of Health (2015)** Mental Health Act, 1983. Code of Practice.

2. Department of Health (2007): Mental Capacity Act 2005, Code of Practice, HMSO, LONDON

3. DFES/DoH (2002): The use of restrictive physical interventions for staff working with children and adults who display extreme behaviour in association with learning disability and/or autistic spectrum disorder, HMSO, LONDON.

4. **NICE Quality Standard (2017):** Violent and aggressive behaviours in people with mental health problems.

5. **NICE (2015).** Violence and aggression: short term management in mental health, health and community settings.

6. Stirling and West (2006). Restrictive Interventions: a professional, ethical and legal perspective for use of physical restraint in educational, social and health care settings. IN: **Paley and Brooke (Eds).** Good Practice in Physical Interventions: a guide for staff and Managers (British Institute of Learning Disabilities).

Monitoring compliance with the processes outlined within this document	Compliance will be monitored through review of incident reporting and staff competency

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	

– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not) – **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage) – **Religion and/or Belief** (includes those with religion and /or belief and those with none) – **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No No No No	

If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.	
Enter details here if applicable	
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?	
Enter details here if applicable	
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	N/A
Enter details here if applicable	
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk	
Was a full impact assessment required?	No
What is the level of impact?	Low

Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There **is no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	
There **is** specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	✓

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)

Career Grade Doctor				
Training Grade Doctor				
Locum medical staff				
Inpatient Registered Nurse (including staff located at Crisis care centre)	✓	One off	change to timeframe for review by QILN/Site manager from 2 hours to 30 mins. • Handout/Poster • Face to face during MAPA course.	✓
Inpatient Non-registered Nurse				
Community Registered Nurse				
Community Non Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Completed by	Robert Sillito	Date	01/05/21

CONTENTS

1. Introduction

Therapeutic environments are most effective for promoting both physical and emotional wellness and restrictive interventions should only be used in a modern, compassionate health service where there is a real possibility of harm to the person or to staff, the public or others (DOH, 2014). The purpose of this policy is to provide a framework to provide the development of service cultures and ways of delivering services which better meet people's needs and reduce the need for restrictive physical interventions.

It is recognised that at times some individuals by their actions can endanger their own safety and/or the safety of others. In these situations staff may need to use restrictive physical interventions in order to safeguard the individuals for whom they care. At such times, it is expected that staff will act professionally in accordance with their level of experience and training, following local policies, professional guidance and legal doctrine. There are many types of restrictive intervention and this policy aims to provide general guidance to staff. It aligns to the following policies which give specific guidance to particular issues:

- Formal detention under the Mental Health Act (MHA)
- Seclusion
- Locked Door Policy
- Weapons Policy
- Guidelines for staff regarding the police use of CS Spray
- Personal searches
- Lone worker guidelines

2. Scope of the policy

The aim of this policy is to ensure that all staff:

- Understand their responsibilities in the use of restrictive physical interventions are trained in their use.
- Understand their responsibilities for their actions or omissions (duty of care).
- Understand the process to follow following incident of using restrictive intervention e.g. incident form, completion of debrief.

The intention of this policy is to prevent undue restriction of patient's liberties, to promote good practice and to enhance the knowledge and skills of staff working within the Trust. The emphasis of care is based on restraint reduction strategies.

2.1 Diversity and inclusion

Clinical practice must take account of diversity and inclusion. All clinicians should consider the manner in which patients are treated, to ensure that this does not inadvertently discriminate against any groups in society based on their race, disability, gender, age, sexual orientation, religion or belief. The Trust is committed to ensuring that people are treated as individuals with privacy, dignity, respect and modesty. Modesty comprises a set of culturally or religiously determined values that relate to the presentation of the self to others. Care must actively promote privacy and dignity and respect modesty at all times.

To monitor this any protected characteristics of people subject to restrictive interventions must be gathered through the trusts incident reporting systems.

3. Framework

3.1 Restrictive interventions

The National Institute for Health and Care Excellence (NICE, 2015) define restrictive interventions as:

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

The Mental Health Act 1983 Code of Practice (DOH, 2015) stipulates that physical restraint should be used only where other strategies such as de-escalation have proved insufficient. Physical restraint should always be used in conjunction with further efforts to de-escalate the situation. It should never be used as a punishment or in a punitive manner. Action taken must be based upon a person centred risk assessment and behavioural support planning or in an emergency, the situation and level of risk.

3.2 Definitions of specific restrictive intervention methods

3.2.1 Physical intervention

Physical holding: The use of physical holds to manage, limit or restrict an individual's ability to move during the provision of safe care or in the management of a violent episode.

Disengagement: The use of physical actions to limit, stop or disengage from harmful or injurious physical contact initiated by another during the provision of safe care or in the management of a violent episode.

3.2.2 Chemical intervention

The use of chemicals or pharmaceutical agents to alleviate, treat or manage an individual's underlying psychological or psychopathological condition or reduce the risks presented by certain behaviours.

3.2.3 Mechanical intervention

The use of splints, straps, tethers, harnesses or furniture (e.g. reclining chairs, wheelchairs, bed rails) to limit or restrict an individual's autonomy.

3.2.4 Environmental intervention

The use of locked doors, baffle handles, time out rooms, low stimulus environments, fences or gates to contain or limit an individual to or from one particular room, building or location. This could be related to legal restrictions e.g. MHA 1983 (2007).

3.2.5 Social/psychological intervention

The use of verbal instructions or commands, withdrawal procedures, social restriction (e.g. time out from positive reinforcement) to limit, interrupt or stop an individual's behaviour which is viewed as potentially harmful, undesirable or socially unacceptable

3.3 Guidelines for best practice

The following guidelines set out standards for staff to safely manage actual or potential aggression ensuring that the prevention of harm is of paramount importance. The guidance within this document is of a generic nature and promotes person centred care therefore staff must interpret accordingly and apply the principles within their various work areas.

3.3.1 Management of actual or potential aggression (MAPA®)

NSCHT has an ongoing programme of training in the Management of Actual or Potential Aggression (MAPA®). This training incorporates theoretical components including legal, ethical and professional issues, proactive management strategies and physical skill components. Each of these aspects are of equal importance and are interdependent, offering a broad continuum of care options when managing actual or potential aggression.

Throughout MAPA training the emphasis is on avoidance and de-escalation, with physical interventions being taught as a "last resort" via a 'least restrictive response model'.

MAPA® is a registered trademark of the Crisis Prevention Institute (CPI) and MAPA® Training is certified by BILD-ACT under the Restraint Reduction Network (RRN) Training Standards. (Ridley J & Leitch S 2019).
CPI, licenses the Trust on annual basis, to teach MAPA® physical interventions to internal staff and through an exception clause to legitimate others, such as informal carers. The Trust is a BILD Association of Certified Training Affiliate Organisation, this means that the MAPA® training delivered to trust staff, by our certified instructors is certified against the RRN Training Standards.

All staff who have undertaken an initial MAPA® training program, must attend an annual update, in order to maintain their live status on the MAPA® training register.

3.4 Recognition and Prevention of Disturbed or Violent Behaviour

The primary focus when managing patients who potentially present with disturbed or violent behaviour should be the establishment of a culture which focuses on early recognition, prevention and de-escalation of potential aggression thereby minimising the risk of its occurrence.

Staff should attempt to engage and gain the confidence of patients so that they can learn to recognise potential stressful events at an early point. Thereby enabling potential

risks to be managed in a pro-active and non-physical way by the use of diffusion, de-escalation and diversion techniques.

Continuity of staffing is an important factor in both the development of skills and consistency in managing behaviours that present risk.

Patients who are identified as being at risk of disturbed or violent behaviour should, where capacity allows, be made aware of and provided with the opportunity to discuss their views and wishes. Any such views or wishes should be recorded in the form of an Advance Statement (Chapter 9, MHA 1983 Code of Practice, (2015)). These wishes should also be recorded in the patient's individual intervention plans.

Staff should demonstrate and encourage respect for diversity and recognise the importance of privacy and dignity in relation to the safe and therapeutic management of patients.

Staff should always see the behaviour of patients in context and not categorise behaviour as disturbed without taking into account the circumstances in which it occurs. Whilst past behaviour is an important factor in assessing risk it should not be assumed that a previous history of violence means that the behaviour will be repeated.

Individual risk assessment or behavioural support plans should be proactive and include primary and secondary preventative strategies. Care should be taken to ensure that there are no negative or stigmatising judgements made about certain diagnosis, behaviours or personal circumstances.

Individual person centred intervention or behavioural support plans are fundamental to the appropriate management of aggressive behaviour. Challenges can be minimised by promoting the therapeutic culture of the environment and by identifying and managing potential areas or concern/risk. Positive measures may include:-

- Empowering patients by engaging, communicating and involving them in their own care and treatment.
- Developing a therapeutic relationship between each patient and named Nurse
- Developing a therapeutic relationship between patient and the wider Multidisciplinary team
- Seeking patient co-operation and encouraging influence in their own care and support.
- Consideration of an appropriate patient mix and good balance of skills within the staff team.
- Encouraging patients to identify their own triggers and early warning signs for aggressive behaviour and assisting to develop individual coping strategies and de-escalation plans that are personal to the patient.

- Positive environmental factors such as patients having access to their own "space", recreation rooms, single sex areas, visitor's rooms and outside areas.

- Providing appropriate activities for all patients, including exercise and encouraging participation in activities **meaningful** to each individual.

- Ensuring that the cultural, religious and spiritual needs of the patient have been discussed, identified and responded to.

- Ensuring that complaints or issues of concern are dealt with promptly, transparently and fairly.

3.5 Use of physical interventions

The most common reasons for the use of restrictive physical holding (MAPA®) are:

- Physical assault
- Dangerous, threatening or destructive behaviour
- Self-harm or risk of physical injury by accident
- Prolonged and serious verbal abuse, threats, disruption of the living environment
- Extreme and prolonged over activity that is likely to lead to physical exhaustion
- Attempts to abscond (where the patient is detained under the Act).
  (Mental Health Act 1983 Code of Practice, DOH, 2015)

The use of restrictive physical holding techniques / skills will always be used as a last resort. They should not be used until all other approaches have been tried and have failed or the risk is so imminent that there is no safer alternative. Staff should balance the risks when deciding whether or not to physically intervene. There may also be times where, following risk assessment and individual behaviour support planning, that the proactive application of restrictive physical interventions are indicated as part of a broader plan of care. All efforts should be made to include/reflect on advance statements.

Individual characteristics aid the decision making process relating to the use of restrictive physical interventions. The person's intent and potential to cause harm to self or others must be considered. Factors to be considered may include the person's physical ability / disability, age, gender, physical characteristics, psychological and sensory disorders. Additional factors are the circumstances (i.e. the environment) and the persons "willingness to disengage" following an incident.

Any restrictive physical holding must be both reasonable and proportional in the circumstances. The force used being the minimum required to effectively reduce the risks of the aggressive behaviour i.e. - the least restrictive option (minimum use of force for the minimum time). All actions taken by staff should facilitate the de-escalation of the aggressive behaviour.

The purpose of the restrictive physical holding is to firstly take control of a dangerous situation and secondly to limit a person's autonomy for no longer than is necessary to reduce the likely hood for harm to self or others.

It is unsafe practice for staff to attempt to physically manage aggression on their own. If staff are alone and faced with actual or potential aggression they should attempt to disengage from the situation and summons assistance by the most appropriate means available e.g. use of alarm systems.

Where there is only a small number of staff present, they may also consider activating appropriate alarms if they feel more staff are required to safely manage the aggressive situation. In any event staff should summon support via alarm systems if they believe that this will decrease or minimise the risks of harm.

3.6 Guidelines for physical means of managing actual or potential aggression

The physical management of aggression will always involve a degree of risk to all parties involved. It is therefore essential that all staff discharge their duty of care in that no reasonable act or omission on their part will knowingly or negligently cause harm to the person displaying aggression, and that any action taken will ensure so far as is reasonably, the safety and wellbeing of everyone involved.

It is neither possible nor desirable to outline specific methods of restrictive physical intervention in these guidelines. However, the training and application of physical intervention skills will NEVER involve weight being applied to a person's neck, chest, or abdomen. Furthermore the use of pain compliance should never be used.

Only staff that have completed the full MAPA© course, including restrictive physical holding skills, and whose names appear on the live MAPA© Register should engage in the application of restrictive physical intervention. However in an emergency individual's who have not been trained or who have allowed their registration to lapse, may do so. However they must act in a manner that is safe, professional, and reasonable in the circumstances to prevent harm to themselves or others. If it is identified post event that it is likely that the individual may find themselves in a similar situation again, then they should attend MAPA® training as soon as it is reasonably practicable.

It is the responsibility of the Line Manager to ensure the safety and wellbeing of patients, staff and visitors. This responsibility will be appropriately delegated when the manager is not available. It is important that managers are aware of the capabilities of their staff in relation to restrictive physical interventions and maintain appropriate levels of training to meet the needs of the service.

3.7 Restrictive holding of children

If it is deemed necessary to physically hold a child, those staff involved must discriminate their size and weight in relation to the child, this may affect type and position of physical hold used. Wherever possible staff should endeavour to avoid the prone position, if this is impossible then staff must adhere to the guidance given in 3.11.

3.8 Points of good proactive practice

Proactive practice is as much to do with attitude as it is about clinical practice. It is about a willingness to actively identify and then manage risks posed by an aggressive person should they display aggressive behaviour (verbal / physical). This will involve a willingness to engage with the individual pro-actively at different levels in order to develop a good rapport.

Activities: Programmes of occupation and / or diversion may be useful in reducing boredom and frustration, both of which are key factors in aggressive behaviour. Additional activities that focus on individual coping strategies are beneficial.

Assessment plans: To support completion of assessment plans, staff will complete clinical risk assessments linked to individual behaviour support plans which highlight the appropriate measures to be taken in the event of the use of the restrictive physical interventions in the management of aggression.

Appropriate communication: It is vital that appropriate information is shared with managers, nurses and other colleagues (multi-disciplinary) about potentially aggressive individuals (patients / relatives).

Dress: Can you move freely? Maintain dignity? Do you have anything on you that could cause injury to yourself or others e.g. scissors, pens, or a tie?

Environment: The environment should be as pleasant and comfortable as possible, offering therapeutic value. This may enhance the service users experience and consequently may minimise the likelihood of an aggressive or violent incident.

- The environment should be managed and designed with consideration as to whether it may under or over stimulate an individual potentially leading to aggressive behavior.

- Dependent on the service provision consideration should be given to the security of the environment (doors, windows), and the availability of weapons (e.g. pens, vases, sharps)

- Only those staff involved in the restrictive physical intervention and required to help minimise risk and facilitate communication should be present, and if possible remove on-lookers so as to facilitate both de-escalation and dignity.

Factors that may increase the likelihood of aggression: People who feel dis-empowered, under represented, frustrated, under or over stimulated and unable to effectively communicate may be more likely to exhibit aggressive behaviour.

Medication: May be used as a proactive measure as well as in a crisis intervention. As required medication, should be given as indicated by the

Responsible Medical Officer or nominated deputy, and its effects monitored closely both in regards to the ability of the medication to treat the patient / client's physical and/or mental condition and minimise their aggressive behaviour (see Policy on Rapid Tranquillisation). *The above statement only applies to those clinical areas where the use of as required medication is a viable option, this will primarily be within inpatient/residential settings.*

Relationships: The establishment and maintenance of a professional therapeutic relationship between staff and service users is a key factor in reducing aggressive behaviour or in facilitating the de-escalation of an aggressive person. Staff should treat service users at all times with dignity and respect.

Training: All clinical staff are required to complete clinical risk training. Through risk assessment managers should be able to identify the further training needs of their staff and arrange appropriate training ensuring that services are appropriately covered. All staff in high-risk areas identified by risk assessments will require appropriate MAPA© training.

3.9 Person centred care planning

All service users who present with a risk of violent/aggressive behaviour should have person centred intervention plans that identify the level of risk, and the primary, secondary and tertiary interventions necessary to reduce the risk to an acceptable level. The intervention plan must be written by a first level nurse and agreed with the multi-disciplinary team. Involvement of the service user in the identification of trigger factors, safety plans and advance statements should always be sought. The plans must be documented, agreed, reviewed and shared across all professions, (NICE Quality Standards, 2017).

Where there is a history of violence, consider the context of this including the stressors e.g. (person/ environment). Ensure appropriate levels of observation and engagement for service users and consider the completion of a functional analysis.

The intervention plan must include a rationale for using restrictive holding, the levels of holding to be used and the preferred position the service user should be held in, bearing in mind any physical/medical conditions which would make certain positions a higher risk.

Re-assessment and evaluation of the intervention plan should be on- going and the restrictive physical intervention removed from the plan as soon as it is practical and safe to do so.

Any plan concerning restrictive physical intervention must not be used in isolation. Plans promoting primary and secondary prevention strategies and engagement must be in operation to minimise the need for physical holding.

All incidents of the use of restrictive physical holding techniques should be

documented via the electronic incident reporting system. This includes those which are required for the administration of planned care and treatments. Any protected characteristics should also be captured.

3.10 Weapons

When dealing with a violent or potentially violent situation it is important to make visual check for weapons.

A weapon may be defined as *"any object that is made for the purpose, adapted for the purpose, or intended for the purpose of inflicting physical injury upon a person",* (Crime & Disorder Act 1956).

If a weapon is identified then withdraw, negotiate, and if necessary call the police. REMEMBER: no staff within NSCHT will have received training in disarmament techniques and they should therefore NEVER attempt to disarm an aggressor.

Within MAPA training, advice is given about what to do if attacked with a weapon; this is distinctly different from disarming an aggressor. In such situations the initial staff response should be to "back off" and try to put some distance between you and the attacker. If this is not possible try to utilise large items of furniture as a barrier between yourself and the attacker e.g. bed, dining table, large sofa or arm chair. Consider if it possible to isolate the attacker in an area whilst the police are summoned via 999.

3.11 Safe Practice

It is recommended that a minimum of two staff are involved in any process of physical holding. This number may have to be increased depending on the level of risk and severity of the incident.

The safety of both staff and service user are paramount therefore a sufficient number of staff should be identified to manage the incident as safely as possible. Staff should be allocated a specific task, bearing in mind that these roles may need to change during the incident.

Clear on-going communication within the team and with the service user is important, aiding de-escalation and co-ordination of the team. Therefore it is best if only one person at a time talks to the service user and leads the team.

Fewer well-briefed staff are likely to be more effective than a large number of staff acting in an un-coordinated manner. If more staff are in attendance than are needed they should be asked to leave the immediate vicinity to facilitate both de-escalation and the maintenance of the person's dignity and privacy.

Staff should seek to reduce the risks of the situation as swiftly as possible and then manage the person's aggressive behaviour. Staff should then consider moving

the person or others to achieve a low stimulus environment, to better facilitate the process of de-escalation. REMEMBER you should only consider moving the person when it is safe to do so and you will need their co-operation. Thus, it may be necessary to ask other service users to leave the area in order to maintain dignity.

In extreme circumstances it may be necessary to manage the aggressive person on the floor, although a seated position is more preferable, as it promotes dignity and avoids some of the risks involved in conducting physical holding on the ground, (NICE, 2015).
Any descent to the ground should be controlled and initiated by the Service User; it should never be initiated by staff. During the descent and when on the ground the service user's head should be protected from harm.

Normal respiratory function should not be compromised, and weight should never be applied to a person's head, neck, chest, or abdomen. A "THIRD PERSON" should always be available for communication with and observation of the service user in order to monitor the service user's physical wellbeing, (NICE, 2015).

Staff must explain to the service user the reasons for the application of restrictive physical intervention, actively seek the co-operation of the person and restore autonomy to the person as soon as it is safe to do so.

During the course of the restrictive physical interventions staff should remain mindful of issues relating to: human rights, dignity, respect, gender, race and ethnicity.

Staff should act without malice at all times.

NB: During all restrictive physical interventions it is imperative that the person being physically held is constantly monitored for signs of physical distress, this is particularly important when the person is held in the prone position i.e. (face down) the restraining staff should monitor breathing, skin colour, pulse rate etc., if possible a pulse oximeter should be applied this will monitor pulse rate and blood oxygen levels, an explanation of what is being done and why should be given to the service user (nursing staff need to be aware that pulse oximetry is only used to assist in good nursing observations and care). If the individual becomes physically distressed i.e. difficulty in breathing, it is essential that staff respond promptly with appropriate first aid/CPR. Where there are concerns about the patients physical wellbeing following a period of restrictive holding, staff, with the patient's consent should utilise a pulse oximeter to assess oxygen saturation levels.

The physical/physiological profile of the individual may offer risk indicators e.g.

- History of respiratory/cardiac problems
- Obesity
- Under the influence of alcohol/drugs
- Recently eaten a large meal
- Pregnancy

The use of physical MAPA® skills should only be seen as a small part of the management strategy. Staff will bring their clinical experience, professionalism, knowledge and confidence to each situation. A confident approach is likely to aid the de-escalation process.

If the restrictive physical holding continues for more than 10 minutes, staff should consider the use of rapid tranquilisation and/or seclusion (NICE, 2015). In rare situations where physical restraint lasts beyond 30 Minutes, then the Quality Improvement Lead Nurse/ Site Manager must be informed and asked to review the situation. They can then make a decision as to the appropriateness of continuing the physical management of the aggression.
In those services where there is an out of hours on call system, the on call manager must be informed who will then carry out the review

The RMO/Doctor or nominated deputy (whichever is appropriate) following the commencement of restrictive physical holding, should see the service user as soon as is reasonably practicable and ensure the application of appropriate medical / psychological care.

The Organisation will always support staff whose practice is compatible with this policy. *"Any reasonable action taken by an employee in good faith during a violent incident, providing appropriate professional judgments and personal behaviour were in accordance with trust and directorate policies and the law will receive the understanding, sympathy and support of the trust".* (Violence and Aggression Policy 5.19).

3.12 Action to be taken after physical intervention

Following an event of restrictive physical interventions procedural responsibilities continue at an individual, service and organisational level. This responsibility falls broadly under three areas; reporting, support and learning.

3.12.1 Reporting:

- All incidents involving staff regardless of setting (centre, ward, community) should be reported.

- A full account of the incident must be recorded in the person's Electronic patient record and the relevant incident forms completed - Safeguard Incident Report Form and forwarded to the Patient & Organisational Safety Dept., Weekly Incident Monitoring Group, and notification should go to the appropriate Service Line Manager/Service Head/Line Manager/Senior Nurse/Quality Improvement Lead Nurse.

- Immediately following the incident, the appropriate manager or designated senior staff member will assess the situation to identify action(s) required to reduce or prevent a recurrence of the incident and to ensure the safety of all individuals. This may include increased observation and / or discussion of the incident with the patient / client.

- The Line/Appropriate Manager must be informed of any aggressive incident as soon as is reasonably practicable, who then in conjunction with the appropriate manager and a senior staff member will review the incident, and assess the need for any additional staffing immediately and in the future.

- In the event of a staff member getting injured during the physical management of aggression, appropriate medical treatment should be sought as soon as is reasonably practicable.

- In the event of an aggressive person being injured during the management of their aggression and / or from an accident a decision has to be made regarding informing the patient's family. With minor injuries (cuts, bruises) these will usually be reported to relatives as soon as practicable but may with agreement of the patient and family be reported at next visit or within agreed time frames. With more serious injuries (fractures, hospitalisation) a senior staff member must inform the relatives as soon as is reasonably practicable and to do so by the most appropriate means.

- Any individual who sustains an injury as a result of violence has Rights under the Criminal Injuries Act to seek compensation (all necessary reporting mechanisms should be utilised to lend support to any subsequent claims). Individuals do not need permission from anyone else to bring a claim against another person who has assaulted them. Advice and assistance is available from the Local Security Management Specialist, Patient and Organisational Safety Department.

3.12.2 **Post** Incident Support:

Following an incident the Trust recognises the need for support for the service user and for staff. Ideally support should be offered to everyone involved in or by default observed the incident. Debrief should take place as soon as is practically possible which may need to be followed by further support as required.

The patient should always be offered the opportunity to be involved in a post incident debrief. This should occur as soon as they have recovered their composure (NICE, 2017). Although the latest NICE Quality Standards (2017) state that a doctor should be involved in patient de-brief, the Trust position is that this will initially be facilitated by a nurse but may involve a doctor if deemed to be necessary or requested by the patient. Longer term, more intensive support may be required in some scenarios. Further advice on staff support can be obtained from the Staff Counselling Service or by consulting Trust Policy.

3.12.3 Post Incident Learning:

The Trust recognises the importance of incident analysis and its role in restraint reduction. This requires clinical teams and the wider organisation to looking objectively at an incident with those involved and where appropriate the service user, to identify what worked well and what can be learned in order to influence and shape individual restraint reduction plans. Risk assessments should be reviewed and / or conducted, as well as Incident Investigation Forms. The multidisciplinary team should meet to discuss the incident and discuss the future management of the individual(s) involved in the aggressive incident, involving the service user where possible.

The staff team are responsible within their available resources to take all reasonable actions necessary to reduce the chance of a re-occurrence of the incident. They should consider consulting with appropriate others for assistance in this task.

Senior Manager's and Department Heads have a responsibility if the incident is seen as actually or potentially serious to forward copies of all reports / forms to the appropriate Associate Director / Professional Head/Clinical Lead, and the Patient & Organisational Safety Department. Further information can be accessed via Trust Policy

4 The use of restrictive holding for invasive/investigative treatment purposes

The use of restrictive physical interventions within services for people with learning disabilities and mental ill health is widely accepted as a possible appropriate response to incidents of severe challenging behaviour, aggression and/or violence.

However the current national guidance presents difficulties in interpretation for clinicians developing a professional framework which supports the use of physical interventions for the purpose of invasive, investigative treatment or the delivery of personal care.

Consequently, there is a danger that some service users may not receive appropriate, safe or effective medical treatment because their behaviour presents a risk to themselves, to the medical practitioner or accompanying staff.

This section of the policy has therefore been developed to help clinicians make appropriate decisions relating to the assessment and treatment outcomes for those service users who may require some level of physical support or intervention as part of their treatment plan.

4.1 Definition

The DH and DFES Joint Guidance broadly defines physical intervention as the "*use of force to control a person's behaviour*", and the Mental Capacity Act, 2005, section 6(4) states that someone is using restraint if they "*use force - or threaten to use force - to make someone do something that they are resisting, or restrict another person's freedom of movement, whether they are resisting or not*".

4.2 Framework

A medical doctor involved in the care of an individual may request for investigative/treatment purposes an invasive procedure to be performed. For example, the use of venepuncture for the purpose of obtaining a sample of blood. Provision of essential care such as personal hygiene might also be an issue.

4.3 Where a service user explicitly consents

A service user with capacity may require physical assistance or support, or may behave in a manner that presents risk to self or others. In such circumstances, clinical holding may be appropriate to support the service user during the course of the treatment. The procedure must have been discussed with the service user prior to it taking place and the patient must have provided informed consent. In such scenarios the patient can withdraw consent at any time and any clinical holding should be immediately terminated.

4.4 Where a service user lacks capacity to consent

Where a person does not have capacity to consent, and it is the view of the treating doctor that it is in the best interests of the individual to undergo the relevant procedure, it may become necessary for staff to consider the use of some form of physical holding in order that the procedure can be undertaken. The Mental Capacity Act, 2005 (Policy MHA16) authorises staff to provide care and treatment to service users who lack capacity as long as it is in their best interests. Where restraint is considered under the Mental Capacity Act it must also be a proportionate response to the likelihood of the service user suffering harm and the seriousness of that harm. The use of holding techniques can only take place once all other efforts at gaining cooperation have been explored and exhausted and should represent the least restrictive and detrimental course of action. In all instances the decision to use an invasive procedure should be based on a "best interests" decision involving the MDT and (where possible) family/carers.

The Mental Capacity Assessment, Best Interests Decision and risk assessment around the use of an invasive procedure must be documented in the individual's clinical notes.

Where there is no one to consult (other than paid staff) as part of the process of establishing Best Interests, an Independent Mental Capacity Advocate (IMCA) must be consulted where the intervention is considered to be serious medical treatment (Chapter 10 MCA Code of Practice provides a definition of serious medical treatment as it can include relatively minor treatment) Referrals should be made to the IMCA service at Assist.

4.5

Where service users are detained under the Mental Health Act and who will not or are unable to consent to venepuncture as part of their treatment where such intervention falls within the definition of *'clinical treatment'* or treatment *'ancillary or concurrent with the core treatment that the patient is receiving'* as defined in Section 145 Mental Health Act 1983 guidance should be sought via the Mental Health Act 1983, Code of Practice, 2015.

Where service users are not subject to the Mental Health Act, but intervention falls within the Section 145 definition of Medical Treatment, the need for restraint may constitute that the patient is objecting to treatment and as such consideration should be given to whether formal detention under the Mental Health Act is required.

Where the intervention does not fall within the Section 145 definition of medical treatment, or the service user does not meet the criteria for detention under the Mental Health Act for other reasons, but the use of restraint is frequent, cumulative and ongoing, it may indicate that the service user is being deprived of their liberty and may need authorisation under the Deprivation of Liberty Safeguards (See Policy MHA 18 DOLS) An example of this may be where the intervention is for an physical disorder that is unrelated to the service users mental disorder.

4.6 Duty of Care

It is the responsibility of all clinicians to avoid acts or omissions that are likely to cause harm to another person. The use of clinical holding as part of a service user's treatment plan is subject to this responsibility, as it could be argued that a failure to provide individuals with the necessary support, care or treatment they require may constitute neglect or an omission of care.

It is the responsibility of all registered practitioners to safeguard the interests and wellbeing of all patients and clients in line with their individual professional codes of practice.

Consent must be obtained for any invasive procedure and an assessment of capacity to consent may be required and regularly reviewed with an individual

where the multidisciplinary team feel that the individual has intellectual impairment. (North Staffordshire Combined Healthcare Policy and Procedure for Advance Statements and Advance Decisions to Refuse Treatment - Policy 1.55)

Information will be shared with the individual at all times. There may be a requirement to utilise alternative methods of communication with individuals where there are communication difficulties and or limited intellectual ability.

The decision made by the multidisciplinary team, in conjunction with family members/carers and/or advocates must be written in the person's clinical and nursing notes. For each instance of clinical holding an Incident Notification Form must be completed under the incident type “Clinical Incident” and cause group “Treatment/Procedure” and cause “Use of MAPA® for Clinical Intervention” with a written description of the reasons for using clinical holding, listing the names of the staff involved

The decision to use clinical holding is considered to be a ‘once only’ decision. For any subsequent instance of clinical holding a further decision must be made by the multi-disciplinary team for its use unless deemed inappropriate by that team.

4.7 Best Practice

The clinical holding intervention to support invasive or investigative procedures will be planned and based on risk assessment. There must be adequate numbers of staff available for the clinical holding intervention to be safely carried out. All staff involved in clinical holding must be MAPA® trained and be live on the current register. If there is uncertainty regarding either the use of clinical holding or the appropriate technique to be used, then advice should be sought from a MAPA® trainer. This will be via the MAPA® Training Department at Harplands Hospital, telephone no 01782 441600 ext. 1389 or 1354. Out of hours, the normal on call arrangements apply, although wherever possible pro-active plans should be made within normal working hours if it is apparent that an issue may arise out of hours.

5. Monitoring of Restrictive Practice within the Trust

The Weekly Incident Review group should review all reported incidents. This multidisciplinary group, which represents all service lines, meets on a weekly basis. The purpose of this group is to identify and evaluate incidents and if deemed necessary investigate them. Additionally they may offer support and assistance to individuals affected by the incident and identify priority-training needs.

A review of all incident reports involving the use of restraint is also undertaken on a weekly basis by the Reducing Restrictive Practices team. Particular attention is focussed on the length of time of physical restraint, restraint

position (particularly around the use of prone restraint), and ensuring that staff adhere to policy, training and national guidelines.

6. MAPA Live Register

In the interests of safety and good clinical practice staff who have undertaken MAPA® training will require updating, and that attending such dates is each individuals own responsibility. The recommendation is that staff should attend at least one update per year. If a member of staff goes beyond 18 months without attending an update the MAPA® training team will decide on an individual basis whether the staff member requires extra training. This may include having to re-attend a 5 day MAPA® Foundation Course. Those that do not attend within the specified time will not be live on the register.

It is also the responsibility of Ward/Service Managers and Associate directors of each directorate to ensure so far as is reasonably practicable that the staff they have responsibility for are trained appropriately for the area in which they work.

Staff who have attended MAPA® training and whose name appears on the live Register (Learning management system located via intranet) should be able to offer advice and guidance to those staff who have not been trained or to those whose names are no longer on the register during an incident where restrictive physical interventions are required (but only qualified / currently registered trainers will teach MAPA® skills).

7. Duties and responsibilities

7.1 The Trust Chief Executive through the Chief Operating Officer, Medical Director and Director of Nursing has overall responsibility to ensure that processes are in place to:

- Ensure that staff are aware of this policy and adhere to its requirements.
- Ensure that appropriate resources exist to meet the requirements of this policy.

7.2 The Associate director of each Directorate are responsible for ensuring that relevant Directorate policies and procedures are in place and their effectiveness is monitored as part of the Directorate Governance Plan. They are also responsible for ensuring that all operational managers in their areas are aware of this policy, understand its requirements and support its implementation with relevant staff.

7.3 Clinical Team Managers (Ward Managers, Community Team Managers) are responsible for implementing the policy with their immediate staff and

ensuring that they adhere to the requirements of the relevant policies and procedures.

7.4 North Staffordshire Combined Healthcare NHS Trust (NSCHT) adopts the policy that all staff regardless of grade or discipline have a responsibility for the safety and well-being of service users, visitors and each other. With this in mind it is the duty of each and every member of staff to offer all reasonable assistance where and when necessary in line with their experience and training. This does not mean that all staff must become directly involved in restrictive physical interventions, but that they may be able to offer all other reasonable assistance in meeting other needs of the situation.

8 References

Department of Health (2015) Mental Health Act, 1983. Code of Practice.

Department of Health (2007): Mental Capacity Act 2005, Code of Practice, HMSO, LONDON

DFES/DoH (2002): The use of restrictive physical interventions for staff working with children and adults who display extreme behaviour in association with learning disability and/or autistic spectrum disorder, HMSO, LONDON.

NICE Quality Standard (2017): Violent and aggressive behaviours in people with mental health problems.

NICE (2015). Violence and aggression: short term management in mental health, health and community settings.

Ridley J & Leitch S (2019). Restraint Reduction Network (RRN) Training Standards First edition Ethical training standards to protect human rights and minimise restrictive practices.

North Staffordshire Combined Healthcare NHS Trust

Document level: Trust
Code: R02
Issue number: 2

Guideline for the Safe Use of Bed Rails

Lead executive	Executive Director of Nursing and Quality
Authors details	Head of Patient & Organisational Safety

Type of document	Policy
Target audience	Clinical
Document purpose	Information & Guidance

Approving meeting	Quality Committee Trust Board	Meeting date	6th May 2021 13th May 2021
Implementation date	30th June 2021	Review date	30th June 2024

Trust documents to be read in conjunction with	
1.46	Prevention and Management of Slips, Trips and Falls
MHA16	Mental Capacity Act Policy
1.41	Clinical Risk Assessment Policy

Document change history		Version	Date
What is different?	Formating		
Appendices / electronic forms	Appendix 1 – Patient Assessment: Safe use of bed rails. Appendix 2 – Safe use of bed rails: safety checklist Appendix 3 – Information for Patients, Relatives and carers regarding the safe use of bed rails.		
What is the impact of change?	N/A		

Training requirements	Prior to utilising bed rails staff must receive appropriate instruction in their use. Training may be from a registered nurse or allied health professional skilled and knowledgeable in the assessment and safety checks contained within this policy.

Document consultation	
Directorates	
Corporate services	
External agencies	

Financial resource implications	None

External references
1. Medicines and Healthcare Related products Agency (MHRA) 2. National Patient Safety Agency (NPSA)

Monitoring compliance with the processes outlined within this document	

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)	No	
– **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who	No	

may or may not be part of the groups above equality groups)		
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
N/A		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
N/A		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	Yes / No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	Yes / No	
N/A		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There **is no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	✓
There **is** specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Career Grade Doctor				
Training Grade Doctor				

Locum medical staff				
Inpatient Registered Nurse	✓	As required	Face to face	
Inpatient Non-registered Nurse	✓	As required	Face to face	
Community Registered Nurse				
Community Non Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist	✓	As required	Face to face	
Clinical bank staff regular worker	✓	As required	Face to face	
Clinical bank staff infrequent worker	✓	As required	Face to face	
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

None

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

National Patient Safety Agency (NPSA)

Any other additional information

None

Completed by		Date	

Contents **Page**

Appendix

1. Introduction

Bed rails are widely used to reduce the risk of falls. Although not suitable for everyone, they can be effective when used with the right bed, in the right way, for the right person.

There are however risks relating to the use of bed rails. Poorly fitting rails have caused deaths where a person's neck, chest or limbs have become trapped in gaps between the bed rails or between the bed rail and the bed, headboard or mattress. Other risks include:

- Rolling over the top of the rail
- Climbing over the rail
- Climbing over the footboard

These guidelines are designed to support the safe use of bed rails in inpatient areas. They are intended to provide clarification of the decision making process regarding whether or not bed rails should be used and are not intended to replace an individual's professional judgement.

Since 2011 the Department of Health included chest or head entrapments in bed rails on the 'Never Events' list for healthcare providers. 'Never Events' are defined as 'serious, preventable patient safety incidents that should not occur if the relevant preventative measures have been implemented by healthcare providers.

Rigid bed rails can be classified into two basic types:

- **Integral** types that are incorporated into the bed design and supplied with it, or are offered as an optional extra by the bed manufacturer to be fitted later.
- **Third party** types are not specific to any particular bed model. They are intended to fit a wide range of domestic, divan or metal framed beds from a different supplier.

2. Scope

This policy applies to all staff caring for people in the inpatient areas of the Trust.

3. Purpose

These guidelines aim to:

- Support patients and staff to make individual decisions around the risks of using and not using bed rails.
- Reduce harm to patients caused by them falling from beds or becoming trapped in bed rails.
- Ensure compliance with the Medicines and Healthcare Related products Agency (MHRA) and National Patient Safety Agency (NPSA) advice.

4. Use of bed rails in an inpatient setting

4.1 All patients should have a documented falls risk assessment. This should be completed within 8 hours of admission and includes an assessment of 'maintaining a safe environment' for the individual. If indicated, specific consideration will be given to the risk of falls from a bed (Appendix 1).

4.2 Any patient identified as being at risk of falling will have a care plan relating to this risk with clear evaluation and reassessment schedules. The assessment will include consideration of the use of bed rails; if indicated then the use of bed rails must be included in the care plan.

4.3 When the assessment indicates the use of bed rails, the justification for their use will be clearly documented in the patient record.

4.4 Where bed rails are indicated, evidence of any potential risk of injury from their use will be considered and documented in the patient record.

4.5 Discussions regarding the use of bed rails and the risk involved will be undertaken with the patient and their family/carers. This discussion must include taking the views of the patient and the family/carers into account. Consideration of the patient's capacity to make a decision in relation to the use or non-use of bed rails must be clearly documented.

4.6 If injury or harm occurs as a result of the use of bed rails, staff will undertake an immediate reassessment and review of the care plan in relation to the continued use of bed rails.

4.7 Where bed rails are in use, they will be checked and made secure each time that they are raised (Appendix 2). Staff have a responsibility to **remove** any unsafe equipment from use.

4.8 Beds will remain at the lowest possible level whilst the bed rails are in use. Staff are to consider the use of HiLo beds, where available.

4.9 Bed rails should only be used to reduce the risk of a patient accidentally slipping, sliding, falling or rolling out of bed. Bed rails used for this purpose are not a form of restraint. Restraint is defined as 'the intentional restriction of a person's voluntary movement or behaviour'. Bed rails are considered to be a restraint when they are used primarily with the intention of limiting the person's movement. Bed rails will not prevent a person from leaving their bed and falling elsewhere and should not be used for this purpose.

5. Decision Making and Risk Assessment

The decision to use bed rails should be made as part of a full risk assessment and be based on the principles of least restrictive practice (Appendix 1). It is essential that any risks are balanced against the anticipated benefits to the patient. In addition to this policy, staff are advised to consider trust policy 1.41 Clinical Risk Assessment.

When completing the risk assessment staff must consider the following:

- If the bed rails **are not used**, how likely is it that the patient will come to harm?
- If the bed rails **are used**, how likely is it that the patient will come to harm?

An alternative to bed rails should be considered such as:

- HiLo beds - these must be set at the lowest setting whilst the bed is in use.
- Use of the sensor care bed alarms which alert staff to when the person has moved from their normal position or have risen from their bed. See policy 1.46 Prevention and Management of Slips, Trips and Falls.
- Use of nurse call systems which people can use to alert staff on their need for assistance

The following decision making tool* may be useful in deciding upon the use of bed rails

	Level of mobility/activity			
Decision making capacity	Cognitive/mental state	Unable to mobilise independently	Requires assistance to mobilise	Independently mobile
No	Delirious, confused, disorientated, agitated, unpredictable, poor memory	Consider bedrails with caution	Bedrails not recommended. Use alternative strategies	Bedrails not recommended. Use alternative strategies
Uncertain	Drowsy/sedated/impaired consciousness	Consider bedrails with caution	Try alternative strategies; use bedrails as a last resort. Frequent monitoring required	Try alternative strategies; use bedrails as a last resort. Frequent monitoring required
Yes	Orientated and alert	Bedrails may be considered if requested by patient	Bedrails may be considered if requested by patient. Ensure they can call for help.	Bedrails not required.

*adapted from Resources for reviewing or developing a bedrail policy. NHS National Patient Safety Agency 2007.

6. Safe fitting and use of bed rails

Bed rails must be fitted correctly to an appropriate bed base allowing for safe use.

6.1 Mattress overlays

Caution must be taken if the standard mattress is replaced with an air flow mattress. The extra height of an airflow mattress, in comparison to a standard mattress, may result in a reduced bed rail height and may allow the patient to roll out over the top of the bed rail. Therefore extra height bedrails are required.

The hazard of entrapment between the sides of the mattress and the bed rail may be exacerbated due to the soft, more easily compressible nature of the overlay and/or mattress edge.

6.2 Bed rail bumpers

Bed rail bumpers, padded accessories or enveloping covers can prevent injury and reduce the potential for limb entrapment when securely fixed into position. Where extra height bed rails are in use, the correct size of bed rail bumpers must be used. However the use of padded bedrails with people who are physically frail or who have involuntary movements may increase the risk of entrapment. This must be considered before using bed rail bumpers.

6.3 Maintenance and Safety

Care must be taken to ensure that bed rails are maintained in good order. Bed rails found to be unsuitable or in poor condition must be withdrawn from use and sent for repair or condemned. The following practices must be maintained:

- Bed rails should be used and maintained in accordance with the manufacturer's recommendations.
- Adjusters, clamps and fixings must be checked as they can wear, become loose or deform giving rise to free play which can increase important gaps between bed and rail.
- Telescopic components can become loose or jammed and must be checked for correct adjustment.
- Systems must be in place to trace and maintain bed rail assemblies, enabling them to be inspected on a regular basis. Records must be kept of inspections.
- When bed rails are not required they will be removed from the bed and stored appropriately. To be stored as a complete set of bed rails, (rails and brackets) in a plastic bag and stored off the floor.

Appendix 1

Patient Assessment: Safe use of bed rails.

This tool should be used in conjunction with the guidelines for the safe use of bed rails

Patient name	**NHS number**
Ward	**Date**
Is the person confused, agitated or disorientated?	Yes
	No
Is the person considered to be at risk of falling if bed rails are not used?-	Yes
	No
Will the person be expected to get out of bed unsupervised e.g. to use the toilet?	Yes
	No
Could alternatives to bed rails be used? If yes, record details	Yes
	No
Does the person require an airflow mattress or dynamic profiling bed? If yes, record details	Yes
	No
Could the person become trapped in the bed rails or any gaps between the bed or the mattress? If yes, consider alternatives	Yes
	No
Does the person have the mental capacity to make a decision regarding the use of bed rails? Record in patient notes.	Yes
	No
Has the use of bed rails been discussed with the next of kin? Record in patient notes	Yes
	No
Has the use of bed rails been discussed with the multidisciplinary team?	Yes
	No

The outcome of this assessment must be documented win the patient records and the risk assessment repeated in the event of change in the person's condition, bed or mattress.

Assessor signature…….Date…….....

Appendix 2

Safe use of bed rails: safety checklist

	Checklist	**Yes**	**No**	**Comments**
1	Is the bed rail suitable for the bed/trolley and mattress?			
	Consider the condition of the bed rails – are they clean and in good condition?			
2	Do the fittings/clamps or mattress allow for the bed rail to be fitted securely to the bed, without excessive movement?			
3	Is the bed rail fitted correctly? Are there gaps at the headboard of <6.5cm and at a height above the mattress of 23cm? Is an extra height bed rail required?			
4	Are there gaps in the bedrails and bedframe which could allow the person to become trapped?			
5	Are bed rail bumpers in use?			
6	Has the person consented to the use of the bed rails – refer to patient risk assessment and falls care plan?			
Assessor signature		Date assessed		

The safety checklist is to be reassessed every 4 days unless there is a change in circumstances.

Date	Comments	Assessor signature

Appendix 3

Information for Patients, Relatives and carers regarding the safe use of bed rails.

Patient Name

Ward

We aim to assist patients to maintain their independence for as long as possible. This may involve consideration of a number of risks, including the risk that the person may fall out of bed.

We are aware that anxiety about falling out of bed may be felt by many people; however the number of reported injuries caused by falling from bed is relatively small.

The use of bed rails will not prevent restless, agitated or confused people from trying to get out of bed and in these cases the bed rails may result in greater injury as the person may attempt to climb over the bed rail. There is also a danger that people may become trapped in between the bed rail and the bed frame or mattress.

It is important to note that bed rails will not be used as a form of restraint.

If a person is agitated, the use of a low bed may be considered. If the assessment indicated that this may the best way to maintain the person's safety, a full discussion between yourselves and the ward team will take place.

The need for bed rails will be reviewed on a regular basis to ensure that they are not in use for longer than necessary and are removed from the bed when no longer required.

The ward team will also consider alternatives such as bed alarms or increased observation levels as part of the risk assessment. This is to ensure that the optimum balance is reached between promoting independence and maintaining safety.

Use of bed rails discussed by…….date……

Family/carer signature……

Copy to family and copy to be scanned into notes

Document level: Trust
Code: R05
Issue number:

Management of Locked Doors, Access and Egress Policy

Lead executive	Director of Nursing and Quality
Authors details	Workforce Safety Lead/Mental Health Law Team Manager

Type of document	Trust Policy
Target audience	Trust Inpatient Staff
Document purpose	Provide guidance to staff

Approving meeting	Quality Committee Trust Board	Meeting date	3rd November 2022 10th November 2022
Implementation date	30th November 2022	Review date	30th November 2025

Trust documents to be read in conjunction with	
MHA03	Nurses Holding Power
MHA04	Holding Power of Doctors and Approved Clinicians
MHA16	Mental Capacity Act
MHA18	Deprivation of Liberty Safeguards

Document change history		Version	Date
What is different?	Updated to reflect recent guidance		
Appendices / electronic forms			
What is the impact of change?	Minimal		

Training requirements	Mental Health Act/Mental Capacity Act Training

Document consultation	
Directorates	
Corporate services	
External agencies	

Financial resource implications	No financial implications

External references
1. D.O.H. (2015): Mental Health Act 1983, Code of Practice. 2. D.O.H. (2005): Mental Capacity Act.

	Minimum requirement to be monitored	Process / Method	Responsible individual / group / committee	Frequency of monitoring	Responsible individual / group / committee for review of results	Responsible group / committee for monitoring action plan
Monitoring compliance with the processes outlined within this document	Breaches in policy	Incident reporting form/ Complaint	Weekly incident review group	Weekly	Chairperson	Mental Health Law Governance Group
	Compliance with Code of Practice	Appropriate signage, information leaflets	Ward Manager and Modern Matron/Senior Nurse/AHP	Ongoing	Modern Matron/Senior Nurse/AHP	Clinical Effectiveness Forum/Team meeting

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
− **Age** (e.g. consider impact on younger people/ older people)	No	
− **Disability** (remember to consider physical, mental and sensory impairments)	No	
− **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
− **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
− **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
− **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
− **Sexual Orientation** (impact on people who identify as lesbian, gay or bi - whether stated as 'out' or not)	No	
− **Marriage and/or Civil Partnership** (including	No	

heterosexual and same sex marriage) - **Religion and/or Belief** (includes those with religion and /or belief and those with none) - **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	N/A	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	N/A	
Enter details here if applicable		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

CONTENTS

1. Executive Summary

This policy sets out the approach to be taken by the Trust in respect of locked ward doors. The Trust operates a locked door policy across all services and expects all staff to ensure patients are aware of their rights, the reasons for the locked door and options for access and egress are made clear to both patients and visitors.

Key features of this policy are the provision of information, engagement with patients and carers, escalation procedures and minimum expectancies for the above. This includes the Trust observation and application of the relevant legislation and consistently seeking to improve the patient experience through research and development in the approach to locked doors on mental health units.

2. Introduction

The Trust believes the safety of patients, staff and visitors is our utmost priority. In recognising its responsibilities and duty of care to ensure provision of safe and secure environments the decision was taken to lock the ward doors in all inpatient areas. This decision has legal and operational implications and this policy sets out our approach for all those affected by this decision.

This policy outlines the Trust's philosophy and provides a systematic and consistent approach to the management of access and egress procedures across the Trust. The Trust recognises its duty to ensure clear communication and offer appropriate routes of escalation to those patients and visitors who experience difficulties with our access and egress policy.

The Trust recognises that those patients admitted to Mental Health wards have complex, specific and individual needs. The locking of ward doors is intended to protect patients from self-harm, suicide, accidents or inflicting harm on others. This extends to protecting our patients and staff from others gaining access to the wards. This approach is compliant with the Mental Health Act Code of Practice 1983 (revised 2015) chapter 8, paragraph 8.10 to 8.15.

3. Purpose and Scope

The overall purpose of this document is to provide guidance to all staff ensuring understanding and consistency in the approach to the management of locked doors and entry and exit protocols.

his policy applies to all inpatient settings across the Trust and to all staff working on those wards in addition to Patient Advice and Liaison Staff and Corporate support staff.

4. Definitions

Mental Health Act
The Mental Health Act covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provides the legislation by which people diagnosed with a mental disorder can be detained in hospital or police custody and have their disorder assessed or treated against their wishes, unofficially known as "sectioning". Its use is reviewed and regulated by the Care Quality Commission.

Detained Patients
This refers to patients who are admitted to the wards subject to the Mental Health Act.

Informal Patients
This refers to patients who have capacity and give their consent to be admitted to a ward without the use of the Mental Health Act and can only be prevented from leaving a ward if the MHA is applied or Deprivation of Liberty Safeguards Urgent Authorisation is sought.

Access and Egress
This refers to the entry and exit of patients, staff and visitors to inpatient wards

Responsible Clinician
The consultant in charge of a detained patients care and treatment.

Best Interest Assessor
This is a role under the Deprivation of Liberty Safeguards. This is a trained professional who is able to consider the appropriateness of applying for a DOLS Standard Authorisation.

Care Plan
In this policy where we refer to a care plan this will be the patients nursing management plan and not their community care plan.

Mental Capacity Act
The MCA provides a framework for acting and making decisions on behalf of people who lack capacity.

Care Quality Commission
The CQC have a responsibility to monitor the application of both the MHA and MCA.

Deprivation of Liberty Safeguards
This is the legal and administrative safeguards which protect patients who may lack capacity and be deprived of their liberty whilst in our services. The DOLS are set out within the MCA.

Absconsion / missing

When an informal patient is not on the ward when expected to be after either not returning from leave or failing to notify staff they are leaving the ward.

Absent Without Leave (AWOL)
When a detained patient is missing from the ward, either not returning from leave or managing to leave the ward undetected by staff, Section 18 (AWOL) of the Mental Health Act applies.

5. Duties and Responsibilities

Trust Board
The Trust Board has responsibility for ensuring the processes and duties set out in this policy are completed and compliant with the relevant legal frameworks.

This duty is delegated to the staff and committees set out below and will monitor the processes through the sub-committee of the board exception or escalation reporting processes.

The Trust Board may request additional reports in addition to the monthly quality domain reporting for mental health act monitoring, patient experience and patient safety to the Quality Committee.

Chief Executive (CEO)
As Accountable Officer, the Chief Executive is ultimately responsible for the processes in the Trust to protect and mitigate known risks for patients and staff. This includes the issues set out in the policy. The Chief Executive will receive assurance of the policy by the committees below.

Director of Nursing and Quality
The Director of Nursing is responsible for providing professional leadership for nursing staff in relation to the management of access and egress. This will extend to reviewing local issues that are escalated and working with nursing staff to seek resolution.

Associate Director
The Associate Director is responsible for ensuring that ward/unit operational policies detail the approach to locked doors on inpatient units and that any changes to practice are compliant with legislation and changes made are reflected in the operational policy.

Modern Matron/Senior Nurse/Allied Health Professional (AHP)
The Modern Matron/Senior Nurse/AHP are responsible for monitoring of incidents, complaints, concerns relating to locked doors and for undertaking quality audits of care plans, signage, information leaflets and observed practice to provide assurance of policy compliance.

Head of Patient Experience

The Head of Patient Experience is responsible for ensuring the Service User and Carer Forum are represented in decisions relating to the access and egress approach across the Trust. This includes consultation, comments and complaints.

Nursing Staff

Nursing staff are responsible for ensuring adherence to this policy and for escalating concerns to their line manager and in turn to the Director of Nursing.

6. Procedure for Access and Egress

Minimum Standards to be applied by Ward Staff

All ward areas will ensure they have clear information displayed by the ward doors to inform patients and visitors how they can leave the ward.

All staff will be clear on the reasons and purpose for employing locked doors on the ward and this will be discussed in supervision, community meetings and any issues will be reported using the Trust Incident Reporting System (Ulysses).

Patients will be provided with verbal and written information how to access and exit the ward, on the availability of this policy, how to raise a complaint with procedures relating to locked doors, and this will be done as soon as practicable following admission and on a regular basis thereafter. This will include information on their legal status and the implications of this on accessing and exiting the ward.

Information should also be provided to the patient's family and carers on admission to ensure they are clear in the wards approach to access and egress. This will include discussion of how they may complain or comment on the procedures and reasons for the approach taken by the Trust.

In the case of informal patients all staff working with the patient should ensure they are supportive of the patient's right to leave the ward, explaining their legal rights where necessary and ensuring any difficulties experienced by the patient are raised as a concern. The information provided and discussions with the patient should include details of how they can discharge themselves from the hospital and their compliance with the agreed care plan and how to request a review of this. Informal patients must not feel they are unable to agree with conditions set out in the care plan and these should not extend into unnecessary or disproportionate restrictions.

All patients must be provided with a copy of their care plan (or in the case of patients who refuse a copy, they should know how this can be requested and this recorded in the clinical record) and this should include information on their access and egress rights. This should incorporate their individual needs e.g. people who smoke (see Trust Smoke Free Policy), informal patients and those deemed to be at risk of self-harm or suicide.

For both informal and detained patients their ability to understand the processes relating to the access and egress to and from wards should be continuously reviewed and documented clearly in clinical notes in cases of any changes to consent/capacity. The Mental Capacity Act is the governing framework for assessments of capacity and this should be adhered to. Support to improve their understanding should be provided and in some areas this will extend to additional tools of communication i.e. picture signs, repeating discussions when carers are present.

As with other information that the Trust produces consideration must be given to the availability of the information on access and egress in other languages and formats.

The ward manager must ensure all staff being inducted onto the ward are provided with information on the approach, philosophy and aims of this policy. The legal implications of not adhering to this policy should be made clear to all staff members.

Minimum Standards for Corporate Services

Any complaints, comments or incidents received regarding the Trust's policy on locked doors, access and egress will be dealt with appropriately and incorporated into strategic planning.

7. Legal Implications

There are several relevant legal implications on the Trust decision and approach to locking doors on inpatient areas. All staff should ensure they are familiar with the frameworks and request additional advice, guidance or training through their line manager and supervisors if they have any training needs relating to the legal issues set out within this section.

7.1 Mental Health Act (MHA)

The MHA allows the Trust to take necessary steps to protect the patient from harm or from causing harm to others. Whilst detained under the MHA the Trust can take reasonable steps to ensure the protection of harm and there are implied powers to control and detain patients in a suitable manner. For detained patients the Trust is able to refuse exit from the ward unless the patient has a valid period of leave (authorised by the Responsible Clinician under Section 17 of the MHA). Any patient exiting the ward without authority should be recorded as AWOL - Section 18 of the MHA and the AWOL policy applied. Even in circumstances where there is a Section 17 is in place the nursing staff may complete a risk assessment and refuse the patient leave from the ward. This should be documented in the patient notes and explanation and rationale offered to the patient and their carer.

Although the law is clear for detained patients that the Trust can restrict their leave from the ward as appropriate this should not negate discussion and engagement with the patient. Section 132 of the MHA sets out the duty to provide information to the patient about their detention status on a regular basis and this should include discussions with the patient about the locked doors and their feelings towards this.

If a detained patient has concerns regarding the locked door policy they can be directed to;

- Patient Advice and Liaison Service - for informal discussions and potential complaint to the Trust.

- Independent Mental Health Advocate - Statutory provision of advocacy services. Independent of the Trust and can assist with complaint or appeal against detention.

- Mental Health Tribunal - If the patient wishes to leave the ward permanently they should be offered the opportunity to appeal their section to the Mental Health Tribunal Service. Further details are set out within the patient rights leaflet or by contacting the MHL Office.

- Hospital Managers - Appeal to the Hospital Managers if the patient chooses to leave the ward permanently. Further details are set out within the patient rights leaflet or by contacting the MHL Office.

Staff dealing with concerns should seek to resolve them directly through changes to the care plan or discussing the issues with the patient directly.

The guiding principles in the Mental Health Act, Code of Practice should be observed by staff when working with patients, carers and processes relating to locked doors;

- Purpose and Effectiveness - Ensure the Trust is clear about the purpose of the locked doors in reducing the negative impacts of mental disorder and reducing the risks to patients, staff, carers and the public.

- Least Restrictive and maximising independence - Observe the least restrictive principle when working with patients regarding the locked door policy. The observance of the requirements set out within this policy should promote the least restrictive approach but all steps necessary and appropriate in individual circumstances should be taken.

- Respect and dignity - The rights of patients should be respected with staff being aware of and mindful that the locked door policy has potential to increase the feeling of a loss of control and impact upon a person's liberty. Individual patient needs should be considered including access to information in other formats, respecting a person's feelings and personal opinions on our policy.

- Empowerment and involvement - - the provision of information, facilitated discussions and openness regarding our locked door policy is fundamental to ensuring patients are involved in our approach. This should be recorded in notes and care plans and ongoing discussions should occur on a frequent basis.

- Efficiency and equity - The Trust must all seek to use the resources that are available

to us and our patients in the most effective, efficient and equitable way. This extends to the way we manage our wards and issues with the locked door approach must be escalated if they have the potential to alter our effectiveness and efficiency.

Section 5 of the MHA provides for detention by nursing staff or doctors in the event of an informal patient requesting to leave the ward against medical advice. These powers are only available to qualified staff who should clearly document their reasons for applying Section 5, explaining the reasons for requesting full mental health act assessment and complete the statutory paperwork. It should be remembered that Section 5 does not allow for treatment of the patient against their wishes unless this is done in compliance with the MCA and recorded as such or with the patient's consent.

7.2 Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act is the legal framework that sets out our approach for decision making in the case of patients who lack capacity to a specific decision. Capacity is decision specific and in the case of locked door environments the bar for capacity will be lower than in the case of some treatment decisions. A capacity assessment can be completed by the nurse who is providing information to the patient regarding the locked door policy.

A capacity assessment will consider if a patient has a disturbance or impairment in the functioning of their mind or brain and has the ability to understand, retain and weigh up information related to Access and Egress and is also be able to communicate their decision. Staff should try and support patients to make the decision themselves, this could include providing written information, revisiting the decision and facilitating communication. Staff should clearly document the consent/capacity assessment in the patient's electronic patient record (Lorenzo). Any concerns regarding the patient's ability to do this should be clearly set out within their care plan and revisited as appropriate.

Where it is determined that the patient lacks the capacity to consent to the restrictions that result from the door being locked, staff must consider if the individual is deprived of their liberty and consider the following test:

Is the person subject to **continuous supervision and control**?
and
Is the person **free to leave**?

Continuous supervision and control does not have a high threshold, being aware of a patients' whereabouts is sufficient to meet this test. Staff should also consider what level of supervision would be in place if the door was not locked. Being free to leave is no longer just about a person saying they want to leave or attempting to leave and now includes if they would be stopped, if they did try to leave. (See MHA18 Deprivation of Liberty Policy and Procedures for further information and a useful checklist).

Where possible staff should consider how they can reduce the level of restraints / restrictions that are placed on the patient.

Where staff believe they are depriving someone of their liberty they must act, and consider using DOLS or the Mental Health Act to authorise the deprivation of liberty. Where an individual is objecting to being in hospital / trying to leave, staff should consider instigating a Mental Health Act assessment. Where an individual is not objecting / attempting to leave, staff should consider DOLS (See MHA18 Deprivation of Liberty Policy and Procedures Section 8).

7.3 Informal Patients with Capacity

In the case of a patient who is deemed to have capacity, understands the locked door policy and gives their consent to remain on the ward the case of Rabone v Pennine Care NHS Foundation Trust is relevant.

This case which considered the Human Rights Act and the duty of NHS Providers to protect a patient's right to life also considered the approach of the Trust and their locked door policy. The Court of Appeal recognised the patient's right to be aware of the possibility of a MHA Assessment being completed if she requested exit / discharge from the hospital.

The Supreme Court found that if an adequate risk assessment had been completed the patient should have been prevented from leaving, due to concerns of self-harm and patient presenting as an immediate risk to herself, by application of Section 5 of the MHA. In this case the Supreme Court also stated that suicidal psychiatric patients are unlikely to have capacity to make a decision about admission and treatment. The Trust view is that each individual would be subject to a capacity assessment by the clinicians involved and the outcomes will obviously vary. A blanket approach to incapacity would not be acceptable and the Supreme Court view is included for information only.

This case demonstrated that the legal implications of access and egress are often complex and may invoke considerations of the Human Rights Act and in particular the right to life. Risk Assessments are crucial to the Trust and professional defence in cases where patients seek discharge or leave against the advice of staff. Records should be made of decisions taken by clinical staff in all areas routinely and particular consideration given to this complex area of treatment and management.

8. Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There **is no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	
There **is** specific training requirements for staff groups - **Mental Health Law Training** (Please complete the remainder of the form-formal training needs analysis required- with learning and development department.	link

Staff Group	□ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (□ if yes)
Career Grade	□			□
Doctor Training Grade	□			□
Doctor Locum medical staff	□			□
Inpatient				
Registered Nurse	□			□
Inpatient Non-registered Nurse	□			□
Community Registered Nurse				
Community Non Registered Nurse / Care				
Assistant Psychologist /				
Pharmacist Therapist				
Clinical bank staff regular worker	□			□
Clinical bank staff infrequent				
worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc. Mental Health Law Training forms part of Trust mandatory training.

Any other additional information

Completed by	Mark Hammersley & Kathryn Ing	Date	26.09.2022

9. Appendices

Appendix 1 - Entry and Exit Trust Wards/Units Door Signage

Darwin Centre - ENTRY TO THE UNIT

DOORS ARE LOCKED IN ORDER TO SAFEGUARD THE SECURITY OF YOUNG PEOPLE. IF YOU WISH TO GAIN ACCESS TO THE UNIT PLEASE PRESS THE BELL AND A MEMBER OF STAFF WILL RESPOND.

THANK YOU FOR YOUR CO-OPERATION.

MANY THANKS
UNIT MANAGER

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Darwin Centre - EXIT FROM THE UNIT

These doors are locked in order to safeguard the security of young people. If you wish to leave the unit please approach a member of staff.

If you are an informal patient you have the legal right to leave however we request that you speak to a member of staff before leaving.

Many Thanks - Unit Manager

Ward 1 - ENTRY TO THE WARD

THESE DOORS ARE ALWAYS LOCKED FOR REASONS OF PATIENT SAFETY. IF YOU WISH TO GAIN ACCESS TO THE WARD PLEASE PRESS THE BELL AND A MEMBER OF STAFF WILL RESPOND.
THANK YOU FOR YOUR CO-OPERATION.

MANY THANKS
WARD MANAGER

Ward 1 - EXIT FROM THE WARD

These doors are always locked for reasons of patient safety. If you wish to leave the ward please approach a member of staff.

If you are an informal patient you have the legal right to leave however we request that you speak to a member of staff before leaving.

Many Thanks - Ward Manager

All other wards - ENTRY TO THE WARD

THESE DOORS MAY BE LOCKED FOR REASONS OF PATIENT SAFETY. IF YOU WISH TO GAIN ACCESS TO THE WARD PLEASE PRESS THE BELL AND A MEMBER OF STAFF WILL RESPOND. THANK YOU FOR YOUR CO-OPERATION.

MANY THANKS
WARD MANAGER

All other wards - EXIT FROM THE WARD

These doors are may be locked for reasons of patient safety. If you wish to leave the ward please approach a member of staff.

If you are an informal patient you have the legal right to leave however we request

that you speak to a member of staff before leaving.

Many Thanks - Ward Manager

Document level: Policy
Code: _R07
Issue number: 1

GUIDELINES FOR WHEN THE POLICE USE INCAPACITANT SPRAY OR TASER ON TRUST PREMISES

Lead executive	Director of Operations
Authors details	Workforce Safety Lead

Type of document	Trust Policy
Target audience	Trust inpatient staff
Document purpose	Provides guidance to staff if police use Incapacitant spray

Approving meeting	Quality Committee Trust Board	Meeting date	6th January 2022 13th January 2022
Implementation date	31 January 2022	Review date	31 January 2025

Trust documents to be read in conjunction with	
5.19	Violence and Aggression Policy with Police Protocol
R1	Guidelines for the use and reduction of restrictive interventions Including the use of physical holding skills (MAPA®) Policy
5.07	Violence and Aggression Policy

Document change history		Version	Date
What is different?	Planned Review Planned Review - changes required as police no longer use CS Gas Planned review	1 2 3	31/03/2014 08/11/2017 16.02.2021
Appendices / electronic forms	Appendix 1 – Clinical side effects from use of incapacitant spray and Tasers Appendix 2 Police principles and decision making for use of force		
What is the impact of change?	-		

Training requirements	No training requirements

Document consultation	
Directorates	Health, Safety and Wellbeing Group

Corporate services	
External agencies	Staffs Police

Financial resource implications	

External references
1. Faculty of Forensic and Legal Medicine (2010) – Incapacitant Sprays: Clinical Effect's and Management (Recommendations for Healthcare Professionals) 2. Guidance on the use of Incapacitant – www.acpo.police.uk/documents

Monitoring compliance with the processes outlined within this document	Any incidence of use of the incapacitant spray within Trust premises should be reported via the Safeguard incident reporting system and the Senior Nurse/Modern Matron and Head of Directorate should be made aware as soon as is practicable.

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	

– **Religion and/or Belief** (includes those with religion and /or belief and those with none) – **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	N/A	
Enter details here if applicable		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Section	Contents	

1 Policy Statement

Over recent years Police throughout the United Kingdom have been trained and equipped with incapacitant spray and tasers. Incapacitant sprays and tasers augment the range of "less lethal" tactical options available to police officers when called to deal with potentially aggressive or violent individuals or those with acute behavioural disturbance.

North Staffordshire Combined Healthcare NHS Trust does not expect that patients/clients will ordinarily be exposed to incapacitant spray or tasers. However, the Trust also recognises that once the Police are requested to attend and safely manage an incident, it is their decision as to whether the incident is so serious that the use of incapacitant spray or tasers is justified.

The Trust expects, wherever possible, that staff work closely with the police to disclose and discuss relevant information about an individual who is potentially liable to be sprayed with incapacitant spray or tasered. This dialogue should include information that might be helpful to defuse the situation and/or prevent the use of the spray/taser, together with the likely effects of the spray/taser (physical and/or psychological) and likely reaction of the individual. Such discussion will help to ensure that wherever incapacitant spray or taser is used, it represents the least restrictive option, and is the most appropriate form of intervention available at that time.

2.0 Use of Incapacitant Spray

2.1 Incapacitant sprays are intended to be used to spray the face of a person from up to 3 – 4 metres, delivering an active chemical to the moist areas of the eyes, nose and mouth. This causes irritation to the eyes, upper respiratory tract and skin. Police officers in Staffordshire are issued with an incapacitant called PAVA spray (chemical name – Pelargonic acid vanillylamide, 0.3%). PAVA is the synthetic equivalent of capsaicin (the active ingredient of natural pepper), in a solvent of aqueous ethanol. The propellant is nitrogen. This solution is used because it represents the minimum concentration which will fulfil the purpose of the equipment; namely to minimize a person's capacity for resistance without unnecessarily their discomfort

2.2 The effects of incapacitant spray on an individual can depend on where and how the spray has been used. Factors that would influence the effects upon an individual are:

- If the spray was used outdoors or in a confined space.
- Hot and moist conditions make the spray more effective than cold dry conditions.
- The quantity of spray used and the accuracy of its delivery.

2.3 For PAVA spray to be effective it needs to enter the eyes and the effects are usually instantaneous if this occurs. There have been occasions where PAVA has failed to work, usually when the subject is under the influence of alcohol. The effects are temporary and in most cases the effects tend to pass after 15 to 30 minutes although substantial minority will remain symptomatic for an hour or more. The effects of contamination on an environment will take approximately 45 minutes to subside to a safe level for occupancy. However, it is recommended that this time period be extended wherever possible.

2.4 Guidance for Staff in relation to incapacitant spray

2.4.1 It is acknowledged that there may be times when Trust staff may come into contact with patients/clients who either have been sprayed with incapacitant prior to admission or have been sprayed with incapacitant on Trust premises. The latter will normally be as a result of the police being requested to attend a situation whereby staff felt they could no longer manage or control a violent situation or where an individual has presented with a weapon e.g. blade/baton etc.

As a result of being sprayed the individual concerned can suffer a number of symptoms (refer to side effects in Appendix 1) and should therefore always be fully examined by an appropriately skilled and trained health care professional, with particular reference to eyes, oral and nasal cavity, respiratory system and skin. Those dealing with the contaminated individual should wear gloves, aprons and eye protection to avoid cross contamination.

2.4.2 Post incident management - The Use of Incapacitant Spray Prior to Admission:

- Where incapacitant spray has been used on an individual prior to admission, it is important that the time lapse between the application of the spray and the arrival for admission is identified - this will give an indication as to what effects the patient/client may be suffering and the likely duration. This information should be requested from the relevant police officer.

- On arrival the patient/client should be escorted to a quiet room well away from others. If the patient/client is still suffering from the effects of the spray they must be discouraged from either rubbing or bathing their eyes, as this may reactivate the irritants. Where possible, access to fresh air or free flowing ventilation should be provided to minimise effects, the use of fan may be helpful.

- As a result of having been sprayed there is a strong likelihood that the Patients/Client's clothing may have become contaminated thereby creating the possibility of reactivation. In order to reduce the likelihood and effects of reactivation, it is necessary to encourage the client to remove their clothing so that it can be aired. If the persons has no separate clothing, suitable alternative clothing must be made available.

- After clothing has been aired it should be washed on a normal wash cycle. Wherever there is heavy contamination of clothing, it may be necessary to wash it 2 – 3 times to be fully successful. Staff are advised to wear disposable gloves and wear protective aprons when handling contaminated clothing. All protective clothing worn by staff should be appropriately disposed of after use.

- Whenever a patient/client is admitted following exposure to incapacitant spray they must be medically examined by a doctor as soon as is reasonably practicable. Additionally, medical attention and advice should be sought whenever an individual suffers prolonged or secondary effects from the incapacitant spray.

- A full report of the situation and use of incapacitant spray must be made in accordance with the Trust recording and reporting policies and

procedures.

243 Incident management – The Use of Incapacitant Spray on Trust Property:

- On rare occasions it may be necessary for the police to attend an incident on Trust property that may indicate the use of incapacitant spray. During these times staff must liaise closely with the police officers and provide them with full details of the situation and any specific information about the identified individual e.g.

- Does the individual suffer from any known condition that may be adversely affected by the use of incapacitant spray e.g. respiratory complaints, heart condition, and mental state?

- Is there any evidence of intoxication or substance misuse by the individual? This might aid the person`s resistance to the effects of the spray but should not cause any medical problems

- Does the individual wear contact lenses? Repeated exposure to incapacitant spray is potentially damaging to 'soft' contact lenses. Therefore wherever possible, patients/clients should be encouraged to remove their lenses after being exposed to incapacitant spray (It is essential that the person washes their hands thoroughly before attempting to remove contact lenses). This action will help to prevent the irritant remaining trapped behind the contact lens. This advice also applies to any individual who may have secondary contact e.g. staff or other patients / clients.

- It is important that both the individual subject to the spray and the immediate environment are segregated from other patients/clients and visitors to reduce the risk of contamination, and only those staff that need to be present should be in the vicinity.

- Alternating staff that are in direct contact with a patient/client who has been sprayed with incapacitant spray might help to reduce the risk and effects of third party contamination. Wherever possible staff with a history of respiratory problems or skin complaints should avoid primary contact with the individual concerned until such times as the effects of the spray have diminished.

- If an area has been contaminated by incapacitant spray it is important that it remains out of use until such times that it is deemed safe to reuse. The affected area will need to be well ventilated and the use of extractor and portable fans will help in this process. A full report of the incident and use of incapacitant spray must be made in accordance with the Trust recording and reporting policies and procedures.

- Open as many windows as possible to ventilate the area. The use of extractor and portable fans will also aid the ventilation and decontamination process. Prevent others from coming into the contaminated area until it is properly ventilated and clear this will usually be after approximately 45 minutes.

If staff are unsure or concerned about an area remaining contaminated after at least 1 hour of contamination, they should seek further advice from the manager and/or police.

3 Use of Tasers
Information for hospitals regarding the medical implications of the use of the Taser on Subjects

The Taser is a battery-operated conducted energy device currently approved for use by police forces in the UK. The device is one of several "**less than lethal"** options available to the police which enable them to manage violent and aggressive people and those with other forms of acute behavioural disturbance. When the trigger of the Taser is pressed and released, the devise generates a default 5 second train of very short electrical pulses, with each pulse lasting about 0.1 milliseconds. These pulses are produced at a rate of around 19 per second.

The pulse produced by the Taser may be applied in two main ways, termed **probe mode** and **drive-stun mode**. In probe mode, two metal barbs are fired from the front of the device which remains electrically connected to the handset by fine wires, each about 10mm long. The barbs attach to the clothing or the skin of the targeted person. In drive – stun mode, the two electrodes on the front of the handset are applied directly to the person's skin or clothing. Most discharges of Taser by police in the UK occur in the probe mode.

3.1 Effects of deploying the Taser

The effect that the pulses produce depends on the mode of use. In probe mode, the wider separation of the barbs produces a combination of intense generalized pain and muscle contraction, the latter effect generally precluding any voluntary, coordinated muscular activity by the targeted person.

3.2 Guidance to staff in relation to Taser aftercare

All persons subjected to Taser discharge must be examined and assessed by a Doctor as soon as practicable after the event. In most cases initial first aid or barb removal may be undertaken by a nurse, however if unsure request trained police officers remove the barbs. Barbs that have penetrated the skin may be removed by stabilizing the skin surrounding the barb whilst grasping it and removing with rapid traction. Where barbs have penetrated or are adjacent to sensitive areas such as eye, ears, face, neck, genitalia, spine or joints, doctors should use their clinical judgement and if necessary seek specialist advice from an A&E doctor re barb removal.

A full examination to document visible injury and completion of NEWS should take place to identify or exclude any Taser associated complications (complications detailed in Appendix 1).

3.3 Taser use on drug and cardiac impaired individuals

It is believed that drugs such as cocaine and pre-existing heart disease may lower threshold for cardiac arrhythmias. Many of the 16 fatalities associated with use of low-power Tasers in Los Angeles survey (Kornblum and Reedy, 1991) had also taken PCP (phencyclidine) prior to the incident. PCP is also thought to be pro-arrhythmogenic but is infrequently used as a substance of abuse in the UK.

There is no experimental evidence that the aforementioned pro-arrhythmic factors increase susceptibility of the heart to low or high power Tasers specifically, sufficient to cause an arrhythmic event. Nevertheless, there is sufficient indication from forensic data and the known electrophysiological characteristics of the heart (and the effects of certain drugs on this) to express a view that excited, intoxicated individuals or those with pre-existing heart disease could be more prone to adverse effects from the high power Taser, compared with unimpaired individuals and therefore enhanced observation may be advisable.

For information on the standards, principles and guidance governing the Police use of force and decision making on use of force by the Police, please refer to Appendix 2.

4 Duties

4.1 The Trust Chief Executive through the Director of Operations, Medical Director and Executive Director of Nursing has overall responsibility to ensure that processes are in place to:

- Ensure staff are aware of this policy and adhere to its requirement.
- Ensure that appropriate resources exist to meet the requirement of this policy.

4.2 The Heads of Directorate are responsible for ensuring that all Operational managers in their areas are aware of this policy, understand its requirements and support its implementation with relevant staff.

4.3 Clinical Team Managers (Ward Managers, Community Team Managers) are responsible for implementing the policy with their immediate staff and ensuring that they adhere to the requirements of the relevant policies and procedures.

4.4 It is the responsibility of individual practitioners (medical, nursing and allied health professionals), to adhere to the principles and standards within this policy and the related reference documents and to raise any queries with their line manager

Appendix 1 – Clinical side effects from use of incapacitant spray and Tasers

Incapacitant spray

The most common effects are:

Eyes:

- **Clinical Effects (expected duration)**

  - Lachrymation (tears – up to 15 mins)
  - Pain (up to 30 mins)
  - Blepharospasm (eyelids closed – up to 15 mins)
  - Conjunctival erythema (redness – up to 30 mins)
  - Blurred vision (up to 30 mins).
  - Photophobia (sensitivity to light – up to 60 mins).
  - Periorbital oedema (swelling around the eye).
  - Damage to ocular surface from direct trauma of a high pressure jet.
  - Conjunctivitis
  - Corneal abrasions due to rubbing the eyes.

- **Management**

  - Air could be blown with a fan directly onto eyes to encourage evaporation, or exposure to external air/wind
  - If eye symptoms persist for more than one hour irrigate eyes with sterile normal saline solution
  - Contact lenses should be removed and either discarded (soft) or cleaned with 10 washes and soaks (it may take several weeks for the eye to settle done enough to allow a return to wearing lenses – advice should be sought from an optometrist)
  - If eye symptoms persist or corneal abrasion is identified, the patient should be referred for ophthalmic assessment.

Mouth:

- **Clinical Effects**
  - Stinging or burning sensation
  - Possible nausea and vomiting although this is rare

- **Management**
  - Nothing specific – treat symptoms based on clinical findings

Respiratory Tract:

- **Clinical Effects**
  - Nose discomfort, pain and rhinorrhea (nasal discharge - up to 30 mins)
  - Sneezing and coughing
  - Sore throat
  - Shortness of breath
  - Bronchospasm (rare)

- Laryngospasm (rare)
- Tracheitis (infection)
- Bronchitis (rare)
- NB patients with pre-existing respiratory disease, such as asthma or bronchitis are more at risk of severe side effects.

➢ **Management**

- The majority of respiratory tract symptoms and signs e.g. difficult, labored or irregular breathing should settle within 10 mins of the exposure
- If there is evidence of continuing bronchospasm a doctor might consider prescribing a bronchodilator or seeking advice from an A&E doctor
- Occasionally upper respiratory tract symptoms may last for up to two weeks and subjects with persistent signs or symptoms may need hospital assessment

Skin:

➢ **Clinical Effects**

- Burning sensation, blistering and reddening (up to 24 hrs.)
- Allergic reaction (rare)
- Loss of pigmentation (rare)
- Flushed appearance to affected area (rare)

➢ **Management**

- Exposure to air and fan
- Exposure to fresh air will normally result in a significant recovery within 15-20 Mins
- If symptoms last beyond 20 mins then copious amounts of cool tap water should be used to flush the remaining incapacitant from the skin
- Under no circumstances should warm water be used as this can reactivate Irritants

Cardiovascular:

➢ **Clinical Effects**

- Pre-existing cardiac problems can be worsened and hypertension exacerbated after exposure. For example angina attacks may develop.

➢ **Management**

- Symptomatic treatment e.g. glyceryl trinitrate
- Complete NEWS and liaise with doctor re possible referral to hospital if any concerns

Taser

Clinical effects that have been associated with the application of Taser discharge include:

- Localised superficial burns and redness arising from passage of electrical current through the skin.
- Barb penetration injury which, in rare instances, may involve deeper lying tissue.
- Muscoskeletal injury from the intense muscle contraction
- bony injuries from Taser-induced falls
- Triggering of epileptic seizures
- Cardiac effects

During or shortly after the use of the Taser, the patient may experience some of the following symptoms:-

- Feeling dazed for several minutes
- Muscle twitches
- Loss of memory of the event
- Unsteadiness and a “spinning” sensation
- Temporary tingling
- Weakness in the limbs
- Local aches and pains and tissue swelling
- The patient should be reassured that these sensations are normal effects of the Taser that will wear off.

Appendix 2 Police principles and decision making for use of force

Ten Key Principles Governing the Use of Force by the Police Service
(From the College of Policing Authorised Professional Practice)

1. *Police officers owe a general duty to protect persons and property, to preserve order, to prevent the commission of offences and, where an offence has been committed, to take measures to bring the offender to justice;*
2. *Police officers may, consistent with this duty, use force in the exercise of particular statutory powers, for the prevention of crime or in effecting a lawful arrest. They may also do so in self-defence or the defence of others, to stop or prevent an imminent breach of the peace, and to protect property;*
3. *Police officers shall, as far as possible, apply non-violent methods before resorting to any use of force. They should use force only when other methods have proved ineffective, or when it is honestly and reasonably judged that there is no realistic prospect of achieving the lawful objective identified without force;*
4. *When force is used it shall be exercised with restraint. It shall be the minimum honestly and reasonably judged to be necessary to attain the lawful objective;*
5. *Lethal or potentially lethal force should only be used when absolutely necessary in self-defence, or in the defence of others against the threat of death or serious injury;*
6. *Any decision relating to the use of force which may affect children, or other vulnerable persons, must take into account the implications of such status including, in particular, the potentially greater impact of force on them;*
7. *Police officers should plan and control operations to minimise, to the greatest extent possible, recourse to lethal force, and to provide for the adoption of a consistent approach to the use of force by all officers. Such planning and control will include the provision to officers of a sufficient range of non-lethal equipment and the availability of adequate medical expertise to respond to harm caused by the use of force;*
8. *Individual officers are accountable and responsible for any use of force, and must be able to justify their actions in law;*
9. *In order to promote accountability and best practice all decisions relating to the use of force, and all instances of the use of force, should be reported and recorded either contemporaneously, or as soon as reasonably practicable;*
10. *Any decision relating to the use of force by police officers must have regard to the duty of care owed by the relevant police service to each individual police officer in the discharge of his duties. Deployment of police officers in a public order context where force may be used can carry grave risks to their own safety, and so must be the subject of rigorous control for that reason also.*

Police officers are also guided by three core questions when determining when, and to what extent, force may be used which should be considered alongside the 'Ten Key Principles Governing the Use of Force by the Police Service' . These are:

1. *Would the use of force have a lawful objective (e.g., the prevention of injury to others or damage to property, or the effecting of a lawful arrest) and, if so, how immediate and grave is the threat posed?*
2. *Are there any means, short of the use of force, capable of attaining the lawful objective identified?*
3. *Having regard to the nature and gravity of the threat, and the potential for adverse consequences to arise from the use of force (including the risk of escalation and the exposure of others to harm) what is the minimum level of force required to attain the objective identified, and would the use of that level of force be proportionate or excessive?*

Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents
Please tick as appropriate

There **is no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	✓
There **is** specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Career Grade Doctor				
Training Grade Doctor				
Locum medical staff				
Inpatient Registered Nurse				
Inpatient Non-registered Nurse				
Community Registered Nurse				
Community Non Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed by	Rob Sillito	Date	16/12/2021

Document level: Trustwide
Code: Restraint R08
Issue number: _____

Policy for Searching Patients and their Property

Lead executive	Director of Nursing and Quality
Authors details	Workforce Safety Lead

Type of document	Trust Policy
Target audience	All Inpatient Staff
Document purpose	

Approving meeting	Quality Committee	Meeting date	5th April 2018
Implementation date	April 2018	Review date	31st May 2024

Trust documents to be read in conjunction with	
	Partner Agency Operational Protocol Trust In-patient Services: Emergency Police Response, Deployment and Post-incident Reporting of Assaults and/or Criminal Activity to Police Services.
	Medicines Management Policy (1.03) – Appendix 3, Suspected Illicit Substances

Document change history		Version	Date
What is different?	SOP changed to become one inclusive appendix.	1	05/08/16
	Policy rewritten and SOP added.	2	08/08/16
	Passed by Health, Safety and Wellbeing Group.	3	25/09/17
Appendices / electronic forms			
What is the impact of change?			

Training requirements	Search Training provided as required by Workforce Safety Team

Document consultation	
Directorates	
Corporate services	
External agencies	

Financial resource implications	

External references
1. National Institute for Clinical Excellence (2005) – Short term Management of Violent (Disturbed Behaviour in Adult Psychiatric In-patient and Accident and Emergency settings Guideline NCC-NSC 2nd consultation. 2. Department of Health (2015) Mental Health Act 1983 Code of Practice, Published 2015 pursuant to section 118 of the Act. TSO

Monitoring compliance with the processes outlined within this document	

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	

– **Religion and/or Belief** (includes those with religion and /or belief and those with none) – **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	N/A	
Enter details here if applicable		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk		
Was a full impact assessment required?	No	
What is the level of impact?	Low / medium / high	

CONTENTS

Appendices

Section 1. Policy Statement and Context

1. Policy Statement

1.1 Relational security is the knowledge and understanding staff have of a patient and of the environment; and how such knowledge and understanding is transferred into effective support and care which minimises risks and builds therapeutic relationships. North Staffordshire Combined Healthcare NHS Trust is committed to ensuring as far as is reasonably practicable, the care, welfare, safety and security of staff, patients and visitors. With this in mind there may be occasions where staff working in inpatient settings are required to undertake the search of a patient. It is important that a clear legal framework is applied in such circumstances. This policy provides the guidance and procedural structure to empower staff on the occasions when a patient should be searched. It also describes the actions to be taken by staff when considering the searching of a patient, their personal property and/or living environment.

2. Introduction - Using this Policy and Associated Procedures

2.1 This policy contains 2 elements which must be considered, they are:

- Section 1 - Describes the legal and practice context within which this policy has been developed and now exists and the manner in which it shall be reviewed to ensure that it reflects best practice and ongoing developments in modern mental health practice.

- Section 2 – Describes the specific Standard Operating Procedures (SOP) for carrying out such searches which will include searches of people, accommodation and property.

2.2 “The undertaking of necessary and lawful searches, of patients can make an important contribution to the effective management of disturbed/violent behaviour in psychiatric in-patient settings. Unlawful, insensitive and unnecessary searches can also exacerbate disturbed/violent behaviour. Searches are the responsibility of nursing staff, save in exceptional circumstances where the assistance of others, including the police, may be sought.” (NICE, 2005)

3. Purpose

3.1 This policy outlines the procedures for searching the persons and/or property of informal and detained patients within the inpatient and residential areas managed by North Staffordshire Combined Healthcare NHS Trust. The search policy is implemented to maintain a safe and therapeutic environment for patients, staff and visitors and the principles set out in Chapter 8 of the 2015 edition of the Mental Health Act – Code of Practice.

4. Scope

4.1 This policy applies specifically to the search procedures to be adopted by staff within inpatient settings.

5. Context

5.1 A human rights values based approach is central to our philosophy of mental health recovery. Keeping everyone safe from harm is equally important as any other aspect of delivering respectful and effective care and support. We should treat people with dignity and respect and take time to develop meaningful and therapeutic relationships. The very nature of care, especially in those circumstances where people are formerly detained, prescribed treatment they do not want or understand, and cared for in environments which they are not allowed to leave and which have rules and restrictions that do not apply to their everyday lives, naturally may lead to points of conflict.

5.2 The balance between individual human rights including being treated with dignity and respect must be balanced with the Trust's duty of care to the safety of individual patients, as well as the health and safety of staff, must be maintained. This includes the need to undertake searches of patients in specific circumstances.

5.3 Where it becomes necessary to carry out a search, reasonable adjustments should be made to ensure that the information regarding searches is communicated wherever possible in a way that the patient is able to understand. Reasonable adjustments should also be made to reflect other individual circumstances of patients, their visitors or staff.

6. Duties

6.1 Responsibility for the development, maintenance and review of this document lies with the Director of Nursing and Quality. The Director of Nursing and Quality has board level responsibility for the development of this document and may delegate this responsibility.

6.2 The Quality Committee will be responsible for the ratification of this policy.

6.3 It is the responsibility of the Unit/Ward Manager to ensure that this policy is implemented.

6.4 It is the responsibility of the nurse in charge of the shift to ensure searches are carried out in accordance with the procedures outlined within this policy and that an incident form is completed.

6.5 All inpatient staff having contact with patients are responsible for using the policy correctly to ensure patient safety.

7. Definitions and Acronyms

- Restricted Items (RI - which will include prohibited items) includes any item that is not allowed by the hospital rules or policies. They include the following items:
  - Knives.

- Any type of firearm including replica / toys.
- Any item intended for use as a weapon e.g. “knuckle duster” “baton” etc.
- Any type of sharp implement e.g. scissors, razors, razor blades etc.
- Any type of explosive including fireworks.
- Personnel Incapacitant e.g. pepper spray, CS gas etc.
- Lighter fuels and combustible gas or liquid.
- Matches/cigarette lighters.
- Caustic chemicals e.g. bleach.
- Poisons e.g. weed killer, pesticides etc.
- Any type of drug or medication.
- Any kind of mind altering substance (legal or otherwise) that can be ingested.
- Alcohol.

This list is not exhaustive and will be reviewed regularly as it needs to be responsive to items which become apparent during searches or where items have been handed in to staff.

- Items of concern (IOC) include any item that the person in charge of the unit or who is in charge of the shift in consultation with other staff available, judge may represent a significant risk. This risk would be to an individual patient, other patients, to the staff, to the unit environment or may be illegal;

- Standard Operating Procedures - Standard Operating Procedures (SOPs) within the context of this policy are a written description of steps for all significant activities relating to the search of patient’s property, person or accommodation that have been widely approved by clinicians and managers within a variety of forums;

- Search levels refer to the search levels identified and defined in greater depth within the Standing Operating Procedures (SOP’s) included within the appendices of this policy. The detail of the search may differ according to what is being searched for in order for the search to be proportionate and lawful e.g. where a search for a large item is required; the search team would not ask the individual to remove their shoes. The search levels are as follows:

    - Level 1 – Is a standard search/item management procedure applicable to all patients in inpatient settings;

    - Level 2 – Is implemented where there is some suspicion that an individual may be in possession of a Restricted Item or Item of Concern (RI, IoC) regardless of inpatient unit.

    - Level 3 – Is implemented where there are reasonable grounds to suspect that the person may have on his/her person or in his/her possession a RI or IOC which would cause reasonable concern to justify Level 3 searches;

    - Level 4 – Is implemented where the individual(s) have been witnessed or credibly reported to be in possession of a restricted item.

- Restricted Item/Item of Concern agreement – Is an agreement which has been developed to ensure that patients are familiar with items that are regarded as Restricted Items. This is signed by the patient to indicate that they are aware that

searches can be performed where there is suspicion that such items are in an individual's possession. (See appendix 3)

- SRS form – Standard Record of Search form is completed after a search at levels 2-4 and is contained in appendix 2 of this document.

8. Review Arrangements

8.1 This policy will be reviewed every three years or sooner if required by changes in law or national policy to ensure that it is contemporaneous to modern mental health practice and research.

Section 2. Policy Implementation

9. On Admission

9.1 As part of the admission process the patient will be given a copy of the Restricted Item/Item of Concern (RI/IoC) agreement which outlines the need for the removal/safe keeping of these items. The agreement will contain a list of Restricted Items as defined within this policy and the patient will be asked to sign the agreement to indicate that they understand the need for their removal. All patient property will be routinely checked with the patient; if restricted items (RI) or items of concern (IoC) are identified during the property check the admitting nurse must discuss the handover/safe keeping of these items and a receipt will be given for the items removed.
In the event of the person refusing to sign the agreement, staff will complete the risk assessment documentation as appropriate. Where the patient has refused to sign the agreement, this will be considered and featured in the risk management plan indicating the patient refused to sign.

Where the person lacks capacity to consent to or sign the agreement, a relative cannot legally consent on their behalf. However, relatives should be informed about the contents of this policy.

9.2 The RI/IoC agreement will clearly state that future searches may be undertaken of:

- the person (patient);
- their property;
- accommodation (including unit wide searches)

and that these searches will occur where the person's clinical presentation gives cause for concern or information is received as to the presence of RI/IoC.

9.3 Visitors to the inpatient settings will also be made aware of the list of Restricted Items when entering by means of posters on walls and also ward leaflets. On rare occasions there may be concerns regarding visitors bringing RI's or IOC into the ward. If this is suspected it should be discussed with the visitor and if concerns remain, following discussion with the staff on duty, a decision should be made as to whether any further action is required. This could include not allowing the visitor to enter or asking the visitor to leave the premises, consideration of supervised contact between the visitor and the person. Staff should consider contacting the Police for

further assistance if the person is suspected to be involved in the committing of a crime or refuses to leave.

10. Decision to Implement a Search

The decision to implement a search must be made following a comprehensive risk assessment of the person. This must be completed on admission and reviewed regularly as part of the ongoing risk management plan.

10.1 Factors for consideration include:

- A patient who has a known history of carrying or hiding any item which could be used to harm self or others.
- A patient who has made threats to harm themselves or others and is suspected of being in possession of an item to do this.
- When information has been received from a third party such as the police, relatives, visitors or other patients that the individual is in possession of an item with which to cause harm.
- When a patient is acting in a threatening manner and is deemed to be likely to have an item that could cause harm in their possession.
- When it is believed that the patient has in their possession any restricted items or items of concern (RI/IoC).

10.2 Prior to the decision to implement a search an assessment should be made as to:

- The evidence that the person possesses a restricted item or item of concern.
- What are the consequences of the person's continued possession?
- Are the consequences only applicable to the person or to other people as well?
- What is the likelihood of immediate danger to the person themselves or someone else?
- What is the current level of risk assessment for harm to self or others?
- Has the person possessed or been suspected of possessing a restricted item/item of concern before and what was the outcome?

10.3 Staff will consider whether a specific search is necessary to maintain the health and safety of the person, staff or others. Staff will consider alternative options to using a search; i.e. is there a staff member with a particularly strong therapeutic relationship with the individual who may be able to negotiate the handing over of the RI/IoC.

11. Following the decision that a search is required

11.1 Once a decision has been reached that a search is required – staff should consider the following:

- Are there any inherent risks for the individual or staff members involved in the search;

- Whether the individual is likely to cooperate passively or actively resist the search;
- The searching of individuals may have an effect on their mental state and/or psychological wellbeing and therefore appropriate arrangements for their support post search is required.

12. What are you looking for when searching?

12.1 The items that any search is aiming to reveal will fall into 2 categories, they are:

- Restricted Items (RI) as defined Section 1; paragraph 7;
- Items of Concern (IoC) as defined Section 1; paragraph 7.

12.2 When any Item of Concern is removed from a patient, a receipt will be issued. The item will then be assessed by the MDT which will result in one of the following outcomes:

- Judged not to be a significant risk based on the criteria detailed in the definition in section 2.1 above and is therefore returned to the person.

- Judged to require specific safeguards although returned to the person and documented within an agreed item management plan.

- Judged to represent a temporary risk to the individual person or others because of their immediate mental state which may be removed and/or used only under supervision until the risk has been assessed to have diminished.

- Judged to be a significant risk to unit safety and security or is illegal and therefore permanently removed and the item is added to the units restricted items list if not already listed.

13. Planned Searches

13.1 Within inpatient settings there may be occasions whereby staff may have to perform planned searches of persons returning from leave. This should be part of the patient's identified risk management plan and is designed to discourage Restricted Items or Items of Concern being brought into the unit.

13.2 The need for a planned search of a patient will be indicated by the person's behaviour on return from leave and/or their risk management plan. A record of any decision to undertake a planned search will be recorded in the clinical notes and via the Trust incident reporting system.

14. Need for Police Support

14.1 Where a patient is believed to be in possession of a potential weapon the police should be involved in line with the guidance entitled –

Partner Agency Operational Protocol Trust In-patient Services: Emergency Police Response, Deployment and Post-incident Reporting of Assaults and/or Criminal

Activity to Police Services.

See also Trust Policy R1 – Policy on the use and reduction of restrictive physical interventions (Section 4.11)

14.2 A weapon may be defined as any object that is made for the purpose, adapted for the purpose, or intended for the purpose of inflicting physical injury upon a person (Crime & Disorder Act 1956).

14.3 Where a patient is believed to be in possession of a potential weapon, is behaving in a threatening manner and has refused to put it down and walk away, the police should be called.

14.4 As far as is safe to do so, the person should be kept separate from other people and under close observation during the time it takes for police to arrive.

15. Unit Wide Searches

15.1 A unit wide search is when more than one room or person requires searching in one clinical area. During this time the movements of patients will be closely controlled.

15.2 Unit wide searches could take place at levels 2, 3 or 4 (See section 16) depending on the level of intelligence informing the need for the search and the nature of the items suspected to be present. The Matron/Duty Senior Nurse must be informed if a unit search is required so that resources required can be established as necessary.

15.3 A unit wide search is a serious and resource intensive procedure which may be necessary if:

- Reliable intelligence suggests that a RI and/or an IoC may be at large within the unit. If this is the case, serious consideration must be made about involving the police in this, e.g. large quantities of substances, a firearm, other deadly weapon is suspected.

- Any other circumstances that puts the health and safety of people at serious risk.

16. Levels of Searches

16.1 Search intensity is divided in to 4 levels that apply to searches of the person, property or accommodation. Each search level is accompanied by a Guidance Section (See section 18) and a specific Standard Operating Procedure for that level (see SOP's) – the search levels are:

16.2 Level 1

- Standard level of search/item management procedure applying to all patients entering the unit/ward.

- This requires each person on admission to consider the restricted items list and sign to confirm that they do not have the items in their possession.

- On returning from leave, all patients must declare and hand in to safe storage any RI or any item of concern (IOC).

16.3 Level 2

- Units/wards will consider having a staff member present when a patient opens post and/or parcels delivered to the unit/ward. This should form part of the patient's risk management plan if identified as a potential risk.

  And/or

- Search requiring person being searched, in addition to level 1 procedure, to voluntarily empty their pockets, expose the contents of their belongings and/or step out of their shoes which can be inspected. This can also involve a visual inspection of person, property and/or accommodation without the need for physical contact between the staff member conducting the search and the individual being searched. If authorised within the Trust, this could also involve the use of metal detection equipment.

16.4 Level 3

- This level involves a physical search of the person (rub down), their property and/or their accommodation. This can also involve the use of metal detection equipment as discussed above.

16.5 Level 4

- This level of search requires a very thorough close physical inspection in high detail of the person (not extending to internal inspection of anus or vagina), their clothing, and possible dismantling of fittings and/or equipment within accommodation. A level 4 search does not require a person to remove clothing to the extent that would expose private/genital areas.

16.6 There is no expectation that clinical staff will conduct intimate searches of body cavities.

If the risk assessment indicates that this level of search may be necessary then the RC/on-call and senior manager on call must be contacted without delay. Use of increased observations and negotiation with the patient should be utilised and where physical health risks are present due to the possibility of intimately concealed items the use of x-ray examination should be considered or presenting the patient at the A&E Department for examination.

17. Patient Capacity

17.1 On each occasion a search is required, the patient must be asked for their consent (MHA COP 8.33, 2015) and their capacity to provide informed consent should be considered. This will be recorded on the Standard Record of Search form.

17.2 Where there is uncertainty as to their capacity the Nurse in Charge must make a decision as to the individual's capacity to give informed consent to the search.

17.3 Where a patient lacks capacity to give consent to the relevant search being proposed but is willing to cooperate, the search can go ahead if it is clearly within their best interests in terms of their health and safety and that of others.

18. Search Process with Consent

18.1 Throughout the search staff should make reference to, and act in accordance with the Standard Operating Procedures (SOP's) section in Appendix 1.

18.2 Searching will occur in a formal and systematic way. As a minimum number, staff will conduct the search in pairs where a search at levels 2 - 4 is required. Staff should be of the same sex as the patient unless absolute necessity dictates otherwise.

18.3 Every effort should be made to protect the patient's dignity and privacy. The nature of the search will be determined by the nature of the suspected item or items.

19. Detained Patients (Not Consenting)

19.1 Where a detained patient refuses to consent for search, their responsible clinician (or, failing that, another senior clinician with knowledge of the patient should be contacted without delay, if practicable, so that any clinical objection to searching by force may be raised and recorded. (MHA COP 8.40 2015) (See also Section 7)

19.2 The patient should where possible be kept separate in an area that is suitable for this that will create the least disruption to other patients. They will be kept under close observation, while being informed of what is happening and why, in terms appropriate to their understanding.

19.3 "Searches should not be delayed if there is reason to think that the person is in possession of anything that may pose an immediate risk to their own safety or that of anyone else" (MHACOP 8.40 2015) unless the criteria is met that would necessitate calling the police (See Section 7)

19.4 "If a search is considered necessary, despite the patient's objections, and there is no clinical objection to one being conducted, the search should be carried out. If force has to be used, it should be the minimum necessary" (MHACOP 8.41 2015). See policy on the Use and Reduction of Restrictive Physical Interventions R01.

19.5 Where there is uncertainty regarding the need to search a detained person advice should be sought from the Matron/Duty Senior Nurse or Manager on call.

19.6 "Where a patient physically resists being personally searched, physical intervention should normally only proceed on the basis of a multi-disciplinary assessment" (MHACOP 8.43 2015)

19.7 This will be recorded in the Standard Record of Search form under the capacity statement.

20. Informal Patients

20.1 There may be occasions where informal patients need to be searched. All such patients will have signed the RI/IOC agreement and will be aware of the need for searches to occur. In this instance a search should be carried out having first made the considerations previously outlined.

20.2 Informal patients cannot be searched without consent. Consent must be given at the time the search is to be carried out. Staff would need to consider whether a refusal to be searched would require the person to be discharged or their ongoing care managed differently.

21. Post Search Support

21.1 Patient

Searching a person or their property can be distressing for the individual being searched, therefore appropriate support should be offered to the patient by a member of staff who has preferably not been involved in the search process. (NICE 2005.)

21.2 Staff

Where a staff member has either carried out a search, or has witnessed one which has subsequently led to some concern or distress, suitable support in the form of a debriefing or other support services should be offered to them by a member of staff who ideally has not been directly involved in the search process.

22. Recording of Searches

22.1 All patients should disclose any knowledge of RI's on their person or in the unit and sign a RI/IOC agreement in which they are agreeing to hand in/identify any items the location of which is known to them (whether on the person, in the individual's bedroom or elsewhere in the unit). This will be done at the point that they are admitted to the Unit/ward as outlined previously within this policy. Where the patient has refused to sign the agreement, this will be considered and featured in the Risk Management plan which indicating the patient refused to sign.

22.2 Searches at level 2 – 4 must be recorded on the Standard Record of Search form (SRS appendix 2). The form should be kept in the clinical records and an incident form should be completed for audit purposes.

23. Removal and Storage of Patient Property

Patients

23.1. At Level 1, the fact that a search has been carried out will need to be recorded within the clinical records. At Level's 2 – 4 the Standard Record of Search form will be used and stored in keeping with the guidance previously outlined.

23.2 Where property has been removed from a patient this must be recorded in the Health Care Record and on a Standard Record of Search form (SRS –see appendix 2). A standard receipt for the item will be issued to the person from whom it has been taken.

23.3 Arrangements should then be made for the item to be safely stored and then returned to the individual on discharge (unless lawfully retained or destroyed - see paragraph 17.1.6)

23.4 The patient must also be informed where the item(s) are to be stored. Each area must have access to appropriate secure storage for patient's personal items (8.45 MHACOP 2015).

23.5 Where suspicious substances or illegal items are removed refer to the appropriate policy for the correct safe keeping and disposal. Medicines Management Policy (1.03) – Appendix 3, Suspected Illicit Substances.

Visitors

23.6 Visitors to the units will be notified of the ward/unit's guidance on restricted items and management of visitors' property via ward posters and information leaflets.

24. Restricting Visitors

24.1 The clinical team must make arrangements allowing for patients to receive visitors. In certain circumstances, visitors may be restricted on clinical or security grounds.

24.2 Any decision to restrict a visitor(s) should be made by closely following the guidance offered in paragraphs 11.4 – 11.22 in the Mental Health Act Code of Practice (MHACOP, 2015). This must be clearly explained to visitors and recorded in the clinical records

25. Training

25.1 All unit/ward based nursing staff require search training. This is delivered by cascade work-based trainers and will involve the use of workbooks, presentation slides and practical searching skills.

25.2 All unit/ward based nursing staff will receive specific in-house training on Search Levels 1 - 4 based upon the following search modules:

Unit 1: Searching Patients – Philosophy and Values
Unit 2: Searching Rationale
Unit 3: Decision Making
Unit 4: Searching Procedures
Unit 5: Documentation and Debrief

a. The training will delivered by authorised cascade trainers. This will ensure that staff involved in the undertaking of searches receive appropriate training and refresher courses (Code of Practice, 2015 8.38).

b. The training is competency based to ensure that all searches are carried out in accordance with best practice and safety and are compliant with the guidance provided within this document. Competency training records will be held by each unit/ward manager.

c. It is the responsibility of managers and staff with appropriate expertise to ensure that initial training is completed and that refresher training is repeated as required. Those

responsible for delivering the training will ensure that it is adapted regularly to take account of any new or changed risk or methods of carrying out searches.

25.3 All new staff employed will undergo a local induction which will include familiarisation with, and their individual responsibilities in relation to the Search Policy and procedures for the unit/ward.

25.4 Where bank and agency staff are utilised there will be a local orientation to ensure that they are familiarised with the specific Search Policy and procedures used and their responsibilities.

Appendix 1 - Standard Operating Procedures

Reasonable adjustments - Where it becomes necessary to carry out a search, reasonable adjustments should be made to ensure that the information regarding searches is delivered/communicated wherever possible in a way that the patient/visitor would be able to understand. Reasonable adjustments will also be made to reflect other individual circumstances of patients, their visitors or staff.

Searches of the person, property and/or accommodation

Standard Operating Procedure (SOP)

Section 1:

Title of SOP	
Standard Operating Procedure (SOP) - Searches of the person, property and/or accommodation	
Dates	
Issue date	
Purpose and Background	
This SOP provides the framework for the completion of person, property and accommodation searches. There may be occasions when staff are suspicious that restricted items/items of concern are present within the inpatient environment and which represent a risk to individuals or the general ward population. There are 4 levels of searches; the most appropriate level of search must be undertaken and the rationale for the level of search clearly identified.	
Scope	
All inpatient areas	
Vital functions affected by this SOP	
Safe management of inpatient environments.	
Escalations	
If you require any further clarification on the processes outlines in this Standard Operating Procedure, please contact: Dean Burgess. Workforce Safety Lead Dean.Burgess@northstaffs.nhs.uk Jackie Clowes. Adult Inpatient Matron JacquelineA.Clowes@northstaffs.nhs.uk Jackie Wilshaw. Senior Nurse/Head of Patient and Organisational Safety JacquelineL.wilshaw@northstaffs.nhs.uk	
Authors	
Dean Burgess	

Level 1 Search: Operating Procedure

Search methodology framework	
1	Level (1) Search - Standard level of search/item management procedure applying to all inpatients.
2	• All patients must sign a Restricted Item/Item of Concern agreement within which they are agreeing to hand in/identify any such items, the location of which is known to them. This is relevant whether the items are on the person, in the individual's bedroom or elsewhere in the unit and will be done at the point that they are admitted to the unit/ward as outlined previously within this policy. Where the patient has refused to sign the agreement, this

	will be considered and featured in the Risk Management plan which indicating the patient refused to sign. • All patients eligible for Unescorted Leave must be made aware of the requirement not to bring back any RI's/IoC prior to going on leave. • On returning from leave, all patients must declare to unit/ward staff and hand in for safe storage any RI or item they consider may be of concern.
3	**Recording the Search Outcome** • Copies of the RI/IoC agreement for the specific patient will be retained in the clinical notes and used to inform risk management plans. • A receipt will be issued for each item removed and a copy retained in the patient's clinical record. • If it is necessary for any item to be permanently removed, a Standard Record of Search (SRS) form should be completed and retained in the patient's clinical record and an incident form completed. • An incident report must be completed on the incident reporting system.

Level 2 Search: Operating Procedure

Search methodology framework	
1	• To be used in conjunction with training syllabus. (This specifies any equipment required and detail of search method.) • Level (2) Search – A search requiring the person being searched, in addition to level 1 procedure, to voluntarily empty their pockets, expose the contents of their belongings and/or step out of their shoes which can be inspected. This can also involve a visual inspection of person, property and/or accommodation without the need for physical contact between the staff member conducting the search and the individual being searched.
2	• All patients must sign a Restricted Item/Item of Concern agreement within which they are agreeing to hand in/identify any such items, the location of which is known to them. This is relevant whether the items are on the person, in the individual's bedroom or elsewhere in the unit and will be done at the point that they are admitted to the unit as outlined previously within this policy. Where the patient has refused to sign the agreement, this will be considered and featured in the risk management plan indicating that the patient refused to sign. • Consent should always be obtained from the patient regardless of MHA status prior to carrying out a search. Consent must be given at the time the search is to be carried out. Staff would need to consider whether a refusal to

	be searched would require the person to be discharged or their ongoing care managed differently. • If a detained patient refuses to be searched their responsible clinician (or, failing that, another senior clinician with knowledge of the patient should be contacted without delay, if practicable, so that any clinical objection to searching by force may be raised and recorded. (MHA COP 8.40 2015). • If a decision is made to search the patient without consent, this can no longer be classed as a level 2 search and would automatically escalate to a level 3 search (see level 3 search page 21). • The patient should where possible be kept separate in an area that is suitable for this that will create the least disruption to other patients. They will be kept under close observation, while being informed of what is happening and why, in terms appropriate to their understanding. • "Searches should not be delayed if there is reason to think that the person is in possession of anything that may pose an immediate risk to their own safety or that of anyone else" (MHACOP 8.40 2015) unless the criteria is met that would necessitate calling the police (See Section 7) • "If a search is considered necessary, despite the patient's objections, and there is no clinical objection to one being conducted, the search should be carried out. If force has to be used, it should be the minimum necessary" (MHACOP 8.41 2015). See policy on the Use and Reduction of Restrictive Physical Interventions R01. • Where there is uncertainty regarding the need to search a detained person advice should be sought from the Matron/Duty Senior Nurse or Manager on call. • "Where a patient physically resists being personally searched, physical intervention should normally only proceed on the basis of a multi-disciplinary assessment" (MHACOP 8.43 2015) • This will be recorded in the Standard Record of Search form under the capacity statement.
3	**Procedure Preparation** <u>Staff Involved</u> • At least 2 members of staff, one of whom is search trained will approach the patient, following the guidance set out below in order to fully inform the patient of the need for the search and the process that the search will follow. • One member of staff will carry with them the standard search item inspection tray. Equipment required • Search form <u>Patient Information and Consent</u>

	• The patient should be given the reason for the search which could be as part of the standard random search program operated by the unit • The verbal consent of the person should be requested and recorded on the Standard Record of Search form and their capacity assessed. <u>Location of the Search (if not accommodation)</u> • The patient should be asked to accompany the staff to a private area which, in the case of patients returning from leave, will be a room close to the ward entrance. Note: Evidence often suggests that the volunteering of one item before the intention to search is declared is often followed by the discovery of more. Therefore, the search should continue and this may be indicative of the need of a higher search level.
4	**Level 2 Search of the Person** • The patient should be given the opportunity to volunteer information pertaining to the search (as required in level 1). • Request that person stand in front of one member of staff with the other observing from the side so that the back and the front of the person can be observed by the second member of staff. • Searching will occur in a formal and systematic way. As a minimum number, staff will conduct the search in pairs where a level 2 search is required. Staff should be of the same sex as the patient unless absolute necessity dictates otherwise. • The staff member to the side should be holding the search item tray. • Request that the person empty their pockets, and place the contents in the search tray. • In the case where the person is also carrying a bag or other containment vessel; they should expose the contents by laying out belongings in the standard search tray. • The person is requested to step out of their shoes for the purposes of inspection.
5	**Level 2 Search of Accommodation** • Request that the patient accompany staff to their room. • One member of staff will be holding the search item tray. • Request that the patient exposes items on request and place them in the search tray for inspection. • Request that the person open drawers etc. and expose the contents for inspection. • During a search of a patient's bedroom all property is to be treated with respect and the room must be returned to a respectable state on completion.
6	**Recording the Search Outcome**

	• Record the search outcome on the Standard Record of Search (SRS) form and make a note in the patient's clinical records with the label RI or IOC including a description of the item if an item is found. • A copy of the receipt issued for any items found will also be retained in the patient's clinical records • The Standard Record of Search form will also be retained in the patient's clinical records. • An incident form must be completed

Level 3 Search: Operating Procedure

Search methodology framework	
1	To be used in conjunction with training syllabus. (This specifies any equipment required and detail of search method.) • All patients must sign a Restricted/prohibited Item/Item of Concern agreement within which they are agreeing to hand in/identify any such items, the location of which is known to them. This is relevant whether the items are on the person, in the individual's bedroom or elsewhere in the unit and will be done at the point that they are admitted to the unit as outlined previously within this policy. Where the patient has refused to sign the agreement, this will be considered and featured in the risk management plan indicating that the patient refused to sign. • Consent should always be obtained from the patient regardless of MHA status prior to carrying out a search. Consent must be given at the time the search is to be carried out. Staff would need to consider whether a refusal to be searched would require the person to be discharged or their ongoing care managed differently. • If a detained patient refuses to be searched their responsible clinician (or, failing that, another senior clinician with knowledge of the patient should be contacted without delay, if practicable, so that any clinical objection to searching by force may be raised and recorded. (MHA COP 8.40 2015) (See also Section 7) • The patient should where possible be kept separate in an area that is suitable for this that will create the least disruption to other patients. They will be kept under close observation, while being informed of what is happening and why, in terms appropriate to their understanding. • "Searches should not be delayed if there is reason to think that the person is in possession of anything that may pose an immediate risk to their own safety or that of anyone else" (MHACOP 8.40 2015) unless the criteria is met that would necessitate calling the police (See Section 7) • "If a search is considered necessary, despite the patient's objections, and there is no clinical objection to one being conducted, the search should be carried out. If force has to be used, it should be the minimum necessary"

	(MHACOP 8.41 2015). See policy on the Use and Reduction of Restrictive Physical Interventions R01. • Where there is uncertainty regarding the need to search a detained person advice should be sought from the Matron/Duty Senior Nurse or Manager on call. • "Where a patient physically resists being personally searched, physical intervention should normally only proceed on the basis of a multi-disciplinary assessment" (MHACOP 8.43 2015) • This will be recorded in the Standard Record of Search form under the capacity statement.
2	Level (3) Search - There are grounds to suspect that the patient may have on his/her person or in his/her possession a Restricted Item or Item of Concern which would cause reasonable concern to Justify a level 3 search. This would include: • An article(s) that may be utilised as a weapon(s), or be used for escape purposes and/or pose a significant risk of harm to others • An article(s) that is intended for deliberate self-harm • Suspicious substances that he/she intends to ingest which may result in a significant deterioration in mental and/or physical health or increase violent propensities. • Suspicious substances that he/she intends to supply to others.
3	**Procedure Preparation** <u>Staff Involved</u> • At least 2 members of staff one of whom is search trained will approach the patient, following the guidance set out below in order to fully inform the patient of the need for the search and the process that the search will follow. • One member of staff will carry with them the standard search item inspection tray. <u>Equipment Required</u> • Standard search tray and Standard Record of Search form • Other equipment as outlined in the training syllabus <u>Patient Information and Consent</u> • The patient should be given the reason for the search. • The verbal consent of the person should be requested and recorded and their capacity assessed. <u>Location of the Search</u> • The patient should be asked to accompany the staff to a private area, in the case of patient's returning from leave, this will be a room close to the ward entrance.

	• In the case of searching accommodation, the patient should be asked to witness the search. However, there may be exceptional circumstances where it is preferable that the search be completed and the patient informed afterwards. Such circumstances should rarely occur and any explanation should be recorded in all cases where individual bedrooms are searched without the patient's knowledge or consent. Note: Evidence often suggests that the volunteering of one item before the intention to search is declared is often followed by the discovery of more. Therefore, the search should continue and this may be indicative of the need of a higher search level.
4	**Level 3 Search of the Person** • The patient should be given the opportunity to volunteer information pertaining to the search (as required in levels 1/2). • Request that person stand in from of one member of staff with the other observing from the side so that the back and the front of the person can be observed by the second member of staff. • Searching will occur in a formal and systematic way. As a minimum number, staff will conduct the search in pairs where a search is required. Staff should be of the same sex as the patient unless absolute necessity dictates otherwise. • The staff member to the side should be holding the search item tray. • Request that the person empty their pockets, and place the contents in the search tray. • In the case where the person is also carrying a bag or other containment vessel; they should expose the contents by laying out their belongings in the standard search tray. • The person is requested to step out of their shoes for inspection purposes. • The training of the search member of staff conducting level 3 personal searches will be consistent with the training syllabus. • If a metallic Restricted Item is suspected staff may consider the use of a search wand if consistent with the training syllabus and Trust Policy in relation to suitable equipment used for this purpose.
5	**Level 3 Search of Accommodation** • Request that person accompany staff to a private area. • One member of staff will carry with them the standard search item tray. • Staff will conduct the search systematically, consistent with the training standards for a level 3 search.

	• During a search of a patient's bedroom all property is to be treated with respect and the room must be returned to a respectable state on completion.
6	**Recording the Search Outcome** • Record search outcome on Standard Record of Search (SRS) form and record in the patient's clinical records. An incident form should also be completed detailing the reason for the search and a description of the item if an item is found. • A copy of the receipt issued for any items found will also be retained in the patient's clinical records. • The Standard Record of Search form should also be retained in the patient's clinical records. • An incident form must be completed

Level 4 Search: Operating Procedure

Search methodology framework	
1	Level 4: It is anticipated that this level of searching would be a rarity in our services and should be preceded by a multidisciplinary discussion. Level (4) Search – The highest standard of search requiring specifically trained staff to perform a very thorough physical inspection including very close inspection of the person (not extending to internal inspection of anus or vagina), their clothing, and possible dismantling of fittings and /or equipment within accommodation. The use of specific search aids e.g. search wand if consistent with training syllabus and Trust policy. A level 4 search does not require a person to remove clothing to the extent that would expose private/genital areas. • All patients must sign a Restricted/prohibited Item/Item of Concern agreement within which they are agreeing to hand in/identify any such items, the location of which is known to them. This is relevant whether the items are on the person, in the individual's bedroom or elsewhere in the unit and will be done at the point that they are admitted to the unit as outlined previously within this policy. Where the patient has refused to sign the agreement, this will be considered and featured in the risk management plan indicating that the patient refused to sign.
2	**Procedure Preparation** <u>Staff Involved</u> • At least 3 members of staff, two of whom are search trained, will approach the patient following the guidance set out below in order to fully inform the patient of the need for the search and the process that the search will follow. • One member of staff will carry with them the standard search item inspection tray, search wand if consistent with training syllabus and Trust policy and other equipment as required. <u>Equipment Required</u> • Standard search tray and Standard Record of Search form.

	• Other equipment as outlined in the training syllabus Patient information and consent • The patient should be given the reason for the search. • The consent and capacity of the person should always be requested and recorded but in some situations a search can take place even if the patient refuses consent (see section 11). • The patient should be asked to accompany the staff to a private area, in the case of patients returning from leave, this will be a room close to the ward entrance. • In the case of searching accommodation, the patient should be asked to witness the search. However, there may be exceptional circumstances where is preferable that the search be completed and the patient informed afterwards. Such circumstances should rarely occur and any explanation should be recorded in all cases where individual bedrooms are search without the patient's consent. • The patient should be given the opportunity to volunteer information pertaining to the search (as required in levels 1/2/3).
3	**Level 4 Search of the Person** • Request that the person stand in front of one member of staff with the other staff members observing from the side so that the back and the front of the person can be observed. One of staff members standing to the side should be holding the search tray and search wand if consistent with training syllabus and Trust policy. • Searching will occur in a formal and systematic way. Staff should be of the same sex as the patient unless absolute necessity dictates otherwise. • Request that the person empty their pockets, and place the contents in the search tray. • In the case where the person is also carrying a bag or other containment vessel; they should expose the contents by laying out their belongings in the standard search tray. • Each individual item in the person's possession should be closely inspected to ascertain if it has been changed or amended in any way in order to conceal items or inflict injury on others. • Any item that cannot be opened that has the capacity to conceal contents should be removed as an Item of Concern. • The person is requested to step out of their shoes for the purposes of inspection. • Items of clothing that can be removed without unreasonably compromising dignity should be handed to a staff member for close inspection. Staff should consider the availability/provision of alternative clothing in order to maintain the patient's dignity. However, this does not extend to asking the patient to remove all clothing or conducting an "intimate" search.

	• The members of staff conducting level 4 personal searches will have received training consistent with the agreed training syllabus.
4	**Level 4 Search of Accommodation** • In most cases, request that person accompany staff to their room. • One member of staff will be in possession of the standard search item tray(s). • Staff will conduct the search systematically, consistent with the training standards for a level 4 search. • During a search of a patient's bedroom all property is to be treated with respect and the room must be returned to a respectable state on completion.
5	**Recording the Search Outcome** • Record search outcome on a Standard Record of Search (SRS) form and an entry made in the patient's clinical records. An incident form should also be completed indicating the reasons for the search and a description of the item if an item is found. The SRS form will also be retained in the patient's clinical records. • A copy of the receipt issued for any items found will also be retained in the patient's clinical records. • The Standard Record of Search form will also be retained in the patient's clinical records. • An incident form must be completed

General unit and unit wide searches: Operating Procedure

Search methodology framework	
1	To be used in conjunction with training syllabus. (This specifies any equipment required and detail of search method) **General Unit/Room Search** • When a patient vacates a bedroom, (either because of discharge, transfer or just moving to a new room), a search (Level 3) will be made of that room when it is empty to ensure that no prohibited items are left and accessible to others. The room should be cleaned and then locked, ready for use by another patient.
2	**Unit Wide Searches** • A unit wide search is so defined when more than one room or person requires searching in one clinical area. During this the movements of patients need to be closely controlled.

	• A unit wide search is a serious and resource intensive procedure which may be necessary if: • Reliable intelligence suggests that a Restricted Item and/or an Item of Concern may be at large within the unit. If this is the case, serious consideration must be made about involving the police in this, e.g. large quantities of substances, a fire arm, other deadly weapon is suspected. • Any other circumstances that puts the health and safety of people at serious risk. • Unit wide searches could take place at levels 2, 3 or 4 depending on the level of intelligence informing the need for the search and the nature of the items suspected to be present.
3	**Procedure Preparation** • The Matron or their Duty Senior Nurse must be informed if a unit search is required so that resources can be established as necessary. • The nurse in charge will act as search coordinator (SC) and a team will be identified to support. The SC will allocate roles to other search team members. At least three members of this team will have received dedicated search training (one of whom will record the search and one of whom will conduct the search). • A suitable room must initially be identified as a holding area and thoroughly searched by the team. Once this has been assessed as 'clean' the patients who have been searched can be contained in this area. The patients who have not been searched will then be assembled in another area, contained and informed of the purpose and nature of the search. The patient's capacity and consent should be assessed and they should be given the opportunity to volunteer information pertaining to the search. • During a Unit Search it is essential that all non-necessary movement through the ward entrance is stopped. This includes all staff not involved in the search and professional visitors. Patients must not leave the ward during a search. • Patients who normally inhabit the unit and who are elsewhere in the service, must be searched on their return.
4	**Room/Property Search** • Patients will be invited to witness the search of their room or possessions. Their decision whether or not to uptake the invitation will be recorded on the appropriate Standard Record of Search form. If the patient wishes to witness the search they must do so from outside the room. • The staff recording the search will stand with them by the doorway.

	• The two search staff will then search the room as directed by the 'recorder', reporting any 'finds' to the recorder who will document this. The search will continue until the whole room area has been searched even if a RI/IOC has been located in one part. • If the patient has declined to witness the search, the search will go ahead. Upon completion, the staff will report any findings to the patient; the patient will then require searching in a 'clean area'. It is suggested that a treatment room or the patient's own 'clean' bedroom is used for this purpose. Once this has been completed they can then be contained in the clean area. • At no time should patients who have been searched be able to mix with those that have not. • During this procedure every effort must be made to promote the dignity and privacy of patients, and access to drink and toilet facilities maintained. • If a patient requires the toilet, they must be escorted and observed during the search period. • Once all patients/rooms have been searched the initial containment room must be locked off and searched. • The Matron and/or Head of Directorate/On-call Manager must be informed at the earliest opportunity of the outcome of the search.
5	**Recording the Search Outcome** • Record the search outcome on the Standard Record of Search (SRS) form for each individual patient and complete an incident form regardless of whether any items are found or not. If an item can be linked to an individual patient this should be noted on the SRS form. A note should also be included within the clinical records with the label RI or IOC including a description of the item if an item is found.
6	**Cultural Considerations** • Religious artefacts and books – These should be handled by a searcher wearing clean gloves. Objects should not be placed on the floor with shoes and underclothes. Patient's should be asked to identify religious items and staff to search them in the presence of the patient. If handling Buddha images these should not be picked up by the head or the 'Enlightened Flame'. • Guidance on how to handle items can also be sought from the individual and/or chaplain. • Search Dogs – If dogs are to be used in room searches, consideration must be given to some faiths in that they must be allowed to wash and change their clothes following the search. Religious artefacts should be removed from the room by the patient prior to the search. These items are then to be searched by supporting staff.

Appendix 2 - Standard Record of Search (SRS) Form

Unit	
Date	
Time	

Name of person being searched	
Room name/number	

Type of search *tick all that apply*	
Person	
Property	
Accommodation	

Search level *tick all that apply*	
Level 1	
Level 2	
Level 4	
Level 4	

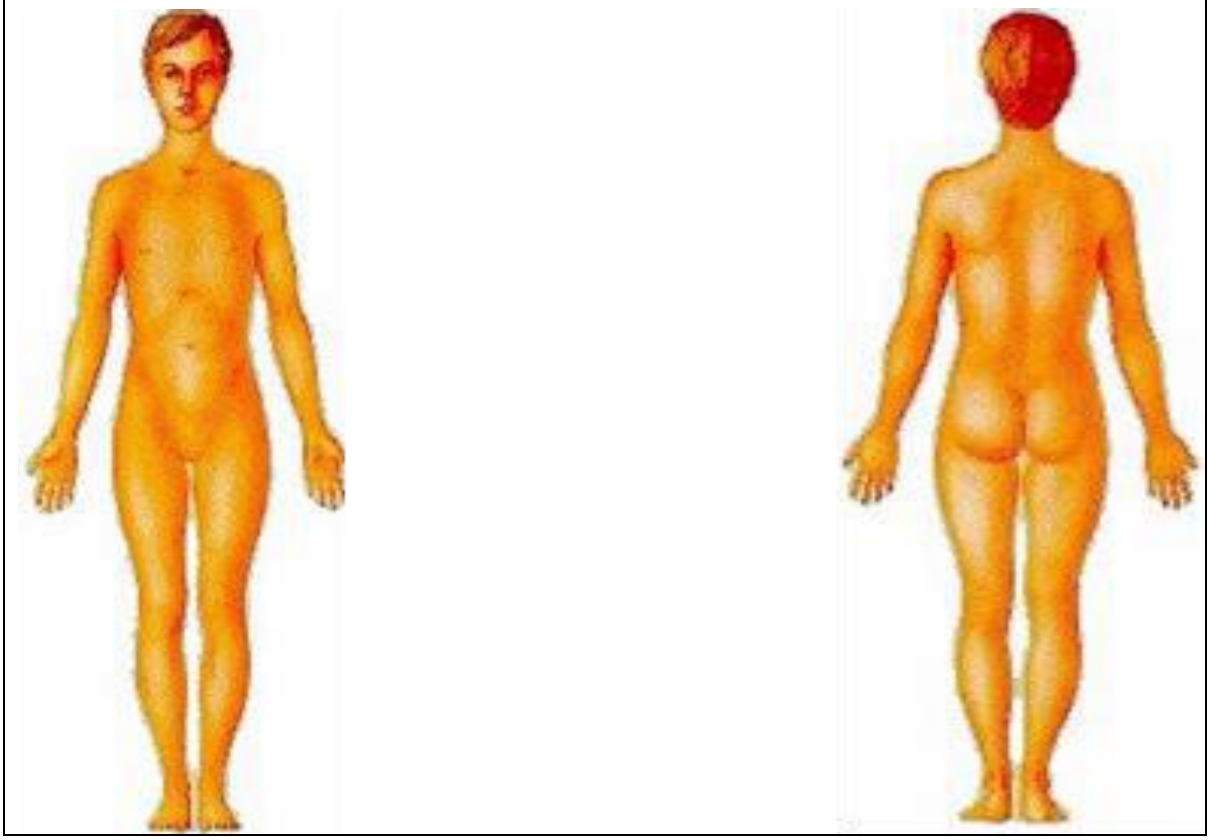
Authorisation for search given by	

Consent and capacity statement

Reason for search

Draw room layout below and enter in the position/location of any item(s) removed and identify them as Restricted Item (RI) or Item of Concern (IoC)

Description of items found: (Person, Property, Room/ Accommodation)

Enter in position any item(s) removed and Identity as Restricted Item (RI) or Item of Concern (IoC)


Other comment/observation (if required)

Signed (staff)	
Date	

Signed (patient)	
Date	

Scanned date	

Appendix 3 - Patient Restricted/Prohibited Items/Items of Concern (RI/IoC) Agreement

Management of restricted items and items of concern patient agreement

Issue requiring intervention

The Unit has responsibility to promote the care, welfare, safety and security of all patients and staff. In order to promote safety there are a number of items which are either restricted (not permitted in the unit) or considered an item of concern requiring specific handling within the unit.

It is a requirement that all patients upon admission, during their stay in the Unit and prior to the granting of unescorted leave, read and sign this agreement.

Intervention

- A member of staff will make available to me a list of restricted items and items of concern. A copy can be kept by me for future reference.
- A member of staff will talk through and discuss this list with me and listen carefully to any views I put forward and answer any questions I may have.
- Any restricted item or items of concern within my possession will be kept within the units secure procedures and signed out to me for use within the restricted item/item of concern supervision policy. This will be detailed in my care plan.
- I am aware that at no time can I bring Restricted Items into the Unit. I should also advise my visitors not to bring any of these items to the unit.
- I am aware that any items of concern are handed into staff in order for their safe keeping and management. This is especially important following periods of unescorted leave.
- On admission or at other times during the stay in the Unit it may come to staffs' attention that a restricted item or an item of concern is in possession of a patient and may need to be removed either permanently or temporarily for health and safety reasons.

Searching

- I have been informed that periodically there may be need for the person or their property to be searched to ensure the care, welfare, safety and security of all patients and staff on the unit.
- I am aware that a search of my belongings will be undertaken on admission to the unit.

Signatures

- A staff members' signature is required at the end of this agreement to confirm that it has been explained to me.

- I am aware that I am required to sign this agreement to indicate that I understand the need for searches and how restricted items and items of concern are managed on the unit.

This agreement has been discussed with (full name)	

Staff Signature	
Print Name	
Date	

Patient Signature	
Print Name	
Date	

Patient Comments:

Appendix 4 - Visitors Information and Declaration

Information Sheet for relatives/friends visiting patients

North Staffordshire Combined Healthcare NHS Trust welcomes relatives and friends and recognises these visits are an important and valuable part of all patient admissions. We would be grateful if you could take the time to read through the information below and kindly sign your name at the end to say you have read and understood the information sheet.

- During the hours of 09.00 – 12.00 and 15.00 and 17.00 patients may be involved in treatment/activity programmes and therefore may not be able to receive visitors.
- Visits will take place in the Dining Room or Family Room and may be supervised at staff discretion.
- At Harplands Hospital, children aged 16 and under are not permitted on the main ward area under any circumstances. Arrangements can be made for visits to take place in the family room.
- Staff may request that any bags brought in for patients are searched prior to them being given to the patient.
- Please read the list of items attached to this sheet and familiarise yourself with these items.
- Items on the “Restricted Items” list should NOT FOR ANY REASON be brought to the unit at any time.
- If you are bringing any items on the “Items of Concern” list in to the unit for a patient, please note they must be handed to staff upon your arrival.

- Staff will then securely store these items and sign them out to patients as and when required.

Drugs and Alcohol

- Do not bring any drugs (prescribed or non-prescribed) to the wards.
- Alcohol is not permitted on the wards.
- If staff have reason to believe that illicit drugs or alcohol have been brought in by a visitor –the visit may not be allowed to continue.
- Staff will ask visitors found to be bringing in illicit drugs to leave the premises and the Police will be informed. Future visiting may be prohibited or supervised.
- The Trust operates a zero tolerance approach to violence or abuse from visitors. Anyone who exhibits aggressive, threatening or intimidating behaviour of any kind will be requested to leave the building. The Police may be called if necessary.

If you require any further information please do not hesitate to speak to a member of staff who will be happy to help you.

Failure to comply with the above rules or to sign up to the rules may result in you not being able to visit.

Name of person being visited (full name)	

Visitors Signature	
Print Name	
Date	

Staff Signature	
Print Name	
Date	

Visitor Comments:

Further information on restricted items/ items of concern (which will include prohibited items)

Restricted Items

- Knives
- Alcohol
- Any type of drug or medication.
- Any kind of mind altering substance that can be ingested
- Any type of firearm including replica/toys.
- Any item intended for use as a weapon e.g. “knuckle duster” “baton” etc.
- Any sharp items e.g. Scissors, razors or razor blades.
- Any type of explosive including fireworks
- Personnel Incapacitant e.g. pepper spray CS gas etc.
- Lighter fuels and combustible gas or liquid
- Matches and lighters
- Caustic chemicals e.g. bleach
- Poisons e.g. weed killer, pesticides etc.

Items of Concern

- Any item that could easily be used as a weapon e.g. cricket/ baseball bat etc.
- Mobile phones
- Electronic tablets and computers
- Electrical equipment
- Cameras
- Nail clippers etc.
- Aerosols
- Energy drinks
- Tools e.g. spanners, screwdrivers etc.
- An item manufactured from glass e.g. jars, ornaments etc.

Appendix 5 Searching Procedures Checklist

Personal Search

1. Set-up

Identify a minimum of two staff to be involved and allocate roles.
Identify private area to undertake search (ensuring area is safe and warm).
Ensure necessary authorisation and approval.
Ensure necessary equipment is available (e.g. wand, gloves, trays, bags, forms).
Explain the purpose of the search, maintaining positive rapport and due regard for individual.
Seek and gain consent.
Proceed with wand and rub-down procedure

2. Wand and rub-down procedure

Working in pairs, one member of staff will undertake the search and one member of staff will observe and assist when asked.
Ask the person to remove all headwear, outer clothing, shoes, jewellery and any items in their pockets. Place to one side and scan with wand before visually checking and manually inspecting.
Facing the person, start from the head and use the wand to scan for metal items working down the front and side. Ask the person to turn and face away so that you can use the wand to scan the rear working down from the head to the feet.
If the individual has long hair/beard, ask them to loosen their hair and to rub their fingers through the hair.

Visually check the ears and mouth.
Facing the person, rub and squeeze the collar, starting from the back moving forwards towards the tips.
Ask the person to raise their arms (shoulder height). Ask the person to rotate their hands so that you can check their palms and fingers. Taking each arm in turn, place both hands around the arm and manually rub starting from the shoulder working down to the wrist.
Manually rub torso starting from the front upper chest, working down to the waist. Check the sides of the torso, working from the armpits down to the waist. When searching a female, do not touch the person's breasts – manually check the upper chest and then begin again from the underneath of the bra.
Check the waist band, starting at the front working to each side.
Ask the person to turn and face away. Manually rub the torso, starting at the neck working along the shoulders and down to the waist.
Check the waist band, starting at the rear working to each side.
Check the seat of the trouser/dress using the back of your hand.
Manually rub each leg. Starting from the groin, work down to the ankle checking the side, front and rear of the leg. If the person is wearing a dress/skirt, do not check the upper inner thigh.
Ask the person to remove their socks. Visually check and manually inspect.
Ask the person to turn a lift each foot in turn to enable you to visually check the soles and toes.
Return person possessions to the person.
Thank person for their co-operation and explain what will happen to any items removed.

Environmental Search

1. Set-up

Identify a minimum of three staff to be involved and allocate roles with two people undertaking the search and one observer/recorder.
Determine if the person should be present when searching bedroom/area. This should be assessed on an individual basis, based on known risk and the potential adverse impact on the individual and or others.
Ensure necessary authorisation and approval.
Ensure necessary equipment is available (e.g. wand, gloves, bags, forms).
Explain the purpose of the search, maintaining positive rapport and due regard for individual.
Seek and gain consent.
Proceed with wand procedure

2. Tandem procedure

It is important that the searchers work in pairs in a careful and systematic manner.
Visually inspect the room before entering.
Place the individual's possessions to one side. Use the wand to scan for metallic items, before visually and manually checking all items.
For the room search, start in the near corner work together and search the floor, walls and all furniture.

Use the wand to scan the mattress and bedding for metallic items, before visually and manually checking.
Use the wand to scan the curtains, before visually and manually checking.
Visually check all fixtures and fittings and look for any evidence of tampering.
The recorder must documents what is found and note the location of the find.

NHS North Staffordshire Combined Healthcare NHS Trust

Welcome to the Harplands Hospital

Items that you cannot bring into Hospital

Any mind altering substance

Any alcohol /products

Lighters

Matches

Any sharp implement

Any items used as weapon

Pepper spray, CS gas etc

Knives

Caustic chemicals /bleach

Any Poisons, weed killers

Any firearms, including replicas/toys

Razors or razor blades

Medication or drugs

spar

For your Safety your property may be searched and removed

PROUD TO CARE

Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents
Please tick as appropriate

There **is no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	✓
There **is** specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Career Grade Doctor				
Training Grade Doctor				
Locum medical staff				
Inpatient Registered Nurse				
Inpatient Non-registered Nurse				
Community Registered Nurse				
Community Non Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed by		Date	

Document level: Trust
Code: R11
Issue number: 1

Seclusion and Long Term Segregation (LTS) Policy

Lead executive	Director of Nursing and Quality
Authors details	Quality Assurance and Improvement Manager

Type of document	Policy
Target audience	All Trust staff involved in Seclusion and Long Term Segregation
Document purpose	The policy provides a set of standards and expectations to ensure that patients requiring seclusion or LTS receive safe, effective care which is compassionate and least restrictive practice remains at the forefront of clinical decision making.

Approving meeting	Quality Committee Trust Board	Meeting date	10th September 2019 26th September 2019
Implementation date	26 September 2019	Review date	31 October 2023

Trust documents to be read in conjunction with	
MHA18	Trust Policy MHA18, Deprivation of Liberty Safeguards, Policy and Procedures (Mental Capacity Act, 2005).
R1	Trust Policy R1, Policy on the Use and Reduction of Restrictive Interventions Including the Use of Physical Holding Skills (MAPA®);
1.27	Trust Policy 1.27, Policy for the Management of Violence and Aggression using Rapid Tranquillisation;
5.01	Trust Policy 5.01, Incident Reporting Policy and Guidance
R08	Refer to R08 Search of Patients (detained and informal), visitors and their property.
1.35	Trust Policy and Procedure for the Safe and Supportive Observation and Engagement of Patients

Document change history		Version	Date
What is different?	Re-write of policy following recommendations identified in the Mental Health Act 1983 monitoring visit (Ref. MHV1-7047245391) to PICU on 19th June 2019 and subsequent report received 24 July 2019. Increased focus on privacy, night time checks, roles and responsibilities and positive engagement.	V1	23.8.19

Appendices / electronic forms	All appendices reviewed and updated; now include flow charts to support the clarity of processes, decisions and reviews required	V1	23.8.19
What is the impact of change?	Policy now reflects CQC recommendations and more robustly reflects the requirements MHA Code of Practice for Seclusion and Long Term Segregation.	V1	23.8.19

Training requirements	There are no specific training requirements for this policy.

Document consultation	
Directorates	All Heads and Clinical Directors of each Trust Directorate
Corporate services	Document quality group and Senior Operating Team Meeting
External agencies	N/A

Financial resource implications	None

External references

1. NICE (2015). Violence and aggression: short-term management in mental health, health and community settings. https://www.nice.org.uk/guidance/ng10;
2. NICE (2010). Delirium: Diagnosis, prevention and management. https://www.nice.org.uk/guidance/cg103;
3. NICE (2014). Head injury: Assessment and early management https://www.nice.org.uk/guidance/cg176
4. RCN (2010). Restrictive physical intervention and therapeutic holding for children and young people https://www.rcn.org.uk/__data/assets/pdf_file/0016/312613/003573.pdf
5. This policy should be read in conjunction with the NICE Guideline (2015) Violence and aggression: short term management in mental health, health and community settings;
6. Mental Health Act 1983 Code of Practice (2015, chapter 26. Safe and therapeutic responses to disturbed behaviour);
7. The Mental Capacity Act, 2005, Deprivation of Liberty Safeguards and the Use of Restrictive Interventions;

Monitoring compliance with the processes outlined within this document	Via SLT performance reporting and as part of the Trust Annual Audit Cycle.

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favorable / More favorable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		

– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
–		
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)	No	
– **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No	

If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	NA
Enter details here if applicable	
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk	
Was a full impact assessment required?	No
What is the level of impact?	NA

CONTENTS

1. Policy Introduction / Background

A safe and therapeutic culture should be provided for all people receiving treatment for a mental disorder including those who may present with behavioural disturbance. As a part of this there is often a requirement to balance the need for patient and staff safety against the need to ensure least restrictive practice for service users.

This policy outlines the procedure for utilising two such restrictive interventions, seclusion and long term segregation, recognising the need for these interventions to be used in a way that respects human rights and ensures these interventions are proportionate, in the best interests of the service user and use least restrictive principles.'

The policy provides a set of standards and expectations to ensure that patients requiring seclusion or LTS receive safe, effective care which is compassionate and least restrictive practice remains at the forefront of clinical decision making.

1.1 Policy Requirement

1.2 Policy Aim:

The Mental Health Act Code of Practice (2015, para 26.103) defines seclusion as "the supervised confinement and isolation of a patient away from other patients in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others".

If a patient is confined in a way that meet the definition above, even if they have agreed to or requested such confinement, they have been secluded. The use of any local or alternative terms (such as "therapeutic isolation") or the conditions of the immediate environment do not alter the fact that the patient has been secluded. It is essential that under such circumstances the person is afforded the procedural safeguards of the MH Act Code of Practice

The seclusion of a service user poses significant ethical and practical dilemmas, awareness of which is essential to promote best practice. Staff should be cognisant of the adverse effects on service users and the need to balance the rights of a person who is secluded to freedom, choice and autonomy with the rights of others to protection from harm. Additionally this should be underpinned by rigorous monitoring and evaluation

The policy aims to reinforce the least restrictive approach to ensuring that patients' needs are met safely and patients requiring seclusion and LTS are care for in line with the Mental Health Code of Practice.

1.3 Key Principle:

Least Restrictive Options:

The MH Act Code of Practice (2015) requires care and treatment to 'always be a means to promote recovery, be of the shortest duration necessary, be the least restrictive option and keep the patient and other people safe'.

In order to meet this requirement, when a person is at risk of presenting with challenging behaviour, assessment of the person's behavioural presentation is important in understanding an individual's needs and should seek to understand the behaviour in the broadest context.

Assessments should consider the views of patients and their families, carers and advocates. The results of the assessment should guide the development and implementation of effective, personalised and enduring systems of support that meet an individual's needs, promote recovery and enhance the quality of life outcomes for the individual and others who care and support them.

When concluded, assessments should describe behaviours of concern, identify factors which predict their occurrence, and describe the functions that behaviours serve or the outcomes they achieve for the individual. This then promotes the use of least restrictive options through proactive use of primary and secondary preventative strategies to respond to a person at risk of presenting with challenging behaviour.

Primary preventative strategies aim to enhance the person's quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbance.

Secondary preventative strategies focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to avoid escalation of challenging behaviour. This includes the use of de-escalation strategies to promote relaxation.

De- escalation is the use of verbal and nonverbal communication to reduce or eliminate aggression and violence during the escalation phase of a patient's behaviour (National Institute of Clinical Excellence 2005). De-escalation offers a safer, less coercive, and alternative to traditional containment methods, such as seclusion, rapid tranquilisation, intensive supervision or physical restraint (Lavelle et al, 2016).

NSCHT requires de-escalation strategies used by staff to be person-centred and should typically involve establishing a rapport and the need for mutual co-operation, demonstrate compassion, attentiveness and concern, negotiating realistic options, use of open questions, empathetic and non-judgemental listening, distracting and redirecting the person into alternate activities that are meaningful to them, removing sources of excessive environmental stimulation and being sensitive to non-verbal

communication. De-escalation strategies are non-confrontational and may, for a minority of patients, include prompts to encourage the person to access a low stimulus, private, relaxing area if this is known to help the person calm; however there is no compulsion for the person to go to or to remain in such areas and staff must be mindful of this to ensure that seclusion or long term segregation criteria are not triggered or that the level of violence and aggression has escalated to the point where seclusion would be an appropriate intervention.

Additionally a member of staff must remain with the person to offer intensive nursing support. Such de-escalation strategies may be used proactively as part of a person's care plan (or equivalent e.g. chained behaviour management plan) to meet their needs in the least restrictive way.

As such the care plan must be individualised, based on assessment of a person's needs, including the continual attempt to understand the function of the behaviour for the person, consider the views of the person and their family/carers and be agreed by the multi-disciplinary team.

There must also be regular review of the person and their care in line with the policy 1.35 Safe and Supportive Observation and policy 1.64 Effective Care Planning.

2. Policy Synopsis:

- To provide guidance on when any period of seclusion is indicated.
- To minimise the frequency and duration of any period of seclusion and minimise any possible anti-therapeutic effects.
- To ensure the welfare and care of a secluded service user is given highest priority.
- To ensure clinical accuracy of documentation thus providing a complete record of all periods of seclusion.

3. When seclusion can be used:

Seclusion may only be used for the containment of severe behavioural disturbance that is likely to cause harm to others. It may not be used solely as a means of managing self-harming behaviour (MHA CoP, para 26.108). When a patient poses a risk of self-harm as well as harm to others, seclusion should only be used when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient's health or safety arising from their own self-harm and that any such risk can be properly managed.

Seclusion should not be used as a punishment or a threat, or because of shortage of staff. It must never form part of a treatment programme (MHA CoP, para 26.107).

Any situation whereby a service user is physically or mechanically confined to a seclusion room against their wishes should be regarded as the commencement of an episode of seclusion.

As seclusion may only be used to contain the severe behavioural disturbance that may cause harm to others, it is the responsibility to staff to assess the risk that a patient poses to others due to their challenging behaviour. In placing a patient in seclusion, staff must be able to demonstrate the decision-making which evidences that seclusion was used:

a) to manage severe behavioural disturbance which is likely to cause harm to others; and
b) as a measure of last resort.

During any period of seclusion it is vital that staff are aware of the need to maintain the service user's dignity. Staff must always be sensitive to age, gender, race, language preference and any sensory impairment and to determining the underlying cause of aggressive behaviour such as a culturally specific form of communication, or an attempt to communicate by an individual with a sensory loss.

3.1 Summary of criteria:

Seclusion should only be considered when the following criteria/conditions are met:

- The nurse in charge, having made an assessment considers that there is an immediate risk of harm to others.

- All other interventions have been considered, attempted or are not feasible. In particular verbal de-escalation, listening skills, negotiation skills, diversion activities and MAPA® techniques.

Where possible when determining if seclusion is necessary, the following factors should be taken into account, clinical need, safety of patient and others, and, where possible, Advance Statements and agreed care plans. Seclusion must be a reasonable and proportionate response to the risk posed by the patient. Consideration should be given to using seclusion and/or rapid tranquillisation as alternatives to prolonged physical intervention as identified in each individuals care plan, as indicated by individual risk assessment.

3.2 Monitoring for Seclusion:

Each episode of Seclusion requires an incident (Ulysses) report.

Each ward utilising the seclusion must have arrangements in place to scrutinise completion of documents used in seclusion (i.e. incident report, patient observation sheet and seclusion monitoring form).

Recording of seclusion will take place, from October 2019, in the Trust Electronic Patient Record (EPR). System "downtime" paper based forms will be available for completion in the meantime and these will be scanned into the EPR (patient clinical notes section) every 24hr period. Once the Electronic form is available, there may be occasions of system failure, the 'downtime' paper based forms will need to be reused and once the EPR becomes available again the relevant seclusion/long-term segregation forms should be transferred to the EPR, and the paper forms destroyed.

The MHA team oversee the audit of all seclusion documentation as part of the Trusts MHA annual audit cycle.

A themed report of Seclusion and LTS practice is provided on an annual and quarterly basis for the Trust Board and periodic reports issued when requested.

On rare occasions and in some exceptional circumstances seclusion may take place outside of designated seclusion facilities, e.g. if a patient is receiving a restrictive intervention that meets the definition of seclusion, this is a breach of the Code. The full safeguards of this policy apply and must be implemented for such incidents of seclusion AND, both the Director for Nursing, AHP and Quality and the Mental Health Act Manager should be informed.

3.3 Seclusion and Informal Patients:

Seclusion should only be used in hospitals and in relation to patients detained under the Act. If an emergency situation arises involving an informal patient, and as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately (MHA CoP, para 26.106)

3.4 Seclusion and Advance Statements:

Patients must have the opportunity to complete an advance statement that expresses their preference on how an episode of severe behavioural disturbance should be dealt with. The purpose of this is to minimise the use of restraint, seclusion and long-term segregation. Nevertheless, the Trust recognises that some patients may indicate, as part of their advance statements, that they would choose seclusion over restraint as a way of managing their behaviour. In such circumstances, it must be explained to the patient that the Trust is obliged to attempt de-escalation in the first instance, that seclusion is a measure of last resort to be used only for managing behaviour that may harm others, and that its use cannot be included in a care plan.

3.5 Advance Care Planning/ Positive Behavioural Support Planning:

All patients who may be at risk of engaging in severe behavioural disturbance likely to cause harm to others should have a Care Plan (some services use the term Positive Behaviour Support Plan). Input should be sought from the patient in developing this plan, and where appropriate, from family members and carers. This plan should be clearly entitled and should describe the interventions that effectively manage incidents of severe behavioural disturbance for that patient.

Where it has been agreed in a Care Plan/ Positive Behaviour Support Plan with the patient that family member's carers or Independent Mental Health Advocates (IMHA) will be notified of significant behavioural disturbances and the use of restrictive interventions, this should be done as agreed in the plan. For patients under the age of 16 years, persons with parental responsibility (parents, family members or local authority children's services for looked after children) must be informed each time seclusion is employed. For patients between the age of 16 and 18 years, information may be shared with those with parental responsibility with the patient's consent.

A well-drafted Care Plan/Positive Behaviour Support Plan that is focused on understanding the patient's behaviour in the context of their needs may help to minimise the use of seclusion.

3.6 Additional Considerations for Children and Young People

Restrictive interventions such as seclusion and long term segregation should only be applied to children and young people after taking into account their physical, emotional and psychological maturity.

Staff must be mindful that seclusion or long term segregation, whilst traumatic for any individual may have particularly adverse implications for the emotional development of children and young people and should take this into account before making a decision to seclusion or long term segregation.

A child and adolescent trained clinician should make a careful assessment of the potential effects of seclusion, especially if the child or young person has a history of trauma or abuse. Seclusion or long term segregation should only be used when other strategies to de-escalate behaviours and manage risks have been exhausted.

Seclusion should only be used in hospitals and for children and young people who are detained under the Act.

4. Who else needs to be informed when initiating seclusion?

Family members, carers or Independent Mental Health Advocates (IMHA) should be informed, as agreed in the Advance Care Plan/Positive Behaviour Support Plan. For young people under 18 years (See above section).

5. Seclusion Environment:

Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purpose of seclusion and which serves no other function on the ward (MHA CoP, para 26.105).

The seclusion room or suite should (MHA CoP, para 26.109):

- Allow for communication for the patient when the patient is in the room and the door is locked, e.g. via an intercom
- Include limited furnishings which should include a bed, pillow, mattress and blanket or covering
- Have no safety hazards
- Have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)
- Have externally controlled lighting, including a main light and subdued lighting for night time.
- Have robust door(s) which open outwards
- Have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature.
- Have no blind spots, and alternate viewing panels should be available when required.
- Have a clock that is always visible to the patient from the room.
- Have access to toilet and washing facilities.

Resuscitation equipment is available within the observation area of the seclusion suite including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, intravenous fluids, and suction and first-line resuscitation medications.

Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serve no other function on the ward, (MHA Code of Practice 2015, chapter 26.105)

Within the Trust the only recognised seclusion room is within PICU at Harplands Hospital. Other services within the Trust may have to consider the transfer of a patient to this ward if assessment indicates that there may be a requirement to utilise seclusion.

Any intervention that meets the definition of seclusion, including such interventions that occur outside of designated seclusion rooms, must be treated as seclusion and the safeguards implemented (see section 3.2)

Staff must be mindful of the risks in attempting to move a service user from one area of the ward to another when they are resistive to this and in a high level of arousal/distress. In most cases best practice would suggest that wherever possible it would be preferable to initially manage the incident where it occurs at least until the service user becomes more agreeable to being moved. This may require staff to ask other service users to leave the area in order to maintain privacy/dignity.

Staff initiating seclusion need to consider whether the seclusion room will be locked or if the person will be supported by staff members. Regardless of this, the person being secluded should always be under continuous observation. In some cases, where physical interventions (MAPA® techniques) are necessary, a minimum of three staff will be required

6. Temporary Unavailability of Seclusion Suite or Emergency use of a non-designated seclusion area:

There may be occasions when the seclusion room is not available. The use of a non-approved room to confine a service user should only occur as an emergency measure, be reasonable and proportionate to the harm it is intended to prevent, be for the minimum time necessary. The full safeguards of this policy apply and must be implemented for such incidents of seclusion AND, both the Director for Nursing, AHP and Quality and the Mental Health Act Manager should be informed.

The environmental risks posed when using non-approved seclusion rooms must be noted and actions taken to safeguard both patients and staff. The use of enhanced observation levels (minimum level 3) and increased staffing levels must be part of the measures used to maintain safety of all concerned.

All reasonable efforts must be made to transfer the service user to a safer environment at the earliest opportunity and prompt referral to a PICU (Psychiatric Intensive Care

Unit) should be sought. The principles of seclusion regarding nursing and medical reviews must be applied. This ensures the provision of regular external clinical review of the intervention thereby providing greater safeguards for both patients and staff.

In such emergency situations, staff must understand that the use of a bedroom or non-recognised environment for seclusion, departs from the guidance in the MHA Code and as such the reasons and rational must be clearly recorded in the service users clinical notes.

Staff should clearly indicate in the seclusion documentation where the seclusion took place and the reasons why the seclusion room was not available. All actions must be documented within the patient's electronic record on Lorenzo.

The Seclusion Care Pathway Procedure:

7. Who can authorise seclusion?
Seclusion may be authorised only by the following:

- A psychiatrist
- An approved clinician who is not a doctor
- The professional in charge of a ward (e.g. lead nurse)

All attempts must be made to manage the patient's severe behavioural disturbance by other means. Seclusion should be used only when all other means have been exhausted

The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion.

7.1 Who needs to be informed?

When the decision to initiate seclusion is made by the professional in charge, by a psychiatrist who is neither the patient's Responsible Clinician nor an approved clinician, or by an approved clinician who is not a doctor, he/she should immediately inform the following personnel that the patient has been secluded:

a) The patient's Responsible Clinician or if unavailable, the duty doctor (this can be the trainee psychiatrist on-call)

AND

b) The Quality Lead Nurse Matron, in hours and Site manager out of hours.

Communicating with the personnel listed above should be within 30 minutes of the initiation of seclusion or as soon as is practicable.

If seclusion is authorised by a psychiatrist, the first medical review will be the one they undertook immediately before authorising seclusion.

8. Initiation of Seclusion:

In the event that all other least restrictive options have been exhausted and there are increasing concerns regarding the safety of the patient and / or others; it is permissible for the professional in charge or the patients Responsible Clinician to make a decision to utilise seclusion.

Staff must complete an incident form (Ulysses) and initiate the seclusion monitoring form (NB, the seclusion monitoring form will be a paper version which needs to be scanned and uploaded into Lorenzo (patient clinical notes section) until it is available as a form in the EPR, from October 2019). The seclusion monitoring form is Appendix 5 of this policy.

8.1 Responsibilities of Professional in Charge:

In addition to completing the incident and seclusion monitoring form's the professional in charge of initiating the seclusion should:

- Complete the Seclusion Monitoring form (this will remain paper based and available in the seclusion suite)

- Draw up an observation roster so that a member of staff trained to carry out such observations is observing the patient in seclusion at all times and inform staff of the existence of such roster

- Inform the care team of the seclusion and delegate responsibility for other patients to members of the care staff

- At each review point (see section 8), assess and decide whether it is appropriate to end seclusion.

- Complete a seclusion care plan on the EPR if seclusion continues beyond the first medical review

- Ensure that the patient's vital signs are identified and recorded accurately in accordance with NICE guidance on monitoring vital signs is given with regards manual restraint, rapid tranquilisation, and delirium and head injury (see Document list above).

- Make a brief entry in the progress notes section of the EPR during each shift to indicate that the patient remains in seclusion.

- Ensure that resuscitation equipment is available within the observation area of the seclusion suite and that this is checked on a daily basis.

9. Searching the patient prior to seclusion:

A member of the care team shall carry out a visual search of the patient to reduce availability of objects that could be used as a weapon, i.e. shoes, belts, lighters/matches, keys.

If staff members feel that a physical search is required, the policy on search of patients and their property must be adhered to and their rights incorporated. Reference should be made to the Trust's Policy for Searching Patients and their Property – R08.

10. Privacy and Dignity of the person using seclusion:

Staff may decide what the patient may take into the seclusion room or suite based on their clinical risk assessment, but patients should wear their personal clothing and retain other personal items such as those of cultural or religious significance, if this does not compromise the safety of the patient or other people.

It may be necessary to remove articles of clothing from the patient, if those clothes are deemed a risk to his/her safety. Should this occur, the privacy and dignity of the patient will be respected while alternative, 'anti-rip' clothing is provided. Sanitary products are available within the seclusion suite.

The seclusion suite is equipped with live feed non-recordable CCTV. The images are relayed to a monitor that is placed outside the seclusion room to provide better observation by increasing the field of vision. The CCTV enables staff to observe the person in seclusion throughout the whole seclusion suite including toilet/shower area, when risk assessed and identified as being appropriate to do so.

When the person first enters seclusion the CCTV is to be switched off in the toilet/shower area. The CCTV must only be used in the toilet/shower area if it is clinically indicated as being in the best interest of the service user. The decision to use CCTV in the toilet/shower area must be informed by an appropriate risk assessment, reflected in the person's seclusion care plan and recorded in the clinical record. There must be clear statements explaining the reason why observations in the toilet/shower area would be via the CCTV monitor, duration and patient presentation / risk factors deeming this appropriate.

The privacy and dignity of the individual must be taken into account and balanced against the potential risk factors when making a decision, about whether the CCTV needs to be turned on within the toilet and shower areas of the suite.

At all subsequent monitoring reviews (by Professionals, MDT and Medical staff), a review of the patients privacy and dignity must be included to establish; where a decision has been made to turn the CCTV on, if the CCTV can safely be switched off in order preserve the individuals privacy and dignity. Each decision must be documented on the patients seclusion record and added to the seclusion care plan where considered necessary and should highlight the rationale and risks identified to either keep the CCTV on or turn it off.

11. Care of the patient in seclusion:

11.1 Who should be observing the person in seclusion?

A suitably trained member of staff who has received an induction regarding the seclusion processes and procedures, should as a minimum be readily available within the seclusion suite at all times throughout the period of seclusion. A registered practitioner should be readily available and contactable at all times throughout the period of seclusion.

Staff should only carry out constant observation for periods not exceeding 2 hours before handing over to another staff member except in exceptional circumstances. Records must be contemporaneous.

The observing practitioner must have access to a personal alarm and they must retain the keys to the seclusion door.

Consideration should be given to gender of the person undertaking observations; this may be informed by the consideration of a patient's trauma history, religious or cultural beliefs.

11.2 Clinical observation:

The aim of clinical observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end.

The patient's behaviour, mental state and physical condition should be constantly observed using Level 3 Observation – by staff who have been inducted into the use of the seclusion suite and the practice of undertaking observations throughout the period of seclusion.

11.3 How often should observations be recorded?

Staff must complete the Seclusion Observation Record Sheet (appendix 6) every 15 minutes (MHA CoP para 26.123).

This will remain paper-based and will need to be scanned into Lorenzo (patient clinical notes section) at the end of every 24hr period.

As a minimum, a record should be made of the patient's appearance, what they are doing and saying, their mood, their level of awareness and any evidence of physical ill-health especially with regard to their breathing, pallor or cyanosis.

Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

11.4 Observation following rapid tranquilisation:

For patients who have received sedation, a trained professional will need to be outside the door at all times (MHA CoP, para 26.122). They must observe respiratory rate, bodily movements etc. The rapid tranquilisation Policy must be followed and observations recorded on a NEWS 2/PEWS tool (if appropriate and safe to do so).

If it is unsafe to approach the service user to obtain physical observations using, the Non-Contact Physical Health observations form (within NEWS 2/PEWS) can be utilised.

The length of time for this additional observation should be care planned in discussion with the staff taking into account the rapid tranquilisation pathway.

12. Seclusion Care Plan:

Staff should complete the form "Seclusion – Care Plan" on the EPR.

What should be in a seclusion care plan?

A seclusion care plan should set out how the individual needs of the patient will be met whilst in seclusion and record the steps that should be taken to terminate seclusion as soon as possible. It will include the following:

- A statement of clinical needs, including physical and mental health problems.
- A plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed.
- Details of bedding and clothing to be provided.
- Details of how the patient's dietary needs will be met.

- Details of any family or carer contact/communication as per agreement in the Advanced Care Plan / Positive Behaviour Support Plan, this should include any gender specific requirements, and should consider the principles of trauma informed care.

- Details of any activities that should be made available to the patient whilst in seclusion. This should include such things as reading materials, entertainment facilities, rehabilitation input, spiritual support, access to physical exercise and specify the conditions under which these are to be facilitated.

- Details of the support that will be provided to the patient when seclusion ends.

The patient should be encouraged to contribute to the seclusion care plan and steps should be taken to ensure that the patient is aware of what they need to do for seclusion to end.

13. Reviews during Seclusion:

The need to continue seclusion should be reviewed in accordance with the procedure laid out in the Code of Practice (MHA CoP, para 26.112). The following principles apply:

• If not authorised by a psychiatrist, there must be a medical review within one hour or without delay if the patient is not known or there is a significant change from their usual presentation.
• Seclusion area to be within constant sight and sound of staff member
• Documented review by person monitoring at least every 15 minutes
• Nursing reviews by two nurses every two hours throughout seclusion
• Continuing medical reviews every four hours until first (internal) MDT
• First (internal) MDT as soon as is practicable
• Independent MDT after 8 hours consecutive or 12 hours intermittent seclusion (within a 48 hour period)
• Following first (internal) MDT, continuing medical reviews at least twice daily (One by Responsible Clinician)
• Following the Independent MDT, continuing (internal) MDT review at least once Daily
• **NB** – Family /Carers should be informed of the outcomes of each review.

13.1 Who should undertake the medical review?

If seclusion is authorised by a Consultant Psychiatrist, then the Consultant Psychiatrist will have seen the patient immediately prior to authorising seclusion. Their assessment may be the first medical review for the purpose of this policy.

If seclusion is authorised by an Approved Clinician who is not a doctor, or the professional in charge of the ward, or a Psychiatrist who is not a Consultant, the first medical review should be undertaken by the patient's Responsible Clinician or the duty doctor (out of hours) within an hour of the commencement of seclusion.

Overnight and on weekends, when the patient's own Responsible Clinician may not be available, the duty doctor must have access to an on-call doctor who is an approved clinician.

13.2. What needs to be included in the first medical review?

NB – any records recorded onto a paper document must be uploaded into the EPR within 24hrs of completion.

The doctor who completes the first medical review must:

- Undertake a medical assessment of the patient's mental and physical state.
- Record any obvious injuries
- Enter the assessment and action plan into the patient's electronic patient record on the seclusion monitoring form.
- Review and complete the Seclusion monitoring form on the EPR (or paper until EPR is updated in October 2019).
- If it is agreed that seclusion should continue, a seclusion care plan should be agreed and prepared by the professional in charge and completed on the EPR.

At each review, if it is agreed that seclusion will continue appropriate amendments should be made to the seclusion care plan.

All subsequent medical reviews should be undertaken by the Responsible Clinician, a doctor who is an approved clinician, or the duty doctor.

13.3 What further reviews are required?

At each review staff should complete the form Seclusion monitoring form on the EPR (Or paper until the EPR is updated) choosing the appropriate review type on the form.

All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient's mental and physical state. Where agreed family members should be advised of the outcomes of reviews.

Patients and their families should be as fully involved as possible in developing and reviewing positive behaviour support plans (or equivalent). Patients eligible for support from an IMHA should be reminded that an IMHA can support them in presenting their views and discussing their positive behaviour support plan. The preparation of positive behaviour support plans also provides an important opportunity to record the wishes and preferences of families and carers and the involvement they may wish to have in the management of behavioural disturbances. Patients must consent to the involvement of families or IMHA's if they have capacity to give or refuse such consent.

13.4 Nursing reviews

Two Registered Nurses should review the patient every two hours from the commencement of seclusion. At least one of these two Registered Nurses should not have been involved directly in the decision to seclude.

Nursing observations should be documented every 15 minutes by a trained professional who is within the seclusion suite at all times (completed on the paper seclusion observation sheet – Appendix 6).

At any time staff should raise any concerns about the patient's condition with the Responsible Clinician or duty doctor.

The nurse in charge can end seclusion at any time if their assessment supports this. Unless the MDT have already determined the time that seclusion should end or be reviewed to end.

13.5 Medical Reviews

Medical reviews must take place every four hours until the first (internal) MDT review has taken place, including in the evenings, night-time, on weekends and on bank holidays. See section 13.9 for when the patient in seclusion is asleep. This will be the duty Doctor in consultation with the on-call approved clinician where necessary.

Medical reviews will include the following:

- A review of the patient's physical and psychiatric health
- An assessment of the adverse effects of medication
- A review of the observations required (the minimum prescribed in this policy must be adhered to)
- A re-assessment of medication prescribed
- An assessment of the risk posed by the patient to others
- An assessment of any risk to the patient from deliberate or accidental self-harm
- As assessment of the need to continue seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner

13.6 MDT Reviews

First (Internal) MDT Review: This should be held as soon as is practicable. Membership should include:

- the Responsible Clinician/a doctor who is an approved clinician or an approved clinician who is not a doctor but has appropriate expertise;
- a senior nurse on the ward (band 6 or above);
- staff from other disciplines who would normally be involved in patient reviews

13.7. Further reviews required:

Medical review - After the First (internal) MDT, further medical reviews will take place at least twice daily in every 24 hour period. At least one will be carried out by the patient's Responsible Clinician, or an alternative approved clinician or duty doctor out of hours.

One of the two medical reviews should be an MDT review, involving staff from other disciplines who would normally be involved in patient reviews, in addition to a doctor and a nurse.

13.8. Independent MDT reviews

This should be held when a patient has been secluded for eight hours consecutively or for 12 hours intermittently in a 48 hour period. Minimum membership will include:

- a doctor who is an approved clinician or an approved clinician who is not a doctor;
- a nurse;
- Other professionals not involved in the incident which led to seclusion and an Independent Mental Health Advocate (IMHA) if possible.

The CoP does not specify the membership of the Independent MDT Review at weekends and overnight. The Trust therefore requires the review to be carried out by the Duty Doctor in consultation with the on-call Approved Clinician, a nurse as well as a senior nurse (band 6 or above) all of whom were not in the incident which led to seclusion.

If it is agreed by the Independent MDT review that seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan.

13.9. What happens if a review is required and the patient is asleep?

When the patient in seclusion is asleep, the Code of Practice (MHA CoP 26.136) allows Trusts to make different review arrangements in order to avoid waking the patient. Therefore, between 2300 hours and 0700 hours, medical and nursing reviews, First (internal) MDT review and Independent MDT reviews may be suspended if the patient is asleep.

In these circumstances, it must be documented that the patient was asleep and the review deferred until the patient is awake or 07:00hrs; whichever is sooner.

At other times, if the patient is asleep, attempts should be made by professionals to wake the patient up, if appropriate.

13.10. MDT reviews required at weekends

At weekends and overnight, membership of the MDT reviews is likely to be limited to medical and nursing staff, therefore the Site Manager should be involved and an on-call Approved Clinician.

13.11. Resolving disputes about ongoing seclusion

If any member of the multi-disciplinary team attending any review disputes the continued need for seclusion, the matter must be referred to either the Quality Lead Nurse / Modern Matron or out of hours; the Site Manager. Furthermore, the opinion of another approved clinician should be sought. For out of hours, as well as referring the matter to the on call manager, an opinion should be sought from the on-call consultant, and the on-call local manager advised of the outcome of the review.

14. Ending Seclusion:

Seclusion should immediately end when an MDT review, a medical review or the independent MDT review determined that it is no longer warranted. Alternatively, when the professional in charge of the ward considers that seclusion is no longer warranted, it may be terminated following consultation with the patient's Responsible Clinician or the duty doctor, either in person or the telephone (MHA CoP, para 26.144).

The Trust requires the nurse-in-charge to regularly assess and decide, in consultation with the senior individual on duty (i.e. Ward Manager, Quality Lead Nurse / Modern Matron, or the Site Manager; out of hours) whether it is appropriate to end seclusion.

Seclusion ends when the patient is allowed free and unrestricted access to the normal ward environment or transfers or returns to conditions of long-term segregation (MHA CoP, para 26.145)

Opening a door for toilet or food breaks or medical reviews do not, in themselves, constitute the end of seclusion.

The MHA Code of Practice recommends that in order to minimise the impact on a patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible. Where seclusion is used for prolonged periods, subject to suitable risk assessments, flexibility may include allowing the patient to receive visitors, facilitating brief periods of access to secure outdoor areas or allowing meals to be taken in general areas of the ward. Such flexibility should be considered during any review, and it may provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction, without termination the seclusion episode (MHA CoP, para 26.111).

Staff should complete the Seclusion monitoring form to clearly indicate when and how the seclusion period was discontinued.

15. Re – integration to the ward & debriefing:

Following a period of seclusion the clinical rational should be explored with the patient, and they should be supported in the process of re-integration to normal ward activities. Nursing time should be set aside to facilitate this process.

Debrief discussions will include the following:

- Does the patient understand why they were secluded?
- How does the patient feel about the necessity, reasonableness and appropriateness of the use of seclusion?
- How does the patient feel now, after the event?
- How can the need for any further episodes of seclusion be avoided in the future?

15.1. Ongoing care planning:

The above discussion will feed into a review of the patient's ongoing Care Plan or Positive Behaviour Support Plan.

15.2. Debrief:

Post-incident debrief should be available to both staff and patients. Staff should be aware of Trust facilities for debriefing and should access this as required.

16. Reporting & Monitoring:

In addition to Incident 'Ulysses' reporting, the following people must be informed at commencement of seclusion:

- Quality Lead Nurse/ Modern Matron
- Associate Director for the Service or nominated manager.

17. Seclusion reviews at times of major disruption:

In the rare event of major disruptions (such as severe adverse weather or transport disruptions) which prevent access to or from inpatient sites over many hours, it may not be possible for doctors to attend in order to carry out seclusion reviews in person, as prescribed by this policy.

If no doctor is available, the senior nursing team (i.e. Ward Manager, Quality Lead Nurse / Modern Matron, Nurse Practitioners) in the inpatient ward should make telephone contact with the required doctor, discuss the patient's presentation, make a decision about whether seclusion is to continue, and record this in the appropriate review form in the EPR.

If seclusion continues, the patient should be reviewed by a doctor as soon as one is next available.

This is to be done only in the event of major disruptions which prevent physical access to the inpatient units. It is otherwise the expectation that all reviews will be completed as prescribed in this policy.

18. Seclusion MUST not be used in the following circumstances:

- As a punishment or a threat.
- As part of a treatment programme.
- As a means of managing staffing shortfalls

Long Term Segregation Care Pathway Procedure:

19. Longer Term Segregation (LTS):

19.1. CODE OF PRACTICE DEFINITION OF LONG-TERM SEGREGATION & GENERAL

Principles:

The Mental Health Act Code of Practice (CoP) 2015 defines Long-term segregation as follows. “Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determine that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment.

The clinical judgement is that: If the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of harm over a prolonged period of time.” (MHA CoP, para 26.150)

The Code of Practice further states that “…it is permissible to manage this small number of patients by ensuring that their contact with the general ward population is limited…” (MHA CoP, para 26.151).

There are exceptional circumstances where Long Term Segregation for an individual is in their best interest, despite it not directly being associated with a risk of violence or aggression (i.e. due to an individual’s sensory needs and associated distress/ risk when in the general ward environment). This policy will therefore apply to ALL individuals who are segregated from the general ward environment.

20. When should LTS be considered?

LTS may only be considered when:

- All other forms of treatment and management have been considered as ineffective/ inappropriate (e.g. Positive Behavioural plans including those to tackle incidents of violence and aggression, rapid tranquilisation and seclusion).
- It is in the best interests of the patient
- It is proportionate to the likelihood and seriousness of the harm threatened.
- There is no less restrictive alternative
- A patient may be felt to require LTS after a period in seclusion, when attempts to end seclusion have failed repeatedly due to ongoing high risk of harm towards others. In such cases, a decision should be made by the patient's Responsible Clinician about whether the use of LTS may be more appropriate than long periods in seclusion.

LTS may only be considered for patients detained under the MHA 1983.

20.1 Who needs to be involved in decisions relating to LTS?

Discussion must take place with the patient and their relatives or carers or advocate. The Code of Practice states that "…when consideration is being given to long-term segregation, wherever appropriate, the views of the person's family and carers should be elicited and taken into account…" (MHA CoP, para 26.150).

21. Long –Term Segregation environment:

The CoP states "…the environment should be no more restrictive than necessary. This means that it should be as homely and personalised as risk considerations allow…" (MHA CoP, para 26.151)

The minimum facilities required are:

- Bathroom facilities
- A bedroom
- Relaxing lounge area
- Access to secure outdoor areas
- Range of activities of interest and relevance to the patient

22. Initiating Long -Term Segregation:

It is anticipated that there would only be a very small number of Trust inpatients who would require Long-Term Segregation whereby their contact with the general ward

population is strictly limited.

At the Harplands clinicians should consider the transfer of an individual to the Psychiatric Intensive Care Unit (PICU), specific guidance for this service (Psychiatric Intensive Care Unit-Operational Framework) is available at the Harplands.

The decision to initiate Long- Term Segregation must be made by the MDT; it is then the responsibility of the patient's Responsible Clinician to complete the initial "Long-term Segregation monitoring form" (on paper until it is available as a form in the EPR from October 2019).

Additionally; The CoP requires a representative from the responsible commissioning authority to be involved in the decision to initiate LTS (MHA CoP, para 26.150).

22.1 Clinical Incident Form:

Where a decision to utilise Long Term Segregation has been made an incident report must be completed by the nurse in charge. This will include:

- The time date and time Long Term Segregation commenced and the name and designation of the person making the decision.
- The full reasons for the commencement of LTS.
- The time LTS ended and the rationale for this decision.

The use of LTS should be regarded as an "extra-ordinary event". It should therefore trigger a retrospective investigation report by the Quality Lead Nurse / Modern Matron.

22.2. Who else must be consulted when initiating LTS?

A decision to place a patient in LTS may only be made by the patient's Responsible Clinician and the multi-disciplinary team. Others who must be consulted:

- The views of the patient and his/her family/carers should be sought and taken into account.

- If it is felt that the patient may lack capacity to understand the rationale for LTS, a capacity assessment must be carried out. If the patient does lack capacity, all decisions made in his/her best interests should be documented.

- The patient's Independent Mental Health Advocate (IMHA) should be consulted. A representative from the responsible commissioning authority should be consulted.

- The local safeguarding team should be informed.

23. Care of the Person in Long-Term Segregation:

The CoP states that "…patients should not be isolated from contact with staff or deprived of access to therapeutic interventions…" and "…it is highly likely they should be supported through enhanced observations…" (MHA CoP, para 26.152).

Services must make an assessment of the appropriate enhanced observations required for supporting the patient and for the safe management of the patient's sustained risk of harm to others. This will generally be a minimum of 2:1.

Staff supporting the patient in LTS should make written records of the patient's condition at least every hour.

It may become necessary for a patient to be placed in seclusion while they are in LTS, if there is acute behavioural disturbance where there is a need to contain an immediate risk of harm to others. At such times, the procedure for seclusion as laid out in this policy should be followed. When seclusion is terminated, the patient will return to LTS.

24. Long-Term Segregation Care Plan:

Staff must complete a LTS Care Plan on the EPR.

24.1 What should be in the Care Plan?

Every patient in LTS must have a specific LTS treatment plan. This should be prepared with input from the patient, where possible.

The aim of the treatment plan should be to end LTS (MHA CoP, para 26.152)

The LTS treatment plan should clearly state why LTS is necessary and should be supported by a comprehensive risk assessment and therapeutic plan.

The LTS treatment plan must detail the steps and therapeutic goals to be achieved in order for LTS to be terminated.

24.2 Who should we share the LTS care plan with?

The patient should have access to a copy of the LTS treatment plan, where possible. If this is not appropriate or possible, the patient must be informed of the steps and therapeutic goals they should achieve in order for LTS to be terminated.

Patients in LTS, and their relatives/carers should be given information by the Ward Manger or Responsible Clinician regarding:

- the visiting arrangements based on risk assessment;
- Emergency procedures e.g. Panic alarms, staff response etc.

The information given to the patient must meet the individual's communication needs, for example people with additional needs such as physical, sensory or learning disabilities, and people who do not speak or read English.

25. Reviews during Long-Term Segregation:

Every formal review should attempt to determine if the risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their health and welfare.

Less restrictive means of managing the patient's risks towards others must be considered at every stage.

25.1 LTS will be reviewed as follows:

Overview of LTS and Monitoring Process:

- Written record every hour by person supporting the patient in LTS.
- Daily review by an approved clinician, (who need not be a doctor)
- At least weekly review by the full MDT (including patient's Responsible Clinician or deputy, ward manager or deputy, and IMHA)
- Weekly review by a consultant psychiatrist not involved with the patient
- If LTS continues beyond 3 months, review by an external hospital, and discussion with IMHA and commissioner

25.2. Hourly Observation

Staff supporting the patient in LTS should make a record of the patient's mental state, communication, behaviour and risks to self and to others on at least an hourly basis.

Staff must complete Long-term Segregation observation record**.** This will remain a paper document and must be scanned into Lorenzo (patient clinical notes section) every 24hr period (Appendix 7).

25.3. Daily Reviews

There must be a daily review by an approved clinician, who need not be a doctor. This should be recorded in the electronic progress notes.

The approved clinician must complete Long- Term Segregation observation form to

indicate that the review has taken place and document the findings in the Clinical note section on the EPR, choosing the appropriate review title.

On weekends, the review may be conducted by telephone with nursing staff contacting the on-call consultant. Nursing staff will then complete the "Long term Segregation observation form" and document the findings in the Clinical note section on the EPR, choosing the appropriate review title.

25.4. Weekly Reviews:

The weekly review by the MDT should be carried out by the patient's Responsible Clinician or deputy, the ward manager or deputy, other members of the MDT who would normally be involved in the patient's care and the patient's IMHA.

Consideration should be given to whether less restrictive alternatives of managing the patient's risk to others are appropriate, and to provision of a full therapeutic programme, including, where appropriate, access to visitors. These considerations must be documented as part of the MDT review within Lorenzo.

Staff must complete the "Long-Term Segregation observation record sheet (Appendix 7) to indicate that the review has taken place and document the findings in the Clinical Note section on the EPR, choosing the appropriate review title.

Where successive MDT reviews determine that LTS continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner (MHA CoP, para 26.159)

The Code also requires periodic review of LTS by a senior professional not involved with the case (para 26.155). To meet this requirement, a weekly review of the patient and the treatment plan must be undertaken by a consultant psychiatrist who is not otherwise involved in that patient's care. The psychiatrist should complete the 'Long-Term Segregation observation' form to indicate that the review has taken place and document the findings in the Clinical note section on the EPR, choosing the appropriate review title.

25.5. Review of Extended Long-term segregation

If LTS continues beyond three months, a comprehensive review must be undertaken by an external organisation. The clinicians involved in this review must discuss the care of the patient with the patient's family, IMHA and the responsible commissioners. A written report should be provided to the detaining authority (e.g. Mental Health Law

Team or Ministry of Justice).

This review must be repeated every 3 months as long as LTS continues. This must be documented in 'Long- Term Segregation observation' form to indicate that the review has taken place and document the findings in the Clinical note section on the EPR, choosing the appropriate review title.

26. Termination of Long-Term Segregation:

LTS must be terminated when it is determined that the patient's risks have reduced sufficiently to allow them to be re-integrated into the ward.

The decision to terminate LTS should be taken by the MDT, following a thorough risk assessment and taking into account observations from staff of the patient's presentation during close monitoring of the patient's presentation in the company of others.

The MDT should consist of, as a minimum, the patient's Responsible Clinician and the Ward Manager. The patient's IMHA should also be consulted.

The RC and Ward Manager should complete the form "Long-term Segregation – observation form" and document the findings in the Clinical note section on the EPR, choosing the appropriate review title on the EPR.

27. Re-integration to the ward and Debrief:

The patient's LTS Care Plan and MDT review documentation should include a detailed account of all the steps to end LTS. The care plan should detail how the patient will be re-integrated back into the wider ward. It is expected that this will take place over a period of time, allowing the patient to gradually re-acclimatise to being in the company of other patients and staff.

Following the termination of LTS and complete re-integration into the ward, the patient should have a de-briefing session to explore their experience of LTS, their understanding of the rationale for it, and their current risks towards others.

28. Reporting and Monitoring:

In addition to Incident 'Ulysses' reporting, the following people must be informed at commencement of LTS, weekly reviews, and at termination:

- Associate Director of Directorate
- Deputy Director of Nursing, AHP & Quality

- Safeguarding Team
- Mental Health Law Manager

29. Trust Wide Monitoring of Seclusion and Longer Term Segregation:

The relevant directorate Clinical Director must monitor the use of seclusion within their services. The use of the Incident Reporting system and subsequent Investigation Report will allow for the monitoring of seclusion within clinical services and generate reports to provide assurance to the Senior Leadership Team meeting.

The Reducing Restrictive Practice Lead will produce quarterly figures on the use of seclusion within services and these will be presented to the Quality Committee on a quarterly basis.

30. Evaluation and Audit

The Trust will annually consider evaluation and audit of seclusion and long-term segregation as part of the Trusts annual audit cycle.

31. Supporting references:

Department of Health (2005): The Mental Capacity Act. Deprivation of Liberty Safeguards and the use of Restrictive Interventions.

Department of Health (2015): The Mental Health Act 1983: Revised Code of Practice.

Lavelle, M., Stewart, D., James, K., Richardson, M., Renwick, L., Brennan, G. & Bowers,
L. 2016, “Predictors of effective de-escalation in acute inpatient psychiatric settings",
Journal of Clinical Nursing, vol. 25, no. 15-16, pp. 2180-2188.

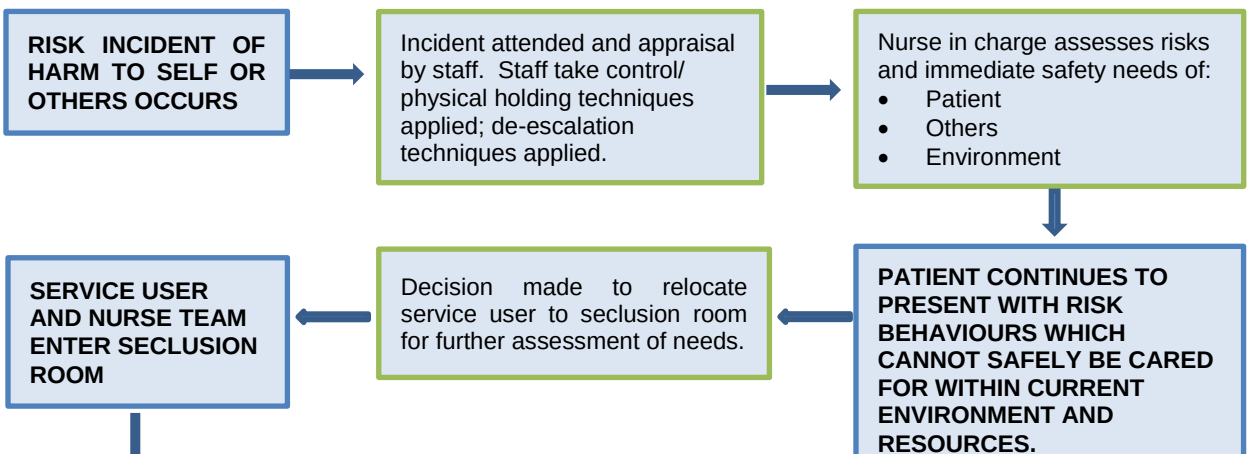
National Institute for Health and Clinical Excellence (NICE, 2005): Clinical Guideline 25; the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments.

National Institute for Health and Care Excellence (2015): Violence and Aggression: short term management in mental health, health and community settings.

Royal College of Nursing (2013): Draft guidance on the minimisation of and alternatives to restrictive practices in health and adult social care, and special schools.

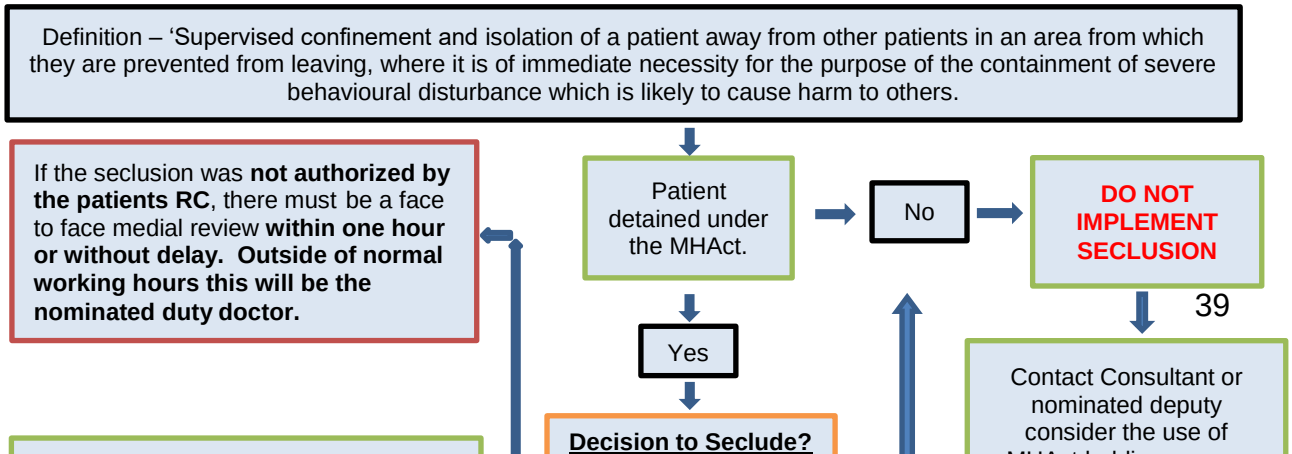
Flowchart – Assessment for Seclusion Process:

Appendix 1



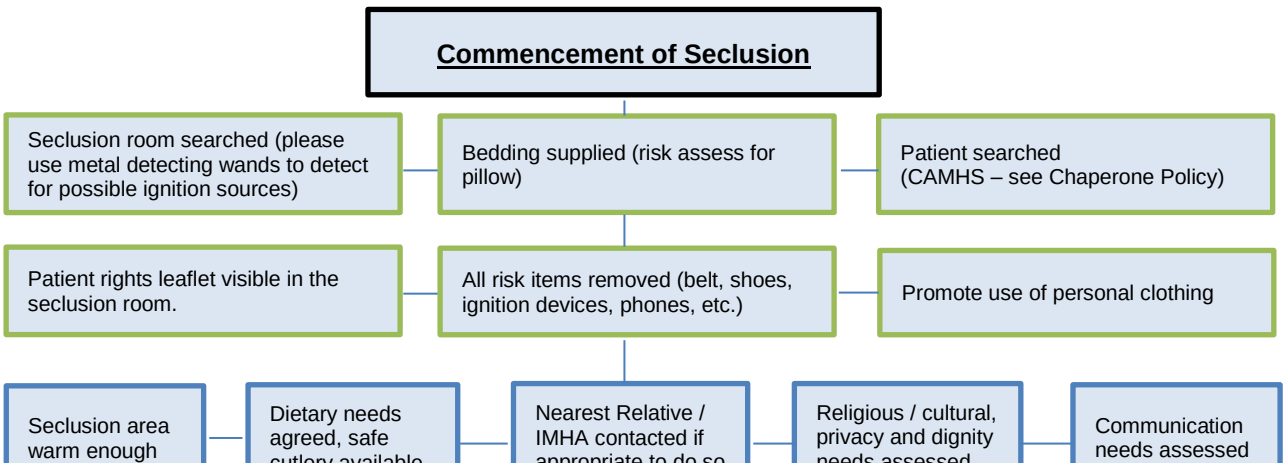
Co-produced between patient and nursing staff

nitiation process-Adults and Young People Appendix 2



Flowchart - Seclusion Procedure

Appendix 3



Risk event or risk behavior observed (self-harm, 'head banging', sexual safety concerns, violence or threats to harm, any other concerns, patient unobservable, physical health concerns noted, patient observed not to be moving).

Co-produced between patient and nursing staff

IMPORTANT POINTS TO NOTE

NURSING

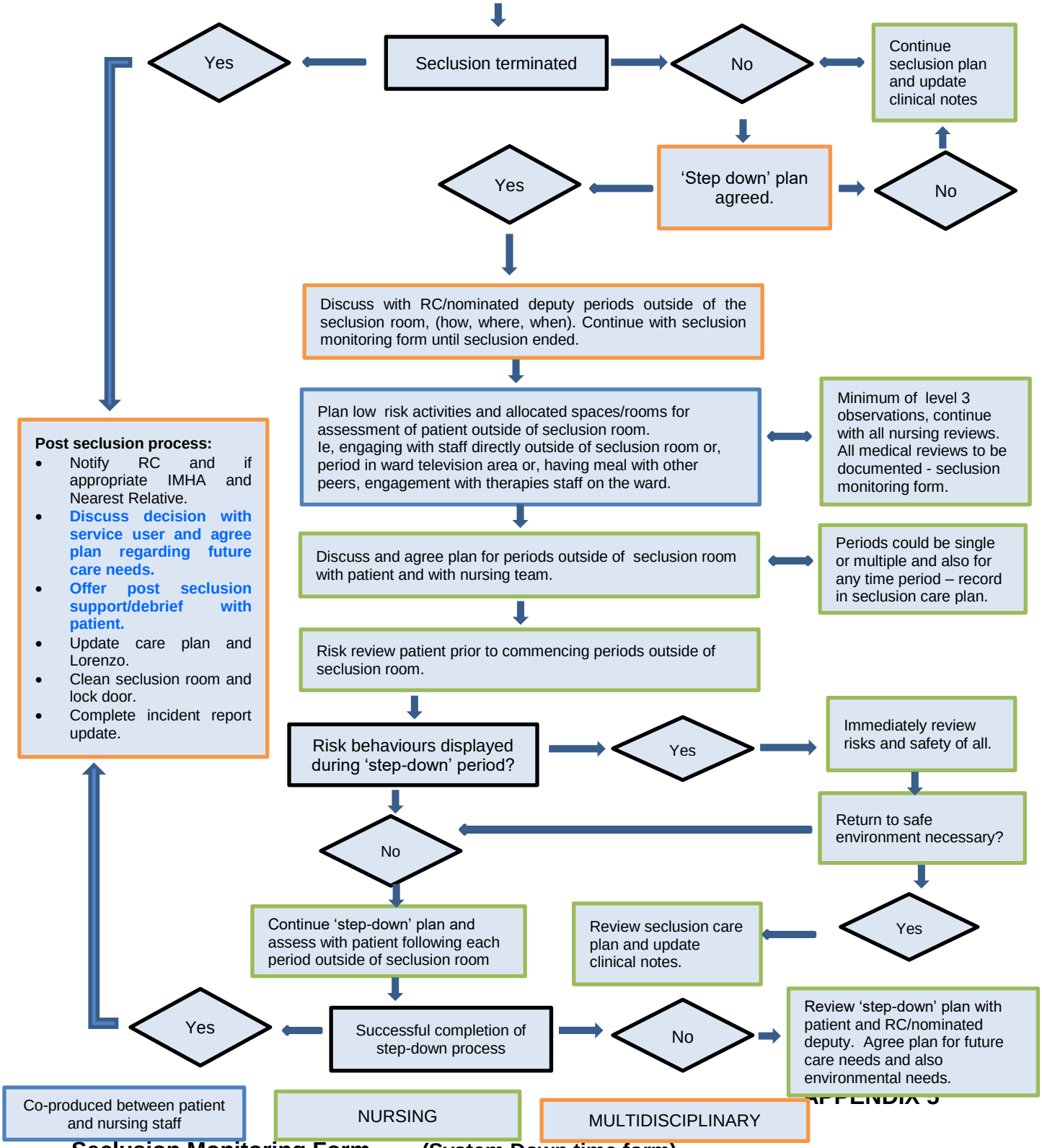
Dis on / rocess Appendix 4

Pathway for discontinuation of Seclusion

Following review of patient care needs, a reduction of risk behavior noted.

⬇

Discuss with RC/nominated deputy possibility of terminating seclusion



Seclusion Monitoring Form (System Down time form)

To be added

SECLUSION OBSERVATION RECORD SHEET – 15 MINUTE CHECK

APPENDIX 6

(The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end)

Level 3 Constant Visual	CCTV / Privacy:		Date:		Time:	
Full Name:		NHS No.				

What items has the patient taken into the seclusion room?

Following to be considered at each 15 minute review

Your assessment - The record made should include: •Diet and Fluids taken: (see chart). • Physical Health presentation • Physical description / ABCDE • the patient's appearance • what they are doing and saying • their mood • their level of awareness • any evidence of physical ill health especially following administration of rapid tranquilisation with regard to their breathing, pallor or cyanosis.

Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:

Two-Hourly Recommendation	Seclusion to continue		Seclusion to end	

Patient's condition - Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

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SECLUSION OBSERVATION RECORD SHEET – 15

MINUTE CHECK

(The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end)

Level 3 Constant Visual	CCTV / Privacy:		Date:		Time:	
Full Name:		NHS No.				

What items has the patient taken into the seclusion room?

Following to be considered at each 15 minute review

Your assessment - The record made should include: •Diet and Fluids taken: (see chart). • Physical Health presentation • Physical description / ABCDE • the patient's appearance • what they are doing and saying • their mood • their level of awareness • any evidence of physical ill health especially following administration of rapid tranquilisation with regard to their breathing, pallor or cyanosis.

Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:

Two-Hourly Recommendation	Seclusion to continue		Seclusion to end	

2

Patient's condition - Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

LONG TERM SEGREGATION (LTS) 1 HOURLY OBSERVATION RECORD SHEET

APPENDIX 7

(The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which LTS and to support subsequent approved clinician and MDT reviews)

Full Name:		NHS No.	
Date:			

The following information is to be considered and recorded as part of the 1 hourly review

Your assessment - The record made should include: •diet and fluids taken • physical health presentation • the patient's appearance • what they are doing and saying • their mood • their level of awareness, engagement with activities • any evidence of physical ill health especially following administration of rapid tranquilisation with regard to their breathing, pallor or cyanosis.

Time:		Observed behaviour:	Time:		Observed behaviour:

Time:		Observed behaviour:	Time:		Observed behaviour:

Time:		Observed behaviour:	Time:		Observed behaviour:

Time:		Observed behaviour:	Time:		Observed behaviour:

Patient's condition - Where a patient appears to be asleep, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

Flowchart - Long Term Segregation
APPENDIX 8

Definition- Long Term Segregation
Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the service user to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a service user should not be allowed to mix freely with other service users on the ward or unit on a long- term basis.

Multi-disciplinary team meeting to discuss service user needs. Discussion regarding need to use LTS to keep the person safe.

Decision to use long term segregation procedure?

No

MDT to agree care plan based on least restrictive intervention necessary and proportionate to the level of risk presented by person.

Inform service user and involve in care plan development

Yes

Inform:
- ✓ Service user and/or advocate or nearest relative
- ✓ Safeguarding team

Complete:
- ✓ Initiation of LTS form
- ✓ Incident form (for initiation of LTS)
- ✓ Observation chart (patient must be on level 3 observations)
- ✓ Long term segregation care plan with service user involvement if possible
- ✓ **Document in service users clinical notes regarding decision to use Long Term Segregation.**

Reviews to be completed:
Every 24 hours: by an approved clinician (Doctor or medical officer/staff)
Weekly: MDT to include person's Responsible Clinician and IMHA/ Advocate
At least every 28 days: Independent review team which should consist of 1 senior clinician (another Consultant Psychiatrist) and two other review team members (from outside the service and who are independent to the case e.g. workforce safety lead, patient safety lead, social worker, Psychologist or QI Lead/modern matron)
3-Monthly: Multi professional team from another trust to be determined by the Director of Nursing and Quality/ or other Executive Director of the Trust. **The review should include discussions with the patients IMHA (where appropriate) and Commissioner.**
THROUGHOUT EACH REVIEW SERVICE USER AND SERVICE USER ADVOCATE/NEAREST RELATIVE TO BE INVOLVED AND INFORMED OF ANY DECISION

Following the end of Long Term Segregation:
Complete an Incident report to report end of Long Term Segregation

Long Term Segregation Monitoring Form (System Down time form)

To be added