Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Use of Force Policy

This should be read in conjunction with the following policies:
Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) – PAT/PA 19
Safeguarding Adults – PAT/PS 8
Safeguarding Children – PAT/PS 10
Aggressive and Violent Behaviour towards Staff – CORP/HSFS 5
Arrangement for the Provision of Care to Individuals who are Violent or Abusive (Age 18 or Over) – PAT/PA 6
De-escalation – Principles and Guidance including restraint – PAT PS v6

Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor(s):	Chief Nurse
Author/reviewer: (this version)	Bethany Cotton, Enhanced Care Matron
Date written/revised:	April 2022
Approved by:	Policy Approval and Compliance Group
Date of approval:	November 2022
Date issued:	March 2023
Next review date:	April 2025
Target audience:	Trust-wide

Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
1	October 2022	New policy – please read in full	Bethany Cotton

Contents

1 INTRODUCTION

This policy is in relation to the Mental Health Units (Use of Force) 2018 Act. While our Trust is not a Mental Health Unit (MHU), in law, when we have patients detained here under the Mental Health Act (1983), our Trust becomes the mental health unit and so the Act is applicable in these circumstances. Throughout this policy, there are references to 'mental health units' and staff should consider our Trust this, when they are caring for patients detained under the MHA (1983).

The Government is clear that the use of force should only ever be proportionately used and as a last resort, when all attempts to de-escalate a situation have been employed.
The Mental Health Units (Use of Force) Act gained Royal Assent in November 2018. Commonly known as Seni's Law, it is named after Olaseni Lewis who died in September 2010 as a result of being forcibly restrained whilst he was a vulnerable voluntary patient in a mental health unit.

The aim of Seni's Law is to clearly set out the measures which are needed to both reduce the inappropriate use of force and ensure accountability and transparency about the use of force in our mental health units. This must be in all parts of the organisation, from Executive Boards to staff directly involved in patient care and treatment.

Every individual has the right to be treated with dignity and in a caring therapeutic environment which is free from abuse. The use of force (which refers to physical, mechanical or chemical restraint, or the isolation of a patient) can sometimes be necessary to secure the safety of patients and staff. The use of force always comes with risk and can be a traumatic and upsetting experience for patients when they are at their most vulnerable and in need of safe and compassionate care. The use of force can also be upsetting for those who witness it, such as other patients or visitors.

Data from the NHS Digital Mental Health Bulletin shows that the use of force is at an all-time high. Whilst there are many reasons for this rise, such as improved recording and reporting and more patients using services, there is still an over-reliance on the use of force. While the reasons behind this may be complex, this data also shines a light on the often, disproportionate use against some groups who share a protected characteristic under the Equality Act 2010 such as people from black and minority ethnic backgrounds, women and girls, and people with autism or a learning disability.

Whilst there is good practice in many of our mental health units, there is still a greater focus on managing behaviour rather than working to prevent situations from escalating to the point at which the use of force is seen to be the only solution. Poor staff communication with patients due to language or cultural barriers, and not understanding the reasons for a patients' behaviour also create an environment where escalation and force is more likely.

2 PURPOSE

The purpose of the Mental Health Units (Use of Force) Act 2018 is to reduce the inappropriate use of force and increase the oversight and management of the use of force in mental health units.

The aim of the Mental Health Units (Use of Force) Act 2018 and the statutory guidance is to clearly set out the measures which are needed to both reduce the use of force and ensure accountability and transparency about the use of force in our mental health units. This must be in all parts of the organisation, from Executive Boards to staff directly involved in patient care and treatment.

It is also widely recognised that there are inconsistencies nationally in the way MHU's record and report data on the use of force, the quality of staff training, and the way in which investigations are carried out when things go wrong. The requirements of the act and the statutory guidance provide a much-needed opportunity to embed a consistent approach across services nationally.

The guidance also promotes and encourages the use of a human rights-based approach to the use of force, working with patients in a trauma-informed, person-centred way, and developing therapeutic environments which ensure that force is used proportionately and only ever as a last resort. The use of force should be rare and exceptional, rather than a common experience for patients and staff.

Through compliance with the act and statutory guidance we must see:-

- An end to the disproportionate use of force on people sharing protected characteristics, particularly race, sex, age, and disability.
- Services which meet the needs of the individual and are preventative in their approach to stop situations reaching crisis point.
- Services which understand the negative impact of the use of force of patients with histories of trauma and abuse.
- Services which involve the individual, their families and carers in the planning and delivery of their care.
- Positive relationships between those receiving care and those providing it.

3 DUTIES AND RESPONSIBILITIES

3.1 Chief Executive / Responsible Person (Executive Staff Member)

Responsible Person: Executive staff member whose role it is to ensure that the Trust complies with the requirements of the act. The responsible person should attend appropriate training in the use of force to ensure they understand the strategies and techniques their staff are being trained in. It is important they are guided by the impact of trauma on their patients and the potentially re-traumatising of the use of force.

3.2 Clinical Site Managers and Duty Matrons

To ensure receipt and forward on for scrutiny, of the necessary paperwork for patients detained under the MHA (1983) and effective communication to ward staff on the need to record all use of force and restraint when it is absolutely necessary to use.

3.3 Ward managers

To ensure their teams are acquainted with this policy and the legal requirements of when patients are detained in their wards. To ensure their staff have completed training as identified in the training needs analysis.

3.4 Clinicians

To care for their patients. To involve the patient, their families and carers (where appropriate) in the care planning and reduction of use of force. To ensure the patient and families carers (where appropriate) are aware of their rights whilst in hospital. To ask for help and support when needed in caring for their patients and balancing the need for use of force in keeping their patients and themselves safe.

4 PROCEDURE

4.1 Requirements of the Mental Health Units (Use of Force) Act 2018

The Mental Health Units (Use of Force) Act 2018 (the act) received Royal Assent (when a bill is made into an act of Parliament) on the 1st November 2018.

The requirements set out in the act are:-

- Section 2 - mental health service providers operating a mental health unit to appoint a 'responsible person' who will be accountable for ensuring the requirements in the act are carried out.
- Section 3 - the responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit. The written policy will set out the steps that the unit is taking to reduce (and minimise) the use of force by staff who work in the unit.
- Section 4 - the responsible person for each mental health unit must publish information for patients about their rights in relation to the use of force by staff who work in that unit.
- Section 5 - the responsible person for each mental health unit must ensure staff receive appropriate training in the use of force. This statutory guidance sets out what that training should cover.

- Section 6 - the responsible person for each mental health unit must keep records of any use of force on a patient by staff who work in that unit, which includes demographic data across the protected characteristics in the Equality Act 2010.
- Section 7 - the Secretary of State for Health and Social Care must ensure that at the end of each year statistics are published regarding the use of force by staff, using the relevant information recorded under section 6.
- Section 8 - the Secretary of State for Health and Social Care must conduct an annual review of any reports made under paragraph 7 of schedule 5 to the Coroners and Justice Act 2009, and may conduct a review of any other findings or determinations made relating to the death of a patient as a result of the use of force in a mental health unit. The Secretary of State for Health and Social Care must then publish a report that includes conclusions arising from the review.
- Section 9 – if a patient dies or suffers serious injury in a mental health unit, the responsible person must have regard to any relevant guidance relating to investigations of deaths or serious injuries.
- Section 10 – explains that the responsible person may delegate their functions where appropriate to do so.
- Section 11 – the Secretary of State for Health and Social Care must publish guidance which sets out in more detail how to implement the requirements of the act.
- Section 12 – if a police officer is going into a mental health unit on duty to assist staff who work in that unit, the police officer must wear and operate a body camera at all times when reasonably practicable.

4.2 What is Restraint and Use of Force?

The Framework for Good Practice on the Prevention and Management of the Use of Restraint (last reviewed December 2011) defines restraint as:

“Anything that prevents someone doing something”

The Mental Capacity Act (2005) describes it in more detail:

“Restraint is being used when a person restricts a person’s freedom of movement, whether they are resisting or not”

The Mental Health Units (Use of Force) Act 2018 introduces the following definitions of use of force.

“Use of force includes physical, mechanical or chemical restraint of a patient, or the isolation of a patient (which includes seclusion and segregation)”.

The act defines the different types of force as:-

- Physical restraint: the use of physical contact which is intended to prevent, restrict or subdue movement of any part of the patient's body. This would include holding a patient to give them a depot injection.

- Mechanical restraint: the use of a device which is intended to prevent, restrict or subdue movement of any part of the patient's body, and is for the primary purpose of behavioural control.
- Chemical restraint: the use of medication which is intended to prevent, restrict or subdue movement of any part of the patient's body. This includes the use of rapid tranquillisation (see NICE guideline (NG10) Violence and aggression: short-term management in mental health, health and community settings)

Types of Restraint

In our Trust, we use the below descriptions and categories.

Type	Description	Examples
Physical Intervention	Holding or moving a person or blocking their movements	Standing in front of a door and preventing someone from passing. Holding a patients arm whilst blood is taken from the other arm Physical holds taught on the Conflict Management Training
Physical/mechanical	Using equipment to stop someone freely moving about or applying physical restraints to someone to limit their movements	Bed rails Tables and chairs used to block someone Arm cuffs/mittens Splints Helmets Nasogastric bridles PEG Belts Lap belts Tipping beds and chairs
Environmental	Using or designing the environment to purposefully limit someone's ability to move around freely	Locked doors Steps or stairs Coded key pads Narrow doorways Safe place
Human/ Electronic Surveillance	Electronic systems that monitor or control someone's movements. This does not include movement sensors that identify when a patient is at risk of falling	1:1 care/enhanced care CCTV Electronic bracelets that set off an alarm when a person moves somewhere
Verbal/Threats	Making a person feel scared of doing what they want to do or to make someone believe they only have the option to stay in the one care setting	Making someone fear repercussions should they try to resist or leave eg. Threatening to withdraw future care should the patient leave the premises

Chemical	Use of medication and prescriptions to change or control someone's behaviour	Sedation
Cultural	Using social or cultural pressure to impose limitations on someone's freedom of movement	Putting someone in bed at an unwanted time Being deprived of social access, activities or other stimulations

Restraint not sanctioned in DBTH

Certain forms of restraint are not sanctioned under any circumstances because they are either deemed to be disproportionate, abusive or detrimental to the wellbeing of the patient. These are as follows:-

- Positioning furniture to restrict movement
- Arm cuffs
- Belt/Lap belt (unless using straps in a person's own wheelchair which have been fitted for the person)
- Tipping beds and chairs (unless using specialist equipment to support posture recommended by therapy staff and after an assessment)
- Any form of verbal or threat related restraint
- Any form of cultural restraint
- Safety sides when used purely to prevent a patient getting out of bed

Staff who undertake any of the above will be subject to investigation and possible disciplinary proceedings.

Restraint should only be used as a **last resort** and only when alternative methods of therapeutic behaviour management have failed. It should be **least restrictive** and the **shortest time possible.**

What is not restraint?

There is sometimes uncertainty with regard to what constitutes restraint. The following actions are not considered to be restraint.

- The use of devices, such as orthopaedic prescribed devices, surgical dressings or bandages, protective helmets
- The physical holding of a patient for the purpose of conducting routine physical examinations or tests or to protect the patient from sliding out of bed, or to permit the patient to participate in activities without the risk of physical harm
- Bed rails/safety sides:
  - used to prevent the patient from sliding out of bed
  - used with trolleys to prevent patients from falling off the trolley
  - used with patients who are experiencing involuntary movements
  - raised for seizure precautions

Patients should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose should never be covered there should be no pressure to the neck region, rib cage and/or abdomen and unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor as this is a high risk restrictive intervention implicated in the deaths of individuals due to asphyxia. If exceptionally a person is restrained unintentionally in a prone or face down position, staff should either release their holds or reposition into a safer alternative as soon as possible as per NICE NG10 guidance.

Staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purpose of an immediate rescue in a life-threatening situation.

4.4 Using Force and restraint

It is important to acknowledge that there are circumstances where it may be difficult to avoid the use of force to ensure the safe care and treatment of the patient, and the safety of other patients and staff. For example, nasogastric feeding for patients with eating disorders or a need to restrain a patient who is resisting or refusing help with personal care and support. Even within these situations it is still essential that the relevant legal principles are applied and that the use of force is proportionate.

'Chapter 26: Safe and therapeutic responses to disturbed behaviour' of the Mental Health Act 1983: Code of Practice provides further statutory guidance in relation to the use of force which staff are under a statutory duty to have regard to in relation to patients in mental health units detained under the Mental Health Act 1983.

In particular paragraphs 26.36 and 26.37 provide further guidance on the meaning of any use of force that amounts to restrictive interventions, as:-

"…deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:

- Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and;
- End or reduce significantly the danger to the patient or others.

Restrictive interventions should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation.

Where a person restricts a patient's movement, or uses (or threatens to use) force then that should:-

- Be used for no longer than necessary to prevent harm to the person or to others;
- Be a proportionate response to that harm, and;

- Be the least restrictive option."

When force is used, it is vital that a clinical staff member completed checks and physical observations on the patient to ensure they are remaining physically well throughout any restraint and they can raise the alarm if the patient becomes unwell. These physical observations should continue, following the use of force as the patient allows.

4.3 Minimising the Use of Force and Restraint

As a Trust we are committed to protecting the human rights and freedom, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including people from black and minority ethnic backgrounds, women, girls and disabled people. The Trust is committed to minimising the use of force, and eliminating the inappropriate use of force, recognising the potentially traumatising impact the use of force can have on patients, families, visitors and staff.

The Trust has a de-escalation policy (PAT/PS 15) which details the causes of challenging behaviours that staff can help alleviate and provides information on TIME AND SPACE, a Yorkshire and the Humber clinical network development on the identification of delirium causes.

It is important for all staff to involve families, friends, carers as available, in the care planning and preventative strategies to the use of force on our patients. It is important though to recognise there may be circumstances where it could be harmful to the patient to involve their family or carers such as if they were survivors of domestic abuse. The patient's wishes and preferences must be taken into account.

Taking the time to get to know our patients means of communicating their wishes and preferences, their feelings and past experiences of trauma will allow clinical staff to formulate a preventative strategy in reducing the use of force and restrictive interventions. Where necessary, involvement of community teams such as their Community mental health team, their learning disability nurse, carers, advocates, social workers etc. should be involved in the care planning.

4.5 Legal Aspects and Frameworks

All uses of force must be rights-respecting, lawful and compliant with the Human Rights Act 1998. Human rights are the fundamental freedoms and protections which everyone is entitled to. They cannot be taken away; but some rights can be restricted in specific circumstances for a legitimate reason, as long as that restriction is proportionate. Some rights, including freedom from torture, inhuman and degrading treatment are absolute and can never be restricted.

The Human Rights Act 1998 incorporates into domestic law the rights enshrined in the European Convention on Human Rights (ECHR). Articles 2 (right to life), 3 (freedom from

torture, inhuman and degrading treatment), 8 (respect for private and family life) and 14 (protection from discrimination) of the ECHR are those which relate to the use of force in mental health settings. It means all public authorities and organisations carrying out public functions (including the provision of mental health units) are legally obliged to respect patient's rights and take reasonable steps to protect those rights.

Alongside the Human Rights Act 1998, the UK Government has signed and ratified other United Nations (UN) human rights treaties which are relevant to the use of force.

Organisations should ensure that all staff are aware of, and understand their duties under this statutory guidance which reflects their obligations under the Human Rights Act 1998 and other relevant UN human rights treaties. These include:-

- International Convention on the Elimination of All Forms of Racial Discrimination (CERD)
- International Covenant on Civil and Political Rights (ICCPR)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- Convention on the Rights of the Child (CRC)
- Convention on the Rights of Persons with Disabilities (CRPD)

The following documents provide further detailed guidance on human rights:-

- Chapter 26: Safe and therapeutic responses to disturbed behaviour - Mental Health Act 1983: Code of Practice
- Equality and Human Rights Commission; Human rights framework for restraint
- Equality and Human Rights Commission; Human rights framework for people in detention
- Mental Health, Mental Capacity and Human Rights: A practitioner's guide – the British Institute of Human Rights.

It is important that staff and senior managers ensure that the legislative framework is applied in a way which is compatible with ECHR rights and freedoms. The Human Rights Act 1998 is the foundation on which other laws and duties are implemented.

There are legal frameworks including those under the Mental Health Act 1983 and the Mental Capacity Act 2005 that are designed to ensure that any use of force is applied only after a proper process has been followed. Such legal frameworks require any force used to be necessary and proportionate, and the least restrictive option.

The principle of least restriction would involve the least restrictive method, using the least amount of force (proportionate to the risk posed) and for the minimum amount of time. Below is a list (not exhaustive) of legislation relevant to the use of force.

- Human Rights Act 1998
- The Mental Health Act 1983 (as amended 2007)
- Mental Capacity Act 2005

- Equality Act 2010
- The Children Act 1989
- The Children Act 2004
- The Children and Families Act 2014
- The Care Act 2014
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

4.6 Recording Use of Force

All use of force, restraint, restrictive interventions and response to challenging behaviour should be recorded in the patients' health notes, and also through the Trust incident reporting system, DATIX. This should be completed for any patient, whether they are subject to the Mental Health Act or not. The additional information required when patients are detained under the MHA within our Trust is including the patients' demographic data across protected characteristics as outlined in the Equality Act (2010).

The act requires that the record of the use of force used on a patient by a member of staff must include the following:

a. The reason for the use of force
b. The place, date and duration of the use of force
c. The type, or types of force used on the patient
d. Whether the type or types of force used on the patient formed part of the patient's care plan
e. Name of the patient on whom force was used
f. A description of how force was used
g. The patient's consistent identifier
h. The name and job title of any member of staff who used force on the patient
i. The reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient
j. The patient's mental disorder (if known)
k. The relevant characteristics of the patient (if known)
l. Whether the patient has a learning disability or autistic spectrum disorder
m. A description of the outcome of the use of force
n. Whether the patient died or suffered any serious injury as a result of the use of force
o. Any efforts made to avoid the need for use of force on the patient
p. Whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan
q. For (k) in the above list the patient's relevant characteristics are:
    - The patient's age
    - Whether the patient has a disability, and if so, the nature of that disability
    - The status regarding marriage or civil partnership
    - Whether the patient is pregnant
    - The patient's race
    - The patient's religion or belief
    - The patient's sex

- The patient's sexual orientation
- Gender reassignment – whether the patient identifies with a different gender to their sex registered at birth.

Within our Trust, we should also be recording what level of observation/enhanced supervision was in place for the person and what injuries to staff and/or others have occurred during the incident.

4.7 Sharing Information on the Use of Force

In Appendix 1, there is a leaflet on the use of force within the Trust. The information will help patients and their families and carers understand what might happen to them whilst they are an inpatient in a mental health unit, what their rights are, and what help and support is available to them should they need it. It provides a clear statement that the use of force is only ever used proportionally and as a last resort and that it can never be used to cause pain, suffering, humiliation or as punishment.

When we have patients in our Trust that are detained under the MHA (1983), they are provided with information about their rights when detained under the MHA also.

There may be patients who do not understanding the information provided; in these circumstances the responsible person may want to consider whether it would be appropriate to involve an independent advocate who can play a vital role in assisting patients to understand their rights in relation to the use of force.

4.8 Chemical Restraint

Please see Appendix 2 for the De-escalation pathway for patients aged over 65 lacking capacity. Currently there is no Trust pathway for patients aged under 65, staff are advised to follow national guidance and act within clinical boundaries and competencies. It is important to complete physical observations following use of chemical restraint due to the potential of respiratory depression. The pathway details the timings of these observations.

Following administration of IM medication, a Datix should be completed to ensure the de-escalation process was followed, and that no less restrictive options were available at the time.

5 TRAINING/SUPPORT

The training requirements of staff will continually be reviewed by the Trust risk assessment process in clinical areas.

The Trust contracts an external company to provide conflict management training at two levels; level 1, high risk and level 2, extreme risk.

Level 1 covers de-escalation, communication skills and disengagement – removing yourself from a threatening and dangerous situation.

Level 2 covers the above and also moves onto low level holding. The training covers both non-restrictive holds and restrictive holds:

Non-restrictive	**Restrictive**
Elbow support	Figure 4 – standing, seated or laying
Straight arm support	Single arm wrap – standing or seated
Bent arm/inside arm support	Double arm wrap – standing or seated

Bed Restraints	**Notes**
GREEN level - Roofing	○ Open Palms ○ wrists turn outwards to ensure straight arms ○ Maintain space above shoulder and knee/thigh (no direct pressure/ approx. 4 inches)
AMBER level – Roofing but patient escalates to grab staff arms	○ Outside arm: hand "cups over the wrist (palm down/thumb to bum), extends down the length of the body (roofing over wrist) ○ Inside arm: Open palm, wrists turn outwards to ensure straight arms, Maintain space above shoulder and knee/thigh (no direct pressure/ approx. 4 inches)
RED level – Roofing but with extreme escalation/requirement to ensure no patient movement	○ Outside arm: Turns thumb towards self so palm up (inward rotation), flexibility reduced (locked in place), extends down the length of the body ○ Inside arm: Open palm, wrists turn outwards to ensure straight arms, Maintain space above shoulder and knee/thigh (no direct pressure/ approx. 4 inches)
RED level with kicking – Roofing but with extreme escalation/requirement to ensure no patient movement and to prevent being kicked	○ Outside arm: Turns thumb towards self so palm up (inward rotation), flexibility reduced (locked in place), extends down the length of the body

	○ Inside arm: Open palm, wrists turn outwards to ensure straight arms, Maintain space above shoulder and knee/thigh (no direct pressure/ approx. 4 inches) ○ One staff member swaps over hands to allow outside arm to reach over legs and support on the bed, above the knees and not lying on the patient facing the head of patient for observation and communication (supports self on bed)
Log Roll with sweeping action	○ Log roll as Moving & Handling training however due to attempts of patient hitting out, a sweeping motion close to the shoulders is used to minimise risk of being struck ○ This then moves down the body to turn the patient over

Security guards will also utilise restraint whilst on duty. All security staff who carry out any physical restraint during their duty will complete an incident report on Trak Tik electronic system, also all staff involved will complete an individual Physical Intervention Report to document what was conducted and on what part of the body. All staff are trained to BTEC Level 2 Physical Intervention Skills and undergo external training from the same company that Trust staff access. Below are the holds that the security guards receive training on:

Non-Restrictive Escort Holds (Low Level)

- Elbow Support
- Straight Arm Support
- Alternative Straight Arm Support
- Bent Forearm Support

Restrictive Escort Holds

- Figure Four Lock – Seated & Standing
- Double Arm Wrap
- Lead and Support into Double Arm Wrap

The responsible person must ensure that temporary, bank or agency staff have received training which is of an equivalent standard to the training requirement under the act before they are allowed to use force on patients when working in the mental health unit.

Temporary, bank or agency staff should also be familiarised with the organisation or trusts policy on the use of force.
For the safety of both patients and staff, it will also be important for the responsible person to ensure that all staff, whether employed or contracted, temporary, bank or agency staff have been trained in the use of the same techniques.

6 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

It is the responsibility of the Divisional Management Teams to put systems and processes in place to achieve the above and monitor staff awareness and understanding and compliance with this policy. This should include:

- Roles and responsibilities
- Risk assessment
- Documentation
- Incident figures and review of any incidents recorded through Datix

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Adverse incident reported on Datix	Division management groups	On an annual basis or more frequently if issues identified	Division Governance Group and Older People's Mental Health Group
Policy Compliance	Division Management Teams	Annual Basis	Division Governance Group
Incidents where there is a safeguarding element	Safeguarding Team	Annual overview plus individual incident reviews	Strategic Safeguarding People Board

7 DEFINITIONS

De-escalation	De-escalation means to bring down, to calm and lessen the escalation of a situation.
Deprivation of Liberty	A deprivation of liberty is where your liberty is taken away from you - that is, you are not free to leave and under continuous supervision and control. The Mental Capacity Act says that the law allows this only in very specific situations. This may happen to you if you need to go into a care home or hospital to get care or treatment, but you don't have the capacity to make decisions about this yourself
Mental Capacity	The ability to understand information and make decisions about your life. Sometimes it can also mean the ability to communicate

	decisions about your life. Assessment of capacity is done one decision at a time, it is not appropriate for a blank statement of 'lacks capacity' – it needs to be specific to a decision.
Restraint	Something that restricts freedom or prevents someone from doing something
Restrictive Intervention	An intervention that is used to restrict the rights or freedom of movement of a person including chemical restraint, mechanical, restraint, and seclusion among others
Safeguarding	To protect the health, well-being and human rights of individuals, which allow people — especially children, young people and vulnerable adults — to live free from abuse, harm and neglect

8 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment for All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 2)

9 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) – PAT/PA 19
Safeguarding Adults – PAT/PS 8
Safeguarding Children – PAT/PS 10
Aggressive and Violent Behaviour towards Staff – CORP/HSFS 5
Arrangement for the Provision of Care to Individuals who are Violent or Abusive (Age 18 or Over) – PAT/PA 6
Privacy and Dignity Policy – PAT/PA 28
Fair Treatment for All Policy – CORP/EMP 4
Equality Analysis Policy – CORP/PAT 27
Enhanced Patient Supervision and Engagement Policy - PAT/PS 20
De-escalation – Principles and Guidance including restraint – PAT/PS 15 v6

10 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

11 REFERENCES

Violence and aggression: short-term management in mental health, health and community settings | Guidance | NICE

APPENDIX 1 – USE OF FORCE LEAFLET

Use of Force Leaflet link: https://www.dbth.nhs.uk/wp-content/uploads/2022/08/WPR48890-Use-of-force.pdf

APPENDIX 2 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Use of Force Policy	Corporate Nursing Division	Bethany Cotton	NEW	September 2022

1) Who is responsible for this policy? Name of Divisional Directorate: Corporate

2) Describe the purpose of the service / function / policy / project/ strategy? To provide staff with the legal framework, and to ensure the safety of patients and staff when use of force is required

3) Are there any associated objectives? Compliance with the law, Care Quality Commission, Safeguarding Laws and Human Rights

4) What factors contribute or detract from achieving intended outcomes? Effective communication between staff, patients, families and relevant parties.

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? As part of the law, characteristics need to be monitored and recorded when use of force is required

- **If yes, please describe current or planned activities to address the impact**

6) Is there any scope for new measures which would promote equality?

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review:

Checked by: **Marie Hardacre** **Date: 31 January 2023**