Information Requested:

1. Have you received Restraint Reduction Network certification?  
   No

2. Are you working towards this and if so what stage are you at?  
The Trust has made an application and is awaiting a review of documentation

3. How many physical intervention instructors (either full or part time) does your Trust employ?  
   6 wte

4. On average, how many physical intervention (Breakaway / Physical restraint) courses does your Trust run per year?  
   4 – Based on 2019 124 programs were delivered
   Has this been affected by Covid-19?  Yes
   If YES in what way?:-
   There was a break in learning during the first lockdown. The Trust returned to face to face training with restricted class size and some of the theory on line to reduce the time in class and enable more classes.

5. Does the Trust deliver a **bespoke** physical intervention training package for staff that may work in the following areas:

   The Trust has a common foundation programme and the instructors each have an area that they work with for bespoke training and guidance based on risk assessment, therefore the questions below are not applicable

   Psychiatric Intensive Care  Y / N  Low / Medium / High Secure Services  Y / N
   Tier 4 CAMHS  Y / N  Acute In-Patient Working Age Adult  Y / N

6. Please provide average numbers of participants and instructors per course for
   a) PS1 / Breakaway  -  18 plus 2 instructors
   b) TASI / Physical restraint training  –  18 plus 2 instructors
   c) Any specific restraint course designed for staff working in areas in Q5  -  The Trust has additional safety pod training delivered to areas who use safety pods.

7. Please provide in hours the length of physical intervention training (Breakaway / Initial Physical Restraint and Refresher, any bespoke package for areas in Q5 if appropriate)
The Trust does not record this data as we have a mixture of staff on the foundation course and then instructors spend up to a day a week in their specialist area – this has gradually been introduced over the last 14 months.

2018 - 2019 - 2020 –

8. What amount of time (in hours) is spent on non-physical elements of the course(s) and what is the ratio of Theory to Practical during both initial training and refreshers?
   Initial is a 60:40 split theory to practical and the update is about 50:50, as detailed in the Trusts response to question 7 above the Trust does not record the hours.

9. Has the ratio of time (theory / practical) changed in the previous three years
   No

   If YES – in what way?
   If NO - is this expected to change in the next 2 years and how? - No – we will just move to making sure the theory is completely in line with the new guidance.

10. What is the total number of individual techniques taught on the physical intervention training (Breakaway and Restraint procedures)

   Breakaway - 6

   Physical restraint Course – depends on the area that the staff come from e.g. older adults, CAMHS etc.

   Refresher - depends on the area that the staff come from e.g. older adults, CAMHS etc.

11. How do you assess the competence of the staff attending the courses?
    Theory test, observation and on-going assessment and review.

12. Are ‘resistance based’ role plays (where participants are expected to respond to simulated aggression by the trainer or other participants), used during training?
    No

13. How many injuries involving participants and or trainers were reported in

   2017 - 3  2018 - 2  2019 - 4  2020 - 3

Please supply course programme and learning outcomes for all Breakaway and physical restraint / intervention courses.
Please find attached

---

**Publication Scheme:**

As part of the Freedom of Information Act all public organisations are required to proactively publish certain classes of information on a Publication Scheme. A publication scheme is a
guide to the information that is held by the organisation. EPUT’s Publication Scheme is located on its Website at the following link https://eput.nhs.uk
Therapeutic and Safe Interventions De-escalation

Name                                       Date

TASID

REV 3     13 03 20

April 2020 – MARCH 2022

5 Day Team Workbook & Journal

This journal is designed to complement and support 5 day Therapeutic and Safe Interventions De Escalation (TASID) course.

The journal will provide you with a summary of Human Rights, National guidance, research, theories on violence. The information found in this journal will support you in completing your workbook.

You will be expected to complete and submit your TASID workbook to the instructors on the last day for marking these will be returned on the last day.
You are required to pass both physical and theory elements to pass this course.

The use of Restrictive Physical Interventions carries many risks. There have been a significant number of patient deaths during and/or after the use of such interventions. The risk of physical injury is significant to both patient and staff.

In 2016-2017 there were a total of 3,652 reported injuries to patients nationally. During the same period, around 2,600 staff were reported as being injured during the use of restrictive physical interventions. These figures were taken from 48 out of 56 mental health trusts, so it may be fair to assume the actual figure could be higher.

An impact that is harder to measure is that of the emotional/psychological effect attributed to the use of restrictive physical interventions. However, we do know that many patients in contact with services have experienced trauma in their past and it is possible the use of such interventions can lead to re-traumatisation.

EPUT has recently published our Restrictive Practice Framework which outlines what the Trust will be doing over a 3 year period to reduce all restrictive practices within our services.

Reducing restrictive interventions is one of our quality priorities in EPUT and the restrictive practice framework describes the steps we will take over the next three years to make our wards safer for people who visit, stay and work within them.

We give a clear and transparent commitment to the people that use and work in our services that all of our leaders, managers and front line staff will work together to ensure that the use of coercive and restrictive practice is minimised and the misuse and abuse of restraint is prevented.

**EPUT’s Aim**

With regards to the management of violence and aggression, we support the mission and values of the Restraint Reduction Network and the desire to deliver restraint-free services.

In order to achieve this we will work to identify and reduce all restrictive practice as this has been shown to have an impact on reducing seclusion and restraint. International best practice shows that a collaborative, positive, proactive approach to ward safety reduces levels of stress on wards and consequently reduces the use of restrictive interventions.
Section 1 Human rights

All public authorities, including NHS organisations, have legal duties under the Human Rights Act (HRA) to respect, protect and fulfil people’s human rights.

This is not something to be frightened of; it is something to embrace. For organisations, especially those providing healthcare services, human rights law can be a powerful driver and useful decision-making framework. For individuals, human rights law provide a means for ensuring services are accountable. But it’s also about so much more…

(BIHR The Difference It Makes: Putting Human Rights at the Heart of Health and Social Care 2013)

Human rights apply to any person receiving care and treatment, and these rights must be at the centre of decision-making. The Human Rights Act 1998 applies to all public authorities.

Human rights apply to the person's family and carers, and others receiving treatment (e.g. patients on a ward) and staff involved in the person's care and support. As shown in the diagram below, the Human Rights Act operates as a foundation for other law, policy, guidance and practice.
Which human rights are particularly relevant to healthcare?

Many of the rights in the HRA can have a significant impact on the quality, provision and access to services.

Some of the key rights are outlined here, such as the right to life, freedom from inhuman and degrading treatment, liberty and security, private and family life and non-discrimination.

Q 1  Why must we consider human rights act when we are working in a health care setting

The Right to Life (Article 2)

This should be thought of as an absolute right in healthcare.

There is a negative obligation on healthcare providers to not take life and a positive obligation to take reasonable steps to protect an individual where there is a known and immediate risk to their life.

There are also procedural obligations to investigate deaths, especially where public officials may be implicated or involved.

Potential issues in healthcare

- Placing Do Not Resuscitate (DNR) orders on patient files where there is no advance directive or discussion with the patient or their advocate/family.
- Refusing to give lifesaving medical treatment on the basis of, for example, someone’s age or disability.
- Avoidable patient deaths for example during a restraint.
- Failing to take steps to protect a staff member (e.g. a nurse or doctor) from a known and immediate risk to their life from a patient.
The Right to be free from inhumane and degrading treatment (Article 3)

This is an absolute right; it is never justifiable to treat someone in this way.

This covers very serious treatment but it does not need to be deliberate; it also includes neglect. Inhuman treatment is about causing severe mental or physical suffering; degrading treatment is that which is grossly humiliating and undignified. This right includes a negative obligation on healthcare providers to not treat people in inhuman and degrading ways and a positive obligation to take reasonable steps to protect people where there is a known and immediate risk of such treatment from anyone.

Potential issues in healthcare

The use of some restrictive interventions may breach this right, including where serious physical or mental harm results either deliberately (abuse) or where it is not intended (neglect). The focus is primarily on the impact on the individual rather than the intentions of staff.

- Patients being abused either physically or mentally (by other patients or by members of staff)
- Patients being left in a soiled state
- Patients suffering from dehydration or malnutrition, for example because they cannot reach their food or are too frail to feed themselves
- Staff using too much force to restrain patients, locking them in or preventing them from any movement for a period of time
- Patients in severe pain and not being given anything to help relieve this
- Patients being ‘punished’ for making complaints, perhaps by making them miss meals or not washing them regularly.
- Treatment which is very painful and humiliating for which the patient has not consented.
- Failing to take steps to protect a staff member (e.g. nurse or doctor) from known abuse from a patient, or other member of staff.
The Right to Liberty (Article 5)

This is not a right to be free to do whatever you want, it is a right not to be detained in a place or have extreme restriction placed on your movement. This is a limited right, which means it can only be restricted in the ways that are set out in the right itself. This includes detaining someone because they require mental health treatment.

Potential issues in healthcare

- Informal detention of patients, who do not have the capacity to decide whether they would like to be admitted into hospital, e.g. those patients with learning disabilities or Alzheimer’s.
- Delays in reviewing whether mental health patients who are detained under the Mental Health Act should still be detained.
- Delays in releasing mental health patients once they have been discharged by the Mental Health Review Tribunal.
- Excessive restraint of patients, such as strapping to beds or chairs for long periods.

The right to respect for private and family life, Home and Correspondence (Article 8)

This right is wide-ranging and protects four interests, much of which is very relevant to healthcare:

- Private life covers more than just privacy, including:
  - Physical and mental well-being,
  - Having choice and control over what happens to you,
  - Participation in the community,
  - Access to personal information.

Family life includes developing ‘ordinary’ family relationships and on-going contact if your family is split up, Home includes enjoying the home you already have (not a right to be given a home), which could include long-stay wards or residential homes.

Correspondence covers all forms of communications including phone calls, letters, emails, etc.
Potential issues in healthcare

- Lack of privacy on the wards, including respecting the privacy of medical records
- Lack of dignity in personal care and washing
- Patients not having information about their treatment or care, or ignoring their wishes.
- Inadequate arrangements to allow patients to remain in touch with family members, for example a very short and restrictive visiting policy.
- Reading patient letters without consent or without a legal power to do so.
- Injury to members of staff because of an inappropriate lifting policy which doesn’t respect the rights of both staff and patients.

The right to non-discrimination (Article 14)

This Article is sometimes called a ‘piggy-back’ right because it must be attached or linked to one of the other rights in the HRA. For example, if a person in hospital is being denied contact with family members because of mental health problems, this may be discrimination in relation to the right of respect for private and family life (Article 8). Unlike the Equality Act which prohibits discrimination on certain grounds, or ‘protected characteristics’ (such as gender, age etc), the prohibition on discrimination in the HRA is open-ended and can include discrimination on a wide range of grounds.

Potential issues in healthcare

- Bullying or harassment.
- Providing a lower standard of care to certain people, e.g. older people.
- Making assumptions about whether a person should be placed in an institution based on discriminatory attitudes about mental health.

Personal notes
Some National Restraint documentation in Mental Health Service

Mental health crisis care: physical restraint in crisis
A report on physical restraint in hospital settings in England June 2015

Positive and Proactive Care: reducing the need for restrictive interventions
Prepared by the Department of Health

Code of practice 1983 revised 2015

Violent and aggressive behaviours in people with mental health problems

Mental Health Units (Use of Force) Act 2018

SENİ S LAW
On 1st November 2018, The Mental Health Units (Use of Force) Act became a law

Seni died at just 23, after being restrained on a mental health ward By 11 police officers. At the inquest into Seni’s death, the restraint used was deemed to be excessive, unreasonable and Disproportionate.

The new law will mean: Mental health hospitals must actively take steps to reduce the use of force against patients, including by providing better training on managing difficult situations.

MIND: We’re delighted that today the Mental Health Units (Use of Force) Bill 2018 receives Royal Assent and becomes an Act – meaning it is enshrined in law. This is a landmark step to improve the safety of people experiencing a mental health crisis.

The Restraint Reduction Network is a registered charity which brings together committed organisations providing education, health and social care services. The Network has an ambitious vision to reduce reliance on restrictive practices and make a real difference in the lives of people. We achieve this mission by sharing learning and developing quality standards and practical tools that support reduction.
No Force First

Changing the culture to create coercion free environments.

‘No Force First’ was originally an initiative within mental health in-patient units in the United States to dramatically reduce, and ultimately eliminate the amount of dangerous restraint and seclusion events. It has a proven record of success in transforming healthcare environments and enhancing safety for both service users and staff.

Key Components

- Commitment to the concept of ‘No Force First’ at the executive level of the organisation.
- Introduction of ‘peer support’ at ward level – people with their own experiences of mental health problems working as fully integrated members of the healthcare team.
- Re-defining the relationship between staff and services users as one of ‘risk-sharing partnership’ rather than ‘risk management control’ through a review of institutional rules that unnecessarily hinder and frustrate service users.
- Promotion and development of the use of ‘recovery focused’ positive and continually optimistic language about service users that seeks to avoid negative stereotyping and the development of negative perspectives around certain behaviours.
- Promotion of the concept of trauma informed care – seeing challenging behaviour in the context of previous traumatic events experienced by the service user, and understanding that the use of restraint and seclusion will only serve to intensify this trauma.
- Defining the use of restraint and seclusion as a ‘treatment failure’ and critically reviewing incidents on that basis. Reviews with both service users and staff established separately, in order to explore alternatives and prevention plans.
**Trauma informed care approach**

A trauma informed approach is a key component of No Force First

Q 2. Why is an understanding of trauma important when we provide care?

We must acknowledge the link between childhood exposure to trauma and long-term adverse mental health outcomes (1) as the structure and function of a developing brain is altered following exposure to significant childhood trauma (2).

It is known that many people in contact with mental health services have experienced physical or sexual trauma. (3)

It is estimated that half of those in the mental health system had experienced physical abuse and more than one-third had experienced sexual abuse in childhood or adulthood, significantly higher than in the general population. (3)

Therefore it is safe to assume that a majority of our patients have experienced traumatic events.

**How Can Someone Become Traumatised?**

Broadly speaking, trauma refers to events or circumstances that are experienced as harmful or life-threatening and that have lasting impacts on mental, physical, emotional and/or social well-being (4).

**Notes**
What is Re-Traumatisation?

Re-traumatisation essentially means to be traumatised again.

It occurs when a person experiences something in the present that is reminiscent of a past traumatic event. This current event or trigger often evokes the same emotional and physiological responses associated with the original event. (5)

Can the mental health system re-traumatise patients?

Unfortunately the answer to this question is yes.

But how can this happen when our role is to support patients and promote recovery?

Q 3. Give some examples of how we can re-traumatise clients in the mental health setting

Historically and sadly still true today, the fundamental operating principles of coercion and control present within the mental health system can contribute to re-traumatisation. (6)

Imagine the effects on a victim of rape when held down by staff and forcibly medicated.

Think about how pressure from staff to accept medication could mimic previous experiences of powerlessness.

What effect will witnessing or being the victim of interpersonal violence on a ward have on an already traumatised patient? (7)
The Principles of Trauma Informed Approaches (TIAs)

TIAs can be defined as “a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service user’s neurological, biological, psychological and social development” (8).

We know this is a very technical description, but if you look at the table below, you will find the key principles of a trauma informed approach. (4) (6) (9)

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recognition</td>
<td>Recognise the prevalence, signs and impacts of trauma. This is sometimes referred to as having a trauma lens. This should include routine enquiry about trauma, sensitively asked and appropriately timed. For individual survivors, recognition can create feelings of validation, safety and hope.</td>
</tr>
<tr>
<td>2. Resist retrauma</td>
<td>Understand that operational practices, power differentials between staff and survivors, and many other features of psychiatric care can retraumatisate survivors (and staff). Take steps to eliminate retraumatisation.</td>
</tr>
<tr>
<td>3. Cultural, historical and gender contexts</td>
<td>Acknowledge community-specific trauma and its impacts. Ensure services are culturally and gender appropriate. Recognise the impact of intersectionalities, and the healing potential of communities and relationships.</td>
</tr>
<tr>
<td>4. Trustworthiness and transparency</td>
<td>Services should ensure decisions taken (organisational and individual) are open and transparent, with the aim of building trust. This is essential to building relationships with trauma survivors who may have experienced secrecy and betrayal.</td>
</tr>
<tr>
<td>5. Collaboration and mutuality</td>
<td>Understand the inherent power imbalance between staff and survivors, and ensure that relationships are based on mutuality, respect, trust, connection and hope. These are critical because abuse of power is typically at the heart of trauma experiences, often leading to feelings of disconnection and hopelessness, and because it is through relationships that healing can occur.</td>
</tr>
<tr>
<td>6. Empowerment, choice and control</td>
<td>Adopt strengths-based approaches, with survivors supported to take control of their lives and develop self-advocacy. This is vital as trauma experiences are often characterised by a lack of control with long-term feelings of disempowerment.</td>
</tr>
<tr>
<td>7. Safety</td>
<td>Trauma engenders feelings of danger. Give priority to ensuring that everyone within a service feels, and is, emotionally and physically safe. This includes the feelings of safety engendered through choice and control, and cultural and gender awareness. Environments must be physically, psychologically, socially, morally and culturally safe.</td>
</tr>
<tr>
<td>8. Survivor partnerships</td>
<td>Understand that peer support and the coproduction of services are integral to trauma-informed organisations. This is because the relationships involved in peer support and coproduction are based on mutuality and collaboration.</td>
</tr>
<tr>
<td>9. Pathways to trauma-specific care</td>
<td>Survivors should be supported to access appropriate trauma-specific care, where this is desired. Such services should be provided by mental health services and be well resourced.</td>
</tr>
</tbody>
</table>
References


4. SAMHSA (2014), SAMHSA’s Working Concept of Trauma and Framework for a Trauma-Informed Approach, National Centre for Trauma-Informed Care (NCTIC), SAMHSA, Rockville, MD


Primary Prevention

Kaplan and Wheeler 1983 Affective model. (a)

The incident cycle suggests that during an incident a person’s level of arousal can be understood by looking at 5 phases:

- **Phase 1**: the trigger phase is experienced when a trigger leads to an increase in a person’s level of arousal. There will always be a trigger even if you are not immediately aware of this.

- **Phase 2**: the escalation phase is when a trigger has occurred and a person’s level of arousal begins to escalate.

- **Phase 3**: the crisis phase may be reached if we are unable to successfully identify or de-escalate a person. If the crisis phase is reached it may be necessary to physically intervene if the situation presents a certain level of risk.

- **Phase 4**: the recovery phase can occur following crisis where the level of arousal begins to decrease. But further incidents can occur quickly perhaps if we misjudge the situation and interact in a way that the person perceives to be inappropriate.
Phase 5: the post crisis depression phase can occur following a crisis. In this phase the person may experience negative emotions which may include embarrassment, frustration at their loss of control or remorse. They may also experience physical tiredness.

There is no time line for the incident cycle and a person’s level of arousal may increase rapidly or more slowly. It is important to remember that if adrenaline is produced (fight or flight) it can take 90 minutes for this to return to baseline levels.

Care Plans

The care plans we are talking about we will refer to as Positive and Proactive Support Plans.

They are designed to improve quality of life for our patients and guide our responses at times of distress.

Patients should be involved when making decisions about their care, this is a human right.

People suffering from a mental disorder should, on admission to hospital, be assessed for immediate and potential risks of behavioural disturbance. Staff should be alert to risks that may not be immediately apparent. Assessments should take account of the person’s history of such behaviours, their history of experiencing personal trauma, their presenting mental and physical state and their current social circumstances. (Code of Practice 2015)

- Primary preventative strategies aim to enhance a patient’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 encourage the patient to be calm

- Tertiary strategies guide the responses of staff and carers when there is a behavioural disturbance. Responses should be individualised and wide ranging, if appropriate, possibly including continued attempts to de-escalate the situation, summoning assistance, removing sources of environmental stress or removing potential targets for aggression from the area. Where it can reasonably be predicted on the basis of risk assessment, that the use of restrictive interventions may be a necessary and proportionate response to behavioural disturbance, there should be clear instruction on their pre-planned use. Instructions should ensure that any proposed restrictive
interventions are used in such a way as to minimise distress and risk of harm to the patient.

Primary, secondary and tertiary prevention should all be addressed when formulating a care plan specifically targeted at behavioural disturbance. The care plans should be individualised and developed in close partnership with patients and people who know them best (relatives/carers) if appropriate.

**Primary prevention recognising potential triggers**

Although identifying potential triggers is vital in formulating a care plan which addresses disturbed behaviour, it will have little value if we do not attempt to address the triggers and put measures in place. Sometimes it may not be possible to identify all potential triggers to disturbed behaviour. Therefore it is important for staff to have an understanding of more generalised factors which may lead to disturbed behaviour.

**Domains for conflict** Taken from Safewards:

The domains for conflict can be a useful aid when considering potential triggers and can help staff appreciate that aggression is a normal human reaction and we would probably respond to being on a ward in exactly the same way if we were in the patients' shoes.

**Q. 4. Identify 3 potential triggers in each domain**

<table>
<thead>
<tr>
<th>Physical environment</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outside hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulatory framework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff team</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q. 5 How will identifying potential triggers help reduce restraint and seclusion?

Attitude and behaviour

The Betari Box

My Attitude

Your Behaviour

My Behaviour

Your Attitude

affects

affects
**Why is staff attitude important?**

Staff attitudes and behaviour are key factors in the prevention of violence. (1)

Staff-patient interaction is the immediate trigger for about a third of patient violence. (2)

Q. 6 Let’s think about factors that can affect staffs’ conscious and unconscious responses to the patients we support. Give some examples

---

**How we communicate with each other**

Quite often we focus on exceptional behaviour on the part of our patients ie: behaviour which is difficult for staff to understand or manage. (2)

This type of communication can promote a negative perception of patients.

Some commonly used words or phrases used to describe patient’s behaviours:

<table>
<thead>
<tr>
<th>‘Acting out’</th>
<th>‘kicking off’</th>
<th>‘attention seeking’</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘manipulative’</td>
<td>‘they’re being difficult’</td>
<td>‘they’re a typical PD’</td>
</tr>
</tbody>
</table>

We must look beyond what we believe to be obvious explanations (which are often wholly inaccurate) and strive to understand and ascribe meaning to behaviour. (3)

If we are able to do this, it can lead to a more positive appreciation of patients.

It will be helpful if we acknowledge that most behaviours are grounded in past trauma.

Think about other factors that may lead to staff adopting an unhelpful attitude towards patients.

**AND BE HONEST!**
Malignant social psychology

Malignant social psychology was the term Kitwood (1997) used to describe the collective impact of certain behaviours and traits in the care deliverer of patients with dementia which led to an overall pervasion and erosion of the care receiver’s personhood.

In the remit of a normal working day spent caring you may come across the use of one or

Probably more than one of the behaviours listed below. These types of behaviour are indicative of an abusive social culture that may be intentional or non-intentional but

Nevertheless exists. Its existence prohibits the provision of any of the positive care factors that are so necessary for good dementia care and invariably generates cultural ill-being.

Malignant social psychology

- **Treachery**: using forms of deception in order to distract or manipulate a person, or force them into compliance.
- **Disempowerment**: not allowing a person to use the abilities they do have, failing to help those complete actions they have initiated.
- **Infantilisation**: treating a person very patronisingly, as an insensitive parent might treat a very young child.
- **Intimidation**: inducing fear in a person through the use of threats or physical power.
- **Labelling**: using a category such as dementia, or ‘organic mental disorder’ or ‘elderly mentally infirm’ as the main basis for interacting with a person or as an excuse for their behaviour.
- **Stigmatisation**: treating a person as if they were a diseased object, an alien or an outcast.
- **Outpacing**: providing information, presenting choices and the like at a rate too fast for the person to understand; putting the person under pressure by expecting them to do things at a rate far exceeding their current capability.
- **Invalidation**: failing to acknowledge the subjective reality of a person’s experience and especially their feelings attached to it.
- **Banishment**: sending a person away, or excluding them – physically or psychologically.
- **Objectification**: treating a person as if they were a piece of dead matter or an item of furniture rather than as the real person they are.
- **Ignoring**: carrying on in the presence of someone as if they were not there.
- **Imposition**: forcing a person to do something, overriding a desire or denying any possibility of choice.
- **Withholding**: refusing to give asked for attention or to meet an evident need.
- **Accusation**: blaming a person for actions or failures of action that arise from their inabilitys or their misunderstanding of the situation.
- **Disruption**: intruding suddenly or disturbing upon a person’s action or reflection – crudely breaking the frame of reference.
- **Mockery**: making fun of a person’s ‘strange’ behaviour, action or remarks, teasing or humiliating or making jokes at the person’s expense.
- **Disparagement**: telling a person that they are incompetent, useless, worthless etc. Giving them messages, verbally or psychologically, that are damaging to their self-esteem.  


### The Therapeutic Relationship

Q.7. What is the therapeutic relationship?

Putting it in basic terms it is the relationship between staff and patient with a shared goal of promoting positive outcomes. But of course it is not that simple.

A quality nurse-patient relationship is considered important in most nursing situations (4)

However, in mental health nursing, the interpersonal interaction between staff and patient is the core of practice (5)

This makes the therapeutic relationship a fundamental element of mental-health care (6).

Indeed, the therapeutic relationship employed in mental health care has been associated with therapeutic outcomes across a range of clinical settings and

Patient populations including helping to achieve a reduction in coercion and restrictive practices (7).
So, now we appreciate how important the therapeutic relationship is, we need to think about what qualities help establish a therapeutic relationship.

Research suggests there are nine constructs to the therapeutic relationship (8)

Think about the therapeutic relationship and try to complete the table below by adding qualities you believe will contribute to this.

**Q. 8. (We’ve added a few to help you in this task)**

<table>
<thead>
<tr>
<th>Having self-awareness</th>
<th>Conveying understanding and empathy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining clear boundaries</td>
<td></td>
</tr>
</tbody>
</table>

**References**


2. Safewards


**De-brief**

What is a De-Brief?

Debriefing is the practice of reviewing an event, in order to process aspects of the experience and learn from it. In the context of seclusion and restraint reduction, debriefing is considered a tertiary prevention strategy (1).

Why De-brief?

Quite simply it is best practice and all national guidance documents already mentioned require that de-brief should be undertaken following the use of RPI's.

It is designed to prevent further occurrences of coercion and is consistent with trauma-informed care and quality improvement principles. (1)

De-briefing is the sixth of the Six Core Strategies for Reducing Seclusion and Restraint Use (6CS) (2).

It is a cornerstone of the No Force First Approach adopted by EPUT.

Finally, if we need to convince you further, debriefing service users, as well as formal team review was linked to a 75% reduction in seclusion and restraint events with no increase in injuries to service users or staff (3).

Who should be offered de-brief?

Anybody affected by the incident should be offered the opportunity to engage in this process, this means staff and patient directly involved and also anyone who may have witnessed what happened. Remember, witnessing an incident could be traumatic!

What should be included in de-brief?

De-brief is sometimes called a post-incident review, but regardless of terminology, it is important we adopt a consistent and evidence based approach.

Best practice and a review of the evidence base suggest there are two main components of post-incident review, each with a distinct purpose (4):
1. Immediate post-incident support - This is the support that is immediately offered to an individual who has been involved in an incident, it should include assessment and treatment of any medical needs and provision of immediate emotional support. Staff will also need to ensure the ward returns to the pre-crisis milieu and all paperwork is completed, for example; DATIX, update of risk assessments etc.

2. Post-incident reflection and learning review - This is a non-blaming review where the factors that led to the restrictive intervention being used are examined and actions are agreed that support the prevention of future incidents or the minimisation of impact and less restrictive response in the future. (5)

If you would like to see a model of de-brief, please refer to the posters around the training room.


**Patient/Resident**

Psychological First Aid

This element may be required if the patient has a history of trauma and/or has been traumatised or re-traumatised as a result of the incident.

**Behavioural analysis**

- Tell me about what happened that led you to being secluded/restrained?
- What sort of things were you feeling leading up to that event and why were you feeling that way?
- So you felt...when...? (Confirm feelings and triggers to develop understanding, trust & engagement)
- Has there been a time when you have experienced those sorts of feelings before and you did something that helped ease them? What did you do?
- What sort of things could staff do that would have helped the situation?
- Are there any things that we haven’t already talked about that you or staff could have done differently to prevent this?
- What can we do to make sure these helpful actions happen in the future? (e.g. explore self-soothing options, develop staff and service user skills and strategies, incorporate into safety/crisis/ plans)
- Is there anything else you would like to discuss related to what happened or that we can learn from the experience to ensure this doesn’t happen again?

**Education**

Some service users have reported that they did not understand the reasons for their seclusion or restraint and perceived that staff used these practices as mechanisms of power and control (Meehan et al., 2004).

If PRN medication has been used in the process of containment, then information about the effects and side effects of this may be needed.
Problem solving and planning

Development of solutions to the issues identified during the behavioural analysis.

An important opportunity for service users to make explicit what they and staff could do differently in possible future crises and record this in their advance directives or PPSP

Staff De-brief

Huckshorn (2008) recommends the use of debriefing after every seclusion or restraint event to create a culture of enquiry and change.

Immediate post-incident analysis

Huckshorn (2004) suggests that the purpose of immediate debriefing is to ensure the safety of all involved, review documentation, talk with staff and others who were present, and attempt to return the unit to its pre-crisis milieu. The benefit of this process is that staff learning is supported while information about the incident is fresh and can support meaningful plan revisions (Azeem et al., 2011; Fisher, 2003; Lewis et al., 2009).

Formal team debriefing

Formal debriefing builds on knowledge gained from the immediate debriefing and provides an opportunity for a more in-depth analysis of events. Key professional, administrative and support staff within the service may attend this meeting to review and analyse the event. The service user’s perspective is seen to be critical and can be presented by an advocate if the service user is unable or chooses not to participate (Bluebird, 2004).

Q. 9 Why Is debriefing so important following an incident?
Safety Cross

A safety cross is a simple wall calendar that staff and patients can mark in colour to show red days (when an incident took place) or green days (incident-free), it should also be used to show when de-escalation was used successfully.

Month ........... Days without incident.............
The safety cross should be displayed in a prominent position on the ward and be visible to staff, patients and visitors. They are an accessible way to share incident data (a key component of reducing restraint) and can provide a focal point on the ward for staff, service users and visitors. The safety cross has proven to improve the way the ward community (service users, multidisciplinary ward team and visitors) engage with each other around the issue of violence. Specifically, it has helped teams take an open approach to sharing the experience of violence and aggression, so that it can become more of a community issue which everyone works through together.

**Communication**

In 1971, American psychologist Albert Mehrabian published his most famous but often misquoted research on communication. This research, which is still relevant today, emphasised the importance of non-verbal communication, referring to the signals that we give another person and the way we interpret the signals given by them.

(Source: Mehrabian A. (1971) Silent Messages)
All 3 elements must be saying the same thing. If your tone of voice and/or body language is contradictory to the words you're using, it is those more powerful messages that will be picked up on.

Q. 10 Why is good communication so important when engaging with a service user

As you can see, communication is a two way process. Sometimes, something may happen that presents a barrier to this process.

Q. 11. What do you think could present as a barrier to communication?
If a patient has identified communication needs, perhaps due to a cognitive impairment, or maybe English is not their first language, then a communication care plan should be in place, After all, it will be very difficult to engage with a patient and meet their individual needs if we cannot communicate effectively with them.

Notes

**De-escalation**

De-escalation can be described as the use of techniques (including verbal and non-verbal communication skills) aimed at preventing potential or actual behaviours of concern from escalating. (1)

A range of interwoven staff-delivered components comprising maintaining safety, effective communication, self-regulation, and assessment and actions, which aim to mitigate or reduce patient aggression and/or agitation irrespective of its cause, and improve staff-patient relationships while eliminating or minimising coercion or restriction. (2)

In order to give de-escalation the greatest chance of success and thereby reducing the likelihood of a dangerous physical intervention, it is critically important that person centred, individualised de-escalation techniques and secondary strategies are developed with the patient.(1)
Let’s think about safety first

Calm Down Methods

Sometimes we can tell when something is brewing for one of our patients. It might be their facial expression, tone of voice, snappish response to a normal reminder, restlessness, breathing pattern, body language, eye contact (or lack thereof) movement around the ward or other cues. PRN medication is an effective strategy, but perhaps we reach for it too easily and too quickly on occasion as the answer to everything. Maybe it might be better sometimes to use the patient’s own strengths and usual coping mechanisms to help them calm down. This initiative suggests a range of alternatives and provides the means to make them available to patients where possible. (3)

Think about some calm down methods that work for you at times when you’re feeling stressed or distressed, angry or anxious and note them in the space below and compare them with the colleagues in your group.

Q. 12. List 3 calm down methods that work for you at times when you’re feeling stressed

Remember our patients are individuals just like you and because something works well with one patient, don’t assume it will work with all patients.
**Talk Down Tips(3)**

**Delimit:**
The first stage is to make the immediate situation safe for yourself and others. So this can include activating any alarm system if necessary, securing support, getting other patients away from the area. All the time maintaining a suitable distance from the agitated or angry person, so as to not put yourself at risk.

**Clarify:**
This is the next stage, find out what the patient is angry or agitated about? To do that, ask open questions such as what is the matter, what is upsetting you, what's happening? Offer to help, and in doing so help the patient maintain orientation by reminding them who you are, where they are, perhaps reminding the patient of any existing relationship you have with them. Be sure to sort out any confusion, make sure you speak clearly, and check out your understandings with the patient.

**Resolve:**
This is the final stage, to try to reach an agreeable compromise with the patient, try to find a way of dealing with the identified issue that will satisfy them. In doing so, you may suggest various courses of action, being as polite as you can. In other words being the opposite of being rigid and authoritarian. Instead be flexible. Above all, take your time and hear what the patient is saying. As long as the patient is talking instead of acting, you are already being successful.

**Control yourself:**
Through this entire process, do not allow any of the anxiety or frustration you may be feeling to be communicated to the patient. Nobody ever said being a mental health nurse was easy. The best mind set of all is one where you understand the patients' point of view and context so thoroughly that no irritation arises, and you are so confident of your own de-escalation abilities, that you have no anxiety. Most of us however, are not that good, so it is important that we don’t communicate any of our own anxiety or frustrations to the patient (remember the importance of our non-verbal communication).

**Respect and empathy:**
In order to communicate these things genuinely, you really do have to make a commitment to trying to see things from the patient's point of view and importantly, treat behaviours of concern as a means of communication and remember they are serving a function.
The Support and Control Continuum (4)

Price et al (2018) interviewed staff in order to understand how they approach de-escalation. 14 strategies were identified (some of which are not de-escalation at all) that are considered supportive or controlling (see diagram below).

- Time
- Rules based culture
- Perceived reason for escalation
- Capacity of patient
- Level of emotional arousal for both staff and patient
- Over reliance on medication
- Care plan
- Lack of communication skills
- Being short staffed
- Patient preference

And remember, it is a good idea to record details of successful de-escalation, this helps with the Trust’s aim to reduce restrictive practices and can support learning. Consider marking
successful de-escalation on the safety cross. This is something that should be acknowledged as a success.

Q. 13. You are asked to inform a client that their planned leave has been cancelled due to staffing issues. What would you need to consider?

Notes

REFERENCES

1. RRN

DEFINITION OF RESTRAINT

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**Physical restraint:** any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person. (CQC)

*WHEN EVER ANY PHYSICAL INTERVENTIONS ARE USED THEY MUST BE REPORTED ON DATIX*

In this section we seek to explore the legislative frameworks in place for the use of restrictive physical interventions. This is quite complex so we have tried to make it as simple as possible. Below are questions we should ask ourselves prior to using RPI's, in order to ensure that any restriction is minimised and is ethically and legally justified.

Quite often many of these decisions may need to be taken quickly and reviewed more carefully later. (1)

- Have you tried all reasonable less restrictive alternatives?
- Is this a planned restriction as part of a care plan?
- Is there a real and immediate risk of serious harm to the individual?
- Is there a real and immediate risk of serious harm to someone other than the individual?
- Is the person detained under the Mental Health Act? And if so, is the restriction necessary for their treatment?
• Does the person have the mental capacity to make this decision themselves?

If no, has every effort been made to help them decide? If every effort has been made to help them decide, is a restriction in their best interests?

The Mental Capacity Act 2005 can provide authority for restraint under Section 6, where:

(a) a person lacks capacity and
(b) it is reasonably believed to be necessary and proportionate to protect them from harm).

• Is this the least restrictive option?
• Does the restriction need to be carried out now?
• What presents the greater risk; intervening or not intervening?
• If the decision is made to use RPI’s,
• They MUST only be used as a last resort
• They MUST represent the least restrictive option to meet the immediate need
• They MUST be used for the shortest time possible
• We MUST take into account any specific needs and/or preferences of the patient

Being short staffed should never be considered a justification to use any restriction.

What do we mean by least restriction?

Quite simply, the restriction must be necessary and proportionate to the potential risks.

Look at the scenarios below and decide whether or not you think the least restrictive options were used.

Sarah is told by the nurse in charge that her leave has been cancelled. She is not happy with this decision and becomes upset. The nurse tells Sarah to go to her room, Sarah requests to be allowed to stay in the communal area and have a drink. The nurse says ‘No’, the nurse and another member of staff then place Sarah in arm holds and take her to her room, where she is told to remain until calm.  

least restrictive options  Yes or No

Daphne is 70 years old and has a diagnosis of dementia. Daphne uses a walking frame to mobilise and spends a lot of her day walking around the ward, she can become tired and unsteady on her feet. Staff decides to place Daphne in a deep chair that she has difficulty
standing up from and to keep her walking frame out of sight in her bedroom.
least restrictive options Yes or No

REFERENCES


Notes

How Can We Reduce the Risks Associated With restraint?
Reducing Risk Factors Associated With Restrictive Physical Interventions
All physical interventions carry a level of risk. It is also important to consider other factors that may increase the risk to the patient. The presence of certain conditions/illnesses should be given due consideration when using physical interventions and should form part of a thorough risk assessment and be incorporated into positive and proactive support plans.

Potential physical risk factors could be:

<table>
<thead>
<tr>
<th>Frailty</th>
<th>Obesity</th>
<th>Musculoskeletal conditions eg: arthritis, Osteogenesis imperfecta (brittle bones)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broken bones</td>
<td>Pregnancy</td>
<td>Respiratory conditions eg: COPD, asthma</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Prescribed medication</td>
<td>Intoxication through illicit drugs or alcohol</td>
</tr>
<tr>
<td>Cardiac problems</td>
<td>Mental state eg: excited delirium</td>
<td>Blood disorders eg: sickle cell (see below)</td>
</tr>
</tbody>
</table>

Q. 14 What physical health observations should you monitor, following a incident resulting in restraint

---

**Excited delirium**

Is a condition that manifests as a combination of delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent and bizarre behaviour, insensitivity to pain, elevated body temperature, and superhuman strength. Excited delirium is sometimes called excited delirium syndrome if it results in sudden death (usually via cardiac or respiratory arrest), an outcome that is sometimes associated with the use of physical interventions.

**Sickle Cell Disease**
The disorder mainly affects people of African, Caribbean, Middle Eastern, Eastern Mediterranean and Asian origin. In the UK, sickle cell disorders are most commonly seen in African and Caribbean people.

Sickle cell anaemia is a serious inherited blood disorder where the red blood cells, which carry oxygen around the body, develop abnormally. Normal red blood cells are flexible and disc-shaped, but in sickle cell anaemia they can become rigid and shaped like a crescent (or sickle). The sickle-shaped cells contain defective haemoglobin, the iron-rich protein that enables red blood cells to carry oxygen from your lungs to the rest of the body.

The abnormal cells are also unable to move around as easily as normal shaped cells and can block blood vessels, resulting in tissue and organ damage and episodes of severe pain.

The above list is not exhaustive and all medical conditions should be taken into account when using physical interventions.

Patients with sickle cell are more at risk during physical interventions.

**Positional Asphyxia**

**Definition:** Death resulting from a body position that interferes with the ability to breathe.

This occurs when compression of the trunk limits chest movement, preventing the diaphragm from moving up and down between the chest and the abdomen and impairing breathing.

Positional asphyxia is a recognised cause of death.

**Physical Intervention Safety**

All physical interventions carry a level of risk and therefore must only be used as a last resort; they should represent the least restrictive option to meet the immediate need; and be used for the shortest time necessary.

All clients should, as soon as possible, have a thorough medical assessment upon admission. Should abnormalities be detected, these will be communicated to all nursing staff that come into contact with the patient, and considered if physical interventions become necessary.

If abnormalities are detected, advice should be sought from a suitably skilled professional as to what equates to the safest means by which to manage an individual’s aggression, medication, physical intervention or where necessary seclusion etc. This should then be placed in the positive and proactive support plan.
The potential risks of emotional trauma during physical interventions should be identified at the earliest opportunity (these could include considerations due to past trauma, cultural or gender issues) we should obtain the wishes of the service user regarding restrictive interventions and record them in a positive and proactive support plan.

Never place pressure on the back, chest, stomach, face, neck, or shoulders.

In all circumstances where restraint is used one staff member must monitor the patients head, airway and physical condition throughout the restraint to minimise the potential of harm or injury. Observations that include vital clinical indicators such as pulse, respiration and complexion (with special attention to pallor or discoloration) must be carried out and recorded. Staff must be trained to be competent to interpret these vital signs. If the person's physical condition and/or their expressions of distress give rise to concern, the restraint must stop immediately.

If a physical intervention ends up on the floor a head person must physically be in place or an identified member of the team accepts that responsibility. In exceptional circumstances if this is not practicable (possibly due to environmental factors) then another member of staff must take over the roles and responsibilities of the head person. (RMPG05)

Staff must continue to monitor the patient for signs of emotional or physical distress in line with clinical guidelines following the application of restraint.

We will not deliberately restrain someone in the prone position unless it is required either to administer rapid tranquillisation or to place in a designated seclusion room or if it is the patient’s preference expressed in a positive and proactive support plan.

Where someone is in a prone position they should be moved to a supine (face up) position, or sitting/ kneeling, at the earliest opportunity.

People must not be deliberately restrained in a way that impacts on their airway, breathing or circulation. Care must be taken that the face remains free from soft materials such as blankets, pillows etc., which could hinder breathing.

We should not use physical interventions whilst a service user is in or on their bed. If, in exceptional circumstances the need arises to do so then advice should be sought from PMVA instructors.

Staff must only use methods of physical intervention for which they have received and passed professional training.

When a decision to use physical intervention has been made the Nurse in charge should where ever practical carry out the following actions:-

Ensure the attendance of a doctor / duty doctor.
Ensure Emergency resuscitation equipment is present at the incident.

Following the administration of rapid tranquillisation, the patient’s condition and progress should be closely monitored. Subsequent records should indicate the reason for the use of rapid tranquillisation and provide a full account of both its efficacy and any adverse effects observed or reported by the patient. And it must follow the trusts rapid tranquillisation policy. (Refer to policy)

Nursing staff must carry out basic vital signs observations as soon as possible after the event especially if physical intervention and rapid tranquillisation procedures have been used. This should be repeated up to every 4 hours (more frequent if necessary) and for up to a period of 24 hours minimum. After this period the Doctor and Nurse should decide if monitoring should continue on a regular basis if necessary

Role of the Head Person

One member of staff (normally designated “head person”) should assume control throughout the process. He or she is responsible for:-

- Liaison with the nurse in charge.
- Maintaining de-escalation techniques with the service user and creating a dialogue of communicating the actions the team will take with the service user to achieve a quick and favourable outcome.
- Setting out for the service user the clear, positive instructions and expectations of behaviour that will end the use of physical intervention.
- Respond to and reinforce all compliance by the service user.
- Protecting and supporting the service user’s head and neck, where required. (The protection of the head constitutes a duty of care owed to the service user).
- Ensuring their airway and breathing are not compromised
- Ensuring vital signs are monitored
- Leading the team through the process by giving clear instructions and relevant information.

In some circumstances restraint is the right thing to do, and not to do so on these occasions could be considered neglect. Restraint can be used:

- If the person consents to it, perhaps because it makes them feel safer
If it is part of a care plan agreed by all
If the person lacks the capacity to consent, but is acting in a way that may cause harm to themselves or others. In this case, The Mental Capacity Act 2005 helps us to understand that restraint can be used if it is believed to be in the individual's best interests, but it must be the least restrictive option and used for the minimum amount of time.

**Post Physical Intervention**

Whilst the risk of death from positional asphyxia during restraint has been increasingly recognised, harm can also occur in the period following restraint from the effect of illicit substances, alcohol, prescribed medications (including any rapid tranquilisation) and co-existing medical conditions. People with diagnoses of severe and enduring mental illnesses are at increased risk of coronary heart disease, cerebrovascular disease, diabetes, infections, epilepsy and respiratory disease [4,5], all of which can potentially be exacerbated by the psychological and physical effects of restrictive intervention; between 2008-2012 there were 11 deaths within 24 hours of restraint in mental health settings in England. (NHS England *The importance of vital signs during and after restrictive interventions/manual restraint* 3 December 2015)

**Compartment Syndrome**

Compartment syndrome is increased pressure within one of the body's compartments which contains muscles and nerves. Compartment syndrome most commonly occurs in compartments in the leg or arm.

Acute compartment syndrome can occur after physical interventions. The trauma causes a severe high pressure in the compartment which results in insufficient blood supply to muscles and nerves. Acute compartment syndrome is a medical emergency that requires surgery to correct. If untreated, the lack of blood supply leads to permanent muscle and nerve damage and can result in the loss of function of the limb.

Signs to be aware of that may indicate compartment syndrome:

- Pain out of proportion to apparent injury (early and common finding)
- Persistent deep ache or burning pain
- Paraesthesia (onset within approximately 30 minutes to two hours of ACS; pins and needles)
- Pain with passive stretch of muscles in the affected compartment (early finding)
- Tense compartment with a firm "wood-like" feeling
- Pallor (unhealthy pale colour) from vascular insufficiency (uncommon)
- Diminished sensation, Paralysis
- Muscle weakness (onset within approximately two to four hours)

**Physical health following an incident**

Patients who have received treatment of acutely disturbed behaviour must not be left unattended. Close monitoring and recording of vital signs by nursing staff is necessary to ensure prompt recognition of serious complications using the Trust’s

**Modified Early Warning System (MEWS).**

Blood pressure, pulse, temperature, respiratory rate, oxygen saturation (pulse oximetry), (or if not available any change in skin colour which indicates cyanosis) should be recorded at regular intervals (see below). The patient’s level of hydration should also be assessed if possible, otherwise physical observation of drinking quantity. The patient should be encouraged to drink water to maintain adequate hydration.

**Notes**

Observations should be particularly frequent when a patient is sedated or if IM or IV injections have been administered. Physical monitoring recommendations following parenteral treatment of acutely disturbed behaviour
For the **FIRST HOUR** after the last parenteral drug administration:

- Alertness (AVPU score)
- Pulse
- Respiratory rate
- Blood pressure
- Temperature
- Level of hydration if available (otherwise visual obs of drinking quantity)
- Oxygen saturation (if available) (otherwise assessment of skin colour for cyanosis)

Every 5 minutes ALERTNESS
Every 10 minutes VITAL SIGNS

After the first hour after the last parenteral drug administration for at least the next three hours and until the patient is ambulatory:

- Alertness (AVPU score)
- Pulse
- Respiratory rate
- Blood pressure
- Temperature
- Level of hydration if available (otherwise visual obs of drinking quantity)
- Oxygen saturation (if available) (otherwise assessment of skin colour for cyanosis)

Every 30 minutes

Once the patient is ambulatory:

- Continue to monitor alertness, mental state and behaviour for 6 hours

Re-start physical observations if there are any concerns Where any irregularities in vital signs are identified, immediate medical assistance should be sought.
Some observations may not be possible if the patient remains agitated or aggressive or refuses to co-operate. Visual observations must be maintained including respiratory rate and skin colour in these circumstances.
Can we use force?

STATUTE LAW: Criminal Law Act 1967

Reasonable Force.

“The amount of force necessary to protect oneself or one’s property.
A person may use such force as is reasonable in the circumstances for the purposes of:
• self-defence; or
• defence of another; or
• defence of property; or
• prevention of crime; or
• lawful arrest.

In assessing the reasonableness of the force used, prosecutors should ask two questions:
• was the use of force necessary in the circumstances, i.e. Was there a need for any force at all? and
• was the force used reasonable in the circumstances?

The courts have indicated that both questions are answered to on the basis of the facts as the accused honestly believed them to be (R v Williams (G) 78 Cr App R 276), (R. v Oatbridge, 94 Cr App R 367).

www.cps.gov.uk/legal/s_to_u/self_defence/

Reasonable Force

For force to be considered reasonable it must be:
both

- Necessary
- Proportionate
**Seclusion** information from Mental Health Act 1983:Code of Practice (2015)

Seclusion refers to 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. (CoP)

If a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded and the use of any local or alternative terms (such as ‘therapeutic isolation’) or the conditions of the immediate environment do not change the fact that the patient has been secluded. It is essential that they are afforded the procedural safeguards of the Code. (CoP)

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.

- Seclusion should not be used as a punishment or a threat, or because of a shortage of staff. It should not form part of a treatment programme.
- Seclusion should never be used solely as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion should be used only 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.

In order to ensure that seclusion measures have a minimal impact on a patient’s autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient’s circumstances. Where seclusion is used for prolonged periods then, subject to suitable risk assessments, flexibility may include allowing patients to receive visitors, facilitating brief periods of access to secure outside areas or allowing meals to be taken in general areas of the ward. The possibility of facilitating such flexibility should be considered during any review of the ongoing need for seclusion. Particularly with prolonged seclusion, it can be difficult to judge when the need for seclusion has ended. This flexibility can provide a means of evaluating the patient’s mood and degree of agitation under a lesser degree of restriction, without terminating the seclusion episode.
ALL STAFF SHOULD BE FAMILIAR WITH THE SECLUSION AND LONG TERM SEGREGATION PROCEDURE

**Long term segregation**

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 determines 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 serious injury or harm over a prolonged period of time. Where 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. The multi-disciplinary review should include an IMHA in cases where a patient has one.

**Q. 15. What is the difference between seclusion and long term segregation?**
## Seclusion and LTS Pathway

<table>
<thead>
<tr>
<th>Scenario 1</th>
<th>Scenario 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A person presents with severely disturbed behaviour likely to cause harm to others (and or self)</td>
<td>A person presents an almost continuous risk of serious harm to others</td>
</tr>
<tr>
<td>Seclusion</td>
<td>Long-Term Segregation</td>
</tr>
</tbody>
</table>

**Differences**

- Unplanned event
- Immediate necessity
- Severely disturbed behaviour likely to cause harm to others
- Supervised confinement and isolation
- Designated room
- Continuous observation, recorded every 15 minutes

- Planned intervention
- Continuous risk of serious harm to others
- Person would benefit from a period of intensive care and support that minimises their contact with other users of the service
- Discrete area
- Continuous observation, recorded hourly

**Similarities**

- Away from other users of service
- Prevented from leaving the area
  - Only be used in hospitals
  - Can be in any area
- A person is prevented from mixing freely with other people who use the service

A decision to either seclude or long term segregate a patient will be the decision of the MDT based on the patients mental health presentation and risk.
<table>
<thead>
<tr>
<th>My triggers which can make me upset or angry are:</th>
<th>I know that if I am upset or angry this helps me</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Triggers</th>
<th>De-escalation strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fill in your own PPSP

USE HAND OUT
Preamble:

Controlling the risks during therapeutic and safe intervention situations are important aspects of managing health and safety of both the service users and the carers.

In terms of risk assessments, you need to think about what might cause harm either to the service user or the carer and decide whether you are taking reasonable steps to prevent that harm.

The rapid entire body assessment (REBA) has been used to assess these procedures.

Disengagement Skills Safety Points

Q. Why use a disengagement skill?

A. Risk to self and, perhaps others, and de-escalation has failed (if appropriate). It is important to continue with de-escalation (if appropriate) throughout.

Q. When would you use an alternative method (reasonable force)?

A. When the disengagement has failed and risk is extremely high.

Q. How do they work?

A. Skill (Technique), Speed and Surprise referred as the 3 S’s. This should be mentioned at the start of the session however highlight the element of surprise is
compromised in a teaching environment. Create space after all techniques outside the fighting arc or exit (if appropriate).

**Demonstration  Safety – Adopt A Side Ways Stance**

**Description of techniques**

Side on stance, soft knees for balance  
Hands up, open palms or philosophers pose  
Stand outside kicking distance  
Left or right side of aggressor (not front on)  
Mindful of eye contact  
Mindful of exit

**Risk assessment**

Risk Factors
No risks associated with this approach

**Posture/Stance**
Posture and stance of carers appropriate
The approach follows the natural defensive approach to protect the carers  

**REBA Score = 1**

**FIGURE 4 HOLD**

![Figure 4 Hold Image]

**DESCRIPTION OF TECHNIQUES**
Outside hand remains on the wrist (YOUR PALM UP)
Inside hand relocates onto staff wrist in an over hand grip (PALM DOWN)

**DISENGAGEMENT SKILLS SAFETY POINTS**
2 staff needed, stable base and hip to hip closing gaps
Mind full of gender issues
Grip own wrist with fingers and thumb

**RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE**

**Risk Factors**
Minimal wrist strain to the service user if force is applied

**Posture/Stance**
Posture and stance of the carer is appropriate
Lock position and posture of both carer and service user are safe

**Avoid**
Twisting of the forearm of the service user
Over forceful grasp of the arm and forearm of the service user.

**Safety**
Safe to use, there are no risks to this hold.
DOUBLE WRIST HOLD

DESCRIPTION OF TECHNIQUES

Outside hand remains on the wrist
Inside hand places on forearm, underhand grip above or below staff other hand
Say “secure”

DISENGAGEMENT SKILLS SAFETY POINTS

2 staff needed, both hands in underhand grip to avoid twisting of staff wrists

RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE

Risk Factors

Minimal wrist strain to the service user if force is applied
Possible twist of the elbow of the service user

Posture/Stance

Posture and stance of the carer is appropriate

Avoid

Any forceful twist or squeeze of the wrist/elbow of the service user

Safety

Safe to use, there are no risks to this hold.
REBA Score = 1

TEAM FORMATION or FORM UP

DESCRIPTION OF TECHNIQUES

ANY TEAM MEMBER CAN REQUEST TO FORM UP IF THEY FEEL THEY ARE AT RISK OF A POTENTIAL ATTACK

This will let the A and your team your intent
2 APE allocated arm and are at front of formation, de-escalation pose or arms up to protect, shoulder to shoulder
Head person places backs of hands on staff shoulder blades
AP (best rapport) communicates with A (teaching purposes person on right)

ROLE OF THE HEAD PERSON
To care, coordinate and communicate with A and team members- 3 C’s
Only secures head when it is presented by the APE
To be mindful of dynamic risk shift
Situational awareness is a key aspect to the role
Have good leadership skills but also able to take direction from other members of the team if appropriate

DISENGAGEMENT SKILLS SAFETY POINTS

3 staff with clear understating to allocated role, APE at front of formation to secure arms before HD partakes, maintain contact with each other at all times up to point of committal.
Role of the head person- side on stance, leading hand on A forehead to prevent spine twist

RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE

Risk Factors
No risks associated with this approach

Posture/Stance
Posture and stance of carers appropriate
The approach follows the natural defensive approach to protect the carers

REBA Score = 1

PRE-ARRANGED TEAM APPROACH UNDER AND OVER ARM

DESCRIPTION OF TECHNIQUES

Assemble in team formation
Communicating AP shouts “go” at point of committal, APE take big step in with inside leg.
Forearms block the A arm
Outside hand secures A wrist in overhand grip, inside arm places under A armpit, supporting at shoulder, staff hip to hip with A
Options to transfer through or to take down supine

DISENGAGEMENT SKILLS SAFETY POINTS

Pre-arranged under arm team approach - ideally 3 staff but can be done with 2, 1 person shouts “GO” (APE with best rapport or teaching purposes person on right), let each other know arm secured “SECURE”, call for HP if not there already

RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE

Risk Factors
Minimal upper limbs twist (especially the shoulders) of the service user

Posture/Stance
The head of the service user is well supported
Posture and stance of carers appropriate

Avoid
Any forceful twist of the upper limbs when securing the service user
Uncoordinated take down in the supine position
Safety
Safe to use minimal to moderate risk

REBA Score = 1

LOWERING THE HEAD 1

DESCRIPTION OF TECHNIQUES
APE drive shoulder down taking step forward with outside leg, Maintain holds throughout
Head person secures A head and takes control

DISENGAGEMENT SKILLS SAFETY POINTS
Ideally 3 staff but can be done with 2, 1 person shouts “GO” (APE with best rapport or
attaching purposes person on right), mindful hand nearest A does not strike head, let each
other know arm secured “SECURE”, call for HP if not there already, APE secure in FIG 4
below A elbow and tug hand to floor to disengage major muscle groups

RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE

Risk Factors
No risk, wrist block of the service user is appropriate

Posture/Stance
Posture and stance of the carer is appropriate

Avoid
Any forceful twist or squeeze of the wrist/elbow of the service user

Safety
Safe to use, there are no risks to this hold.
REBA Score = 1

LOWERING THE HEAD 2

DESCRIPTION OF TECHNIQUES
APE release outside grip on the wrist
Maintain thumb and finger hold
Place hand on A shoulder, pull down with hand and drive down with shoulder simultaneously
taking step forward with outside leg
Head person secures A head and takes control

DISENGAGEMENT SKILLS SAFETY POINTS
APE together place outside hand of A shoulder and pull at same time to minimize risk to A, step forward with outside leg for leverage and stability

RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE

Risk Factors
No risk, wrist block of the service user is appropriate

Posture/Stance
Posture and stance of the carers is appropriate

Avoid
Any forceful twist or squeeze of the wrist of the service user
Any forceful twist or squeeze of the elbow/shoulder of the service user

Safety
Safe to use, there are minimal risks to this hold.
REBA Score = 1

SUPPORTING THE HEAD SHORT ARM

DESCRIPTION OF TECHNIQUES
Head person gives command “lower the head” if not done so already
Head person on side on stance collects head with leading hand on the forehead, other hand places on top of the head
A head should remain in contact with head persons’ side between shoulder and hip

DISENGAGEMENT SKILLS SAFETY POINTS
Securing the head short arm- HP leading hand places on forehead (minimizes twisting) and other hand cradles top of head, A head maintains contact with HP between hip and shoulder to prevent A driving forward, allow A to turn head and do not restrict as could damage neck and spine

RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE

Risk Factors
Minimal upper limbs twist (especially the shoulders) of the service user

Posture/Stance
Head of service user well supported
Posture and stance of carers appropriate

Avoid
Avoid any forceful twist of the upper limbs (shoulder and elbow) especially when taking the
upper limb backwards to fully secure the service user
Uncoordinated action by carers

**Safety** Safe to use minimal risk

**REBA Score = 1**

**SEATED DEESCALATION 2 POINTS OF CONTACT**

**DESCRIPTION OF TECHNIQUES**

Head person communicates with A and team to take small steps, Once the chairs can be felt by team and A at the back of the legs head person asks team to “sit”. Head person lets go of head and steps back, outside fighting arc, comes to same eye level as A. Head person hands over to person with best rapport but remains in sight at all times. APE work back down the holds one at a time using a 3 wrist grab. Leave together at 45 degree angle.

**DISENGAGEMENT SKILLS SAFETY POINTS**

**Seated de-escalation (HP)**- clear communication with A and team, small steps, feel for chair at back of legs before sitting, when team sit release head and step outside fighting arc.

**Seated de-escalation (APE)**- feel for chair at back of legs before sitting, spread legs for wide base and stability, move down holds keeping A as upright as possible to minimize positional asphyxia potential, when ready to leave block A elbow, do not use A as lever when leaving.

High aggression may be a situation, may be moved to a standing position as this will give the team more control to take A to kneeling or supine position, if landing in an unintentional prone turn immediately.

**RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE**

**Risk Factors**
No risk, forearm hold and body lock of the service user is appropriate

**Posture/Stance**
Sitting posture of the carers and service user are appropriate

**Avoid**
Any forceful twist or squeeze of the forearm of the service user
Any forceful twist or squeeze of the elbow/shoulder of the service user

**Safety**
Safe to use, there are minimal risks to this hold.

Benefits
Adequately secures the service user, Prevents the service user lashing out at the carers

REBA Score = 1

RELOCATION TO FLOOR SUPINE
TO BE RISKED ASSESSED for 2 STAFF TAKE DOWN - WHAT IF?

DESCRIPTION OF TECHNIQUES to be risk assessed by victor

Team formation and action prearranged approach 1

Head person relocates to back of A, side on stance, no gaps, hands on A shoulders now long arm for head person or sniper

Head person gives command “knees”
APE tug A wrist to floor, remain hip to hip, take big step with outside leg and drop inside knee to floor, A arm rests on outside knee
Head person, at the same time, extends arms, steps back and drops inside knee to floor, outside knee up for support, A spine rests on head person side
Head person gives commands “to floor”, turns fingers to floor and places hands at base A neck, moves inside leg away and creates space, collects A head on forearms and rests on knees when A is on back
APE drop outside leg, bring forearm to floor, maintain wrist grab, on floor bring inside arm out and over A arm and place on the floor with all weight on forearm, adopt sniper position
Head person brings head to their knees in resting position, places A head on the floor placing knees either side of A head and cups head, allow free movement of head

DISENGAGEMENT SKILLS SAFETY POINTS

Relocation to floor supine (HP) - clear command “TO KNEES”, create space for A to sit, knee nearest A on floor to stop damage to back (swap leg for pregnant woman and keep in semi recumbent position due to risk of positional hypotension using outside of calf for support), clear command “FORARMS TO FLOOR”, adjust hands place at base of neck and cradle head to floor, keep A head on lap to minimize knee damage unless A is resisting or wants head on floor.
Relocation to floor supine (APE)- ensure hip to hip for controlled decent, do not over extend A shoulder when resting on knee in sitting position, in sniper ensure all weight is on your forearm and not A bicep/ triceps to avoid compartment syndrome.

Risk Assessment and Rapid Entire Body Assessment Score

Risk Factors
Minimal upper limbs twist (especially the shoulders) of the service user
Taking down the service user from standing to supine may be tricky

Posture/Stance
Posture and stance of the service user is appropriate
Posture and stance of carers appropriate

Avoid
Any forceful twist of the upper limbs
Avoid the service user been forcefully moved down to the supine position. Co-ordinated approach by the cares will prevent any mishap

Safety
Safe to use with proper communication and co-ordination of the carers. This procedure has minimal to moderate risks

REBA Score = 2
SECURING THE WRIST / ARM SUPINE

DESCRIPTION OF TECHNIQUES
A: APE secures elbow/s between knees, hooking thumbs over wrist, sits upright and sits back.
B: APE secures arm sits upright and sits back, knee up to side of are, extend and lock out arms with palms down and avoiding major joints.
C: APE secure arm by laying down next to A, APE nearest arm over forearm/shoulder, outside hand secures wrist palm down in a sniper position, legs lay parallel with a legs of A

DISENGAGEMENT SKILLS SAFETY POINTS
(APE)- ensure hip to hip for control, do not over extend A shoulder when resting on knee in sitting position, in sniper ensure all weight is on your forearm and not A bicep/ triceps to avoid compartment syndrome.

RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE

Risk Factors
Securing the ARM of the service user on the floor is appropriate, no risk involved

Posture
Posture of the service user in supine is appropriate.
Posture of carer securing the ARM is appropriate.

Avoid
Avoid putting any forceful pressure on the fore-head of the service user

Safety
Safe to use, there are minimal risks to this hold.

REBA Score = 1
SECURING THE LEGS SUPINE

Above the knees on there back at the ankles on there front

DESCRIPTION OF TECHNIQUES

Leg person approach side on
Inside knee drops to floor, head tucked in to protect
Sweep inside arm across A legs above knee, place forearm on floor, place backside on floor, Forearm on floor lays along A thigh with flat hand, knee and thigh nearest A secures alongside A hip and thigh. Squeeze together tight as possible.

DISENGAGEMENT SKILLS SAFETY POINTS

Securing legs supine- keep vital organs away from kick when approaching, tuck head, choose moment and sweep arm across putting forearm on floor supporting your weight, close gap with upper body on A legs, flat hand comes under A legs being mindful of gender issues, S grip for extra security

RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE

Risk Factors
Securing the legs of service user is appropriate, no risk involved

Posture
Posture of the service user in prone is appropriate.
Posture of carer securing the legs is appropriate.

Avoid
Any forceful twist or squeeze of the legs of the service user

Safety
Safe to use, there are minimal risks to this hold. REBA Score = 1
PROTECTING THE HEAD PRONE AND SUPINE

DESCRIPTION OF TECHNIQUES

1. HP supports A head to floor, HP hand to touch the floor first
   HP lightly places hand to back of A head with no pressure

2. HP supports A head to floor, HP hand to touch the floor first  Secure between the knees, arms fully extended sitting back palms face down just above forehead not touching

DISENGAGEMENT SKILLS SAFETY POINTS

Securing head prone- all weight should be on HP thighs when fixing bar and not on A head (NOT TOUCHING)

RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE

Risk Factors
Securing the head of service user is in prone or supine position appropriate, no risks involved

Posture
Posture of the service user in crunch kneeling position is appropriate. Posture of carer securing the head is appropriate.

Avoid
Any forceful twist or squeeze of the upper limbs of the service user
The head of the service user needs to be adequately secured and protected

Safety
Safe to use, there are minimal or no risks to this hold.

REBA Score = 1
TURNING OVER PRONE TO SUPINE

DESCRIPTION OF TECHNIQUES

APE straighten arms to A side
HP gives command to turn in the opposite
direction A head is facing, disengages from head
APE place hands on A same hip and shoulder and roll opposite way A is facing
HP reengages

DISENGAGEMENT SKILLS SAFETY POINTS

(HP)- ensure APE know which way you are turning (environmental issues or the opposite
way the A is facing to minimize neck injury), communicate covertly for element of surprise,
on command “TURN” disengage from head completely until fully turned

(APE)- non-verbal with HP to communicate way you are turning is understood, fix A at
wrists and do not let go, roll form hip/ shoulder and secure arm when fully turned

RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE

Risk Factors
Minimal upper limbs twist (especially the shoulders) of the service user
Turning is appropriate, but needs to be properly timed to avoid squashing the upper limb

Posture/Stance
Head of service user need to be well supported
Posture and stance of carers on the floor is appropriate

Avoid
Any forceful twist of the upper limbs
Uncoordinated turning from the prone to supine position
Avoid any forceful twist of the upper limbs (shoulder and elbow) especially when turning
service user from supine to side lying to prevent squashing the shoulder.
The head needs to be secured and protected from start of procedure to finish

Safety
Safe to use minimal risk REBA Score = 2
**Doorways**

Head exposed for teaching purposes

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**DESCRIPTION OF TECHNIQUES**

HP in line with leading AP  
HP adopts “swan like hold” to A head, leading arm secures on leading AP shoulder APE hip to hip and guide A through door

**DISENGAGEMENT SKILLS SAFETY POINTS**

Doorways- HP gets in line with AP who is going through door first and protects A head with forearm, mindful of A backside on doorframe, close gaps for stability

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**RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE**

**Risk Factors**  
Moderate risks to the service user and the carers while going through the door way  
The head of the service user needs to be supported from the beginning to the end of this procedure

**Posture/Stance**  
Posture and stance of the carers appropriate in the standing position  
Posture and stance of carers going through the door way is appropriate

**Avoid**  
Any forceful twist of the upper limbs when securing the service user  
Prevent forceful and uncoordinated movement of the service user through the door way  
Avoid heavy handedness of the service user during this procedure

**Safety**  
Safe to use, but has moderate risks especially when going through the door way

**REBA Score = 2**
**DESCRIPTION OF TECHNIQUES**

Team enter seclusion with intent to leave via the head (A head facing towards door)
HP directs team to bottom of bed, HP stops at corner, APE in shallow angle rotate around to face bed, HP moves to head of bed
APE drive A on to bed, LP secure the legs
HP gives command to APE (one at a time to “transfer”) triangular fix hold
HP gives command to APE (one at a time “prepare to exit”) APE bring A arm into armpit and maintain hold, HP takes over hand grip on A and blocks triceps with forearms, leans back slightly
HP commands LP to leave, on hearing “clear” asks AP to leave then other AP to leave, HP leaves, All tapping the shoulder of LP to say you are exiting door closes

**DISENGAGEMENT SKILLS SAFETY POINTS**

(HP) - at foot of bed stop at corner and relocate to head to get out of AP way and avoid collision, clear commands to team ensuring all know when the right time is to transfer and to leave. Seclusion head exit

(AP)- shallow approach to bed to prevent A putting leg on bed, close all gaps, ensure instruction is clear and understood from HP

**RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE**

**Risk Factors**
Minimal upper limbs twist (especially the shoulders) of the service user
Turning and securing the upper limb is appropriate, but needs to be properly timed to avoid squashing the upper limb
The fall needs to be supported to avoid the service user banging their head severely on the mattress

**Posture/Stance**
Head of the service user supported to a certain extent, but not during the fall
Posture and stance of carers on the floor is appropriate

**Avoid**
Avoid any forceful twist of the upper limbs
Uncoordinated turning in the prone position
Avoid a free fall where the service user bangs their head on the mattress

**Safety** Safe to use but has moderate risks **REBA Score = 2 – 3**
DE ESCALATION SUPINE: LEAVE PATIENT TO GET UP ON THERE OWN

RISK ASSESSMENT AND RAPID ENTIRE BODY ASSESSMENT SCORE

Risk Factors
Minimal upper limbs twist (especially the shoulders) of the service user
The long arm head support can cause choking/strangling feeling to the service user hence this hold needs to be adequate

Posture/Stance
Head of service user needs to be well supported
Kneeling posture and stance of carers on the floor is appropriate

Avoid
Any forceful twist of the upper limbs (shoulder and elbow)
Uncoordinated movement from the crunch kneeling to half kneeling position
The head needs to be secured and protected from start of procedure to finish

Safety
Safe to use minimal to moderate risk depending on the size and body built of the service user

REBA Score = 1