

Physical Intervention: Reducing Risk

A guide to good practice for employers of security personnel operating in healthcare settings in England.



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In memory of Peter Boatman: 1953 -2010

Peter was awarded the Queen's Police Medal for the contribution he made to the safety of staff and the public in potentially violent situations. He helped raise awareness within the NHS of strategies to reduce violence risks and with the development of this good practice guide. Peter was a pioneer in this field and a true professional dedicated to raising standards. He was a proud, loyal and generous man who was always willing to help.

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Introduction

There will be occasions in the public and private health sectors when it is lawful and necessary for security officers to use physical intervention skills to protect themselves and others from imminent danger. This may be in conjunction with clinical involvement, or independent of it in an emergency scenario. Physical intervention however carries risk of injury to staff and the individual's they are dealing with and can result in a restraint related death.

Physical intervention should therefore be a last resort when other responses have failed, or are likely to fail.

This guidance is intended for employers including NHS Trusts and independent healthcare providers, as well as the providers of contract security personnel, the majority of which operate in the Acute Sector. It considers preventive measures and alternatives to physical skills and then examines steps that can be taken to equip security officers in terms of training and guidance, to contribute to a safe outcome when physical intervention is legitimately used.

Aim

The purpose of this guidance is to assist public and private health bodies and the providers of contract security officers to recognise how they can better protect staff, patients and their services by reducing the need for physical intervention and encouraging appropriate training and safe practice.

Sector Overview

The range of services provided by public and private health in the United Kingdom is dynamic, diverse and highly regulated. The NHS is the largest single employer in Europe with around 1.3 million employees, treating 1 million patients every 36 hours in a variety of settings including acute hospitals, ambulance services, primary care and mental health services. There are a further 500,000 people in the independent healthcare sector, quite apart from carers and social workers.

The recognition that multi-disciplinary support, including security, is a critical asset to ensuring that the best possible service is delivered is developing rapidly. Many hospitals have teams of dedicated security officers that they employ directly in-house or in-directly under contract.

Public and independent healthcare services have a responsibility to provide a safe and secure environment within the wider community and that employees including contractors are adequately protected from harm.

Context

Conflict and violence at work is a historical and significant issue for health services. It is a fact that health services are not, and never have been, immune from the changes and ills of society. However, not all violence in health settings is with criminal intent. For example, some behaviour may result from a clinical condition or response to treatment. Such assaults, often involving confused patients, are common across a range of settings and often go unreported.

Statistics from the NHS Security Management Service (NHS SMS) show that in 2008/09, 54,758 incidents of physical assault against staff were reported in the NHS in England. Of these around 11,000 occurred within the acute sector and 39,000 in mental health and learning disability services. The remainder were in primary care and the ambulance sector. Figures from the Health and Safety Executive (HSE) show that around 1,500 incidents result in 3 or more days absence from work.

While healthcare providers accept that there are inherent risks associated with the provision of some services, they have a duty to address the risk of harm to staff (deliberate and unintentional) and the risks to individuals they come into contact with. Case law shows that employers, employees and security suppliers are vulnerable if they fail to identify and reduce risk and adopt safer methods of work.

This guidance sets out to complement existing legislation and guidance on the identification, prevention and management of work-related violence offered by organisations such as the NHS Security Management Service (SMS) and Health and Safety Executive (HSE). Training and guidance in the use of physical intervention should sit within a wider strategy and health care system that responds effectively to the needs of patients and visitors and thereby reduces much conflict and risk.



While specifically addressing physical intervention, this guide to good practice is not definitive. It is intended to complement existing and emerging good practice and requirements. It is important that employers seek appropriate advice to ensure that their policy, risk assessments and control measures are suitable and sufficient in this area of risk.

Scope and Definitions

This good practice guidance is for the benefit of employers and is specifically aimed at the role of the security officer operating within a healthcare setting.

Violence is defined by the Health and Safety Executive (HSE) as:

‘Any incident in which a person is abused, threatened or assaulted in circumstances related to their work’.

Physical Assault is defined by the NHS SMS as:

‘The intentional application of force against the person of another without lawful justification resulting in physical injury or personal discomfort’.

Non Physical Assault is defined by the NHS SMS as:

‘The use of words or inappropriate behaviour causing distress and/or constituting harassment’.

An offence of common assault is committed when a person either assaults another person or commits a battery:

- An assault is committed when a person intentionally or recklessly causes another to apprehend the immediate infliction of unlawful force.
- A battery is committed when a person intentionally and recklessly applies unlawful force to another

There are various definitions surrounding physical intervention and the Security Industry Authority (SIA) uses the following for its physical intervention competency requirements:

Physical Intervention is used to cover the use of direct or indirect force, through bodily, physical or mechanical means, to limit another person’s movement.

Restrictive Intervention describes a use of force to limit the movement and freedom of an individual and can involve bodily contact, mechanical devices or changes to the person’s environment. Such interventions can be:

- Highly Restrictive i.e. severely limit the movement and freedom of an individual
- Low Level Restrictive i.e. limit or contain the movement and freedom of an individual who is less resistant with low levels of force

Non-restrictive Intervention allows a greater degree of freedom where the individual can move away from the physical intervention if they wish to. This would include prompting and guiding an individual to assist them walking, also defensive interventions such as disengagement for protecting oneself or others from assault.

Least Forceful Aversive Intervention describes the physical intervention with the least force and potential to cause injury in achieving the given objective.

Employer covers public and private health services managers and companies providing contract security officers.

Security Officer includes those persons employed in healthcare, either directly in house or supplied under contract, who undertake duties to protect patients, visitors, staff and assets. Other healthcare employee’s jobs may contain dual roles and encompass security duties, such as portering services. Therefore, in addition to dedicated security officers, this guidance may also apply to those roles that have a partial responsibility for security, and as part of this, it has been identified that physical intervention may be required in their role.



Stakeholder includes patients, employees, relatives and visitors, contractors and suppliers, regulatory bodies including the NHS SMS, HSE, Care Quality Commission (CQC), local authorities and other agencies. These include, and are not limited to, the police, health service professional and representative bodies, such as the Royal College of Nursing, Unison, National Association for Healthcare Security (NAHS), and local communities.

Intervention

In health services, security intervention will often be at the request of, or directed by, a clinician using one or more of these options:

- Manual – in which a person is held
- Chemical – the administration of a drug orally, or by intravenous or intramuscular injections as with rapid tranquilisation
- Mechanical – typically using equipment to wholly or partially immobilise a patient.
Can also include blocking, or locking a door

Services and organisations differ in their policies and expectations of the security officer in terms of their involvement in clinical situations and physical intervention. It is vital that there is clarity on these issues, and that both security and clinical staff have a shared understanding and appropriate training on an ongoing basis. It is important that as far as is practicable staff share a consistent skill set if expected to operate together in a restraint.

It is critical that unless the situation is extremely serious, i.e. there is an honestly held belief that there is imminent risk of injury to the patient, or others, security officers should not perform any degree of physical intervention on a patient unless under the direction of a clinician. There will be occasions outside the clinical setting in which security officers must decide whether or not to intervene. The legalities of this and risk considerations must be incorporated into their training, as well as working protocols. It is vitally important that security officers are trained, understand their organisational policies and why it is often safer not to physically intervene.

Relevant Common Law and Statutory Legislation

Separate legislation applies to the member countries of the United Kingdom. Key aspects of the legislation applicable in England are summarised below.

Common Law

Common law has the established principle of ‘duty of care’. This often forms the basis of civil actions/compensation claims and is an important factor in deciding the need, and recognising the consequences of physical intervention. Common law allows reasonable force to be used where necessary in:

- The removal of trespassers
- Protecting life
- Self defence.

The Criminal Justice and Immigration Act 2008 (Sections 119 & 120)

This contains provisions for NHS staff to deal with nuisance or disturbance behaviour that is caused on English NHS Hospital premises. Section 119 creates a criminal offence of causing a nuisance or disturbance on NHS hospital premises, and section 120 provides a power for police constables or authorised NHS staff to remove a person suspected of committing this offence. The use of Section 120 (power of removal) is voluntary, and should only be considered as a last resort if all other efforts to deal with the behaviour prove unsuccessful. However, when the power is considered for use, particular attention should be paid to recognising potentially vulnerable people and ensuring they are not removed from the premises. It is important to note that the legislation does not apply to patients, or those individuals on NHS hospital premises for the purpose of obtaining medical advice, treatment or care for themselves.



The 2005 Mental Capacity Act

This is an important foundation in determining the need for physical intervention. It is underpinned by five key principles:

- A presumption of capacity to make decisions unless proved otherwise
- Individuals being supported to make their own decisions
- An unwise decision should not result in an assumption that the individual lacks capacity
- An act carried out under the Act must be in the interests of the individual
- Least restrictive options should not restrict basic rights and freedoms

The 2007 Mental Health Act (amends the Mental Health Act 1983)

Among the fundamental principles of the 1983 Act that are relevant to this guidance are:

- Respect for patients' past and present wishes and feelings
- Respect for diversity generally including religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006)
- Minimising restrictions on liberty
- Public safety
- The deprivation of liberty safeguards were added to the Mental Capacity Act 2005 by the Mental Health Act 2007

Health and Safety Legislation

- The Health and Safety at Work Act (HSAW) 1974, which establishes a statutory duty of care on both employers and employees
- The Management of Health and Safety at Work Regulations (MHSWR) 1999, specify actions to be taken by employers in assessing and controlling risks
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995, requires certain serious incidents to be reported to the enforcing authority
- The Corporate Manslaughter and Corporate Homicide Act (2007) dictates that an employer can be found guilty of corporate manslaughter as a result of serious management failures resulting in a gross breach of a duty of care
- The Personal Protective Equipment at Work Regulations (PPE) 1992 governs assessment, suitability and use of PPE

Employment law

Employment law also considers health and safety cases and specifically:

- S.44 of the Employment Rights Act (ERA) 1996 establishes health and safety as a shared responsibility of employers and employees
- Contract law imposes obligations on the employer in providing a workplace with minimal exposure to risk

Security Regulation

The Private Security Industry Act 2001 sets out duties upon the Security Industry Authority (SIA) that include ensuring persons who engage in licensable conduct:

- Are fit and proper to engage in such activity
- Have the training and skills necessary to engage in the conduct for which they are licensed

The SIA operates across the UK and has established communication and conflict management as a core training competency within its licence to practise for security guards. In 2010 the SIA introduces a level 2 qualification requirement in physical intervention for the private security industry that will be mandatory for new door supervisors and an option for licensed security officers.



Human Rights Act 1988 and the European Convention on Human Rights

While the Human Rights Act focuses on 'public authorities', its principles have developed into wider individual responsibilities. Physical Intervention is relevant to:

- Article 2 – Right to life
- Article 3 – Prohibition of torture, inhumane or degrading treatment
- Article 5 – Right to liberty
- Article 8 – Right to respect for private and family life
- Article 14 – Right to freedom from discrimination in respect of convention rights
- Lawfulness necessarily includes compliance with the Human Rights Act 1998

Interference with the individual's human rights must be necessary, legitimate and proportionate to the aim being pursued. If force is not proportionate, then this may amount to a breach of Articles.

Secretary of State's Directions

The Secretary of State for Health has issued various 'Directions' on Measures to Deal with Violence against NHS staff (2003), and Directions to NHS bodies on security management measures (2004). The remit of the SMS is to provide the best protection for its patients, staff and property with the remit to develop policy and operational responsibility for the management of security in the NHS.

- Requires employers to list measures to deal with violence and aggression against staff and suppliers of services to the NHS
- Specified the establishment of the Legal Protection Unit to help with legal advice
- Established a national reporting system
- Published a National Syllabus on Conflict Resolution training
- All NHS bodies have to appoint an accredited local security management specialist with support from an executive director on the board
- SMS has subsequently issued sector specific conflict resolution training specifications for Therapeutic Services (PSTS) and Ambulance Services

Other Legislation and Requirements

Employers will need to consider various pieces of legislation, for example, the Children Act 2004 and the Corporate Manslaughter and Corporate Homicide Act 2007. The Care Quality Commission sets requirements to safeguard service users from abuse and its Outcome 7 makes specific reference to restraint. This is underpinned by the Health and Social Care Act (Regulated Activities) Regulations 2008.

Case Law

Case law is continually developing and in particular in relation to vicarious liability. This has shown how health bodies may, in certain circumstances, be held responsible for the actions of security officers, even if they do not directly employ them. The Court of Appeal ruling in *Hawley Vs Luminar and ASE* 2006 illustrates this well.

Violence Risk Management

Work related violence is a complex risk to manage because of the many factors that can contribute to escalation and possibly assault. Some of these factors can be controlled and employers and employees can influence, such as the interaction between staff, patients and visitors. Physical intervention may be necessary in certain situations when despite other control measures, a significant residual risk of assault remains.

The decision to teach physical intervention and the scope of such training needs to be underpinned by an objective assessment of the risks. Clarity over the policy, procedures and role expectations is essential and any such training needs to form part of a balanced strategy that emphasises prevention rather than intervention.



This guidance therefore considers physical intervention in the context of risk assessment, alternative strategies and supporting policy and guidance. This guidance therefore considers physical intervention in the context of risk assessment, alternative strategies and supporting policy and guidance. The goal of employers should be two fold:

1. To reduce the need for physical intervention and the use of restraint in particular
- 2 To reduce risk when such interventions are necessary through effective training, guidance and supervision

Key Messages

- The purpose of this guidance is to help employers recognise how they can better protect staff, patients, service users and the organisation through reducing the need for physical intervention and encouraging appropriate training and safe practice
- Training and guidance in violence reduction and management should sit within a wider strategy and health care system that responds effectively to the needs of patients and visitors and thereby reduces much conflict and risk
- Health bodies employing in-house and contracted security officers are legally obliged to ensure the safety of their employees, contractors, patients, service users and others using their premises
- In the health setting, security contractors have a duty of care to ensure that their employees are adequately trained and equipped to perform their role and responsibilities
- Health bodies may, in certain circumstances, be held responsible for the actions of security officers, even if they do not directly employ them
- Security officers have a key role to play in creating a safe and secure environment for staff, patients, service users and visitors
- Physical intervention should be seen only as a last resort and one part of a broader strategy to manage behaviour of those who pose a risk to their own safety or the safety of others

Assessing Risk

Employers are required by law to assess the risk of violence as they would any other workplace hazard. This is the start of an objective process that informs control measures including training.

As well as assessing the risk regarding violence in the context of health and safety, health bodies must assess risk in the context of the clinical services provided and related legislation and guidelines. The threat of violence must be mitigated in the promotion of crime and disorder prevention, public safety, public nuisance and the protection of vulnerable adults and children in healthcare premises.

There are different types of risk assessment helpful to assessing the risk of violence and these broadly fall under planned or dynamic risk assessment.

Planned Risk Assessment

A 'planned' assessment should be undertaken and reviewed at set intervals in accordance with health bodies' policies on risk assessments by designated individuals. It is important that employers clearly set out responsibilities in terms of who undertakes what level of assessment, how and when. Recording systems and tools need to support this process. They must be effective in distilling key management information in relation to the risks of violence and where necessary evidence the need for further improvements/controls. Risk assessments should be recorded on organisational risk registers.

Planned risk assessments should be carried out by departmental managers, in conjunction with the security manager and/or an NHS local security management specialist and health and safety officer. In conducting planned risk assessments it is important to analyse reported incidents and near misses, and to identify common events along with their frequency. The value of this information will depend greatly on the quality and consistency of reporting. It is therefore important to consult with staff that are at risk, plus other staff groups, subject matter experts and service users to ensure a balanced picture.

In planned risk assessments employers will consider for example:

- Incident reports, near misses and trends
- Root causes
- Policy and role expectations
- Environmental factors
- Patient / service user considerations
- Tasks and activities performed by the role

For a healthcare security officer there can be significant risks, for example:

- Dealing with highly emotive situations where individuals may be frustrated or angry with the service provided or are distressed following bereavement
- Intervening in disputes
- Refusing access or declining service
- Preventing a patient leaving on the direction of clinical staff
- Requesting people to leave the premises
- Enforcing rules such as a no smoking policy or parking restrictions
- Citizens arrest
- Restraint of a patient in a clinical context
- Restraining someone experiencing severe mental illness and / or learning disability / autistic spectrum disorder who may continue to struggle for prolonged periods
- Coming into contact with bodily fluids.



The risk assessment needs to consider the risks relating to service users. There can for example be a risk of injury when dealing with unpredictable behaviour from patients whose clinical condition or response to treatment can unintentionally result in a blow, from a flailing arm for example. Such behaviour can result from a range of conditions including trauma such as head injury, substance abuse, hypoglycaemia and hypoxia, or through an adverse reaction to medication or during post operative recovery.

Although most individuals with mental health issues or learning disabilities present little risk to staff there are times when they may be particularly confused and vulnerable and present a risk to themselves and occasionally others. It is important that security officers are provided guidance by their employers on their interactions with such potentially vulnerable groups and are made aware of appropriate sources of information such as care plans in helping to understand patient needs and in reducing risk.

There will also be site specific issues and risks that need to be considered, such as an accident and emergency department or a ward presenting specific risks. These could include:

- Location and aspects of environmental design
- Access control
- Layout that create flashpoints
- Availability of public amenities
- Availability of dangerous fixtures, such as ligature fixing points
- Remote or confined spaces that isolate staff and restrict restraint
- Client group
- Competency of clinical and non-clinical staff in conflict resolution
- Availability of trained healthcare security officers

Major incidents and events can dramatically impact on the risks, and specific risk assessments need to be undertaken for these, with controls measures planned and implemented. Major incident planning should always involve the health body emergency planning officers (EPOs) in conjunction with local authority EPOs and the Police. An example of an event assessment is a planned New Year Eve's major event in a city centre, which could impact on the city hospital's accident and emergency department with many minor injuries presenting, but aggravated by heavy consumption of alcohol and/or drugs.

Environment and premises specific assessment

Planned risk assessments will identify specific risk factors relating to the premises that need to be addressed. These could include the location, and aspects of design and layout that create flashpoints, hazards such as stairs and escalators, remote or confined spaces or reception areas. Staff should be consulted as part of the risk assessment process to ensure that all hazards and risks are identified.

Consideration should also be given to security measures that can contribute to the reduction of the risk of violence. This may include early warning or detection systems, where staff may summon help should they believe they are in imminent threat of violence. These include CCTV, static and personal alarms, central monitoring systems, raised counters and screens, adequacy of lighting, positioning of reception areas or nursing stations to provide a clear unobstructed view, safe areas. A review of minimum staffing levels, times of demand on the service, and opening hours will also contribute to the risk assessment.

Dynamic risk assessment

Situations can unfold quickly and an accurate dynamic (situational) risk assessment by staff will help them to decide on a sound and justifiable course of action. Dynamic risk assessment is especially relevant in addressing the risks of conflict and violence as the outcome of an interaction can usually be influenced by staff responses. These situational assessment skills need to be developed and reinforced through all levels of training and practice.



All risk assessments should be regularly reviewed to ensure the risks identified were accurate and appropriately mitigated for and/or the risk environment has changed.

Debrief and Post Incident Review

Incidents and near misses provide valuable learning that should continually inform risk assessments and evaluate controls. Line managers, health and safety officers and security managers need clearly defined roles and responsibilities in the aftermath of an incident. They also need the tools and understanding to be able to conduct a professional and sensitive review of an incident. Reporting and learning from incidents is addressed in further detail on page 16 of this guidance.

Key Messages

- Effective violence risk assessment is the key to a successful violence prevention strategy
- Planned risk assessments will help to inform decisions on the control measures necessary to reduce the risk of violence
- Certain tasks and activities that carry inherent risks should be identified within the risk assessment and considered in line with related policy, role expectations and guidance
- Dynamic risk assessment of situations will help staff to respond appropriately to a developing situation and minimise the risk of escalation
- Incidents and near misses need to be professionally and sensitively reviewed to ensure personal support and learning from root causes to inform risk assessments/controls

Reducing Risk

Identifying underlying causes

Consulting all staff groups, patients and service users during risk assessments is vital in developing a truer picture and in establishing the underlying root cause of incidents. This will provide the insights necessary to tackle the causes of conflict and factors that fuel escalation and risk.

It is often the case that front line staff will suggest simple, creative and cost effective solutions to the problems they are facing. They are also more likely to embrace safe working practices that they have contributed to and view to be workable.

Identifying causation is critical to minimising and preventing violence and aggression and then developing control measures. One method of establishing root cause is the 'five whys?' approach, for example:

Q. Why have incidents increased?

A. Because of confrontation caused by a lack of control in the accident and emergency department waiting room, on Friday and Saturday nights, following fights in the town centre.

Q. Why did these occur?

A. Because people associated with the injured, who gained entry to A&E, continued being violent when treatment was administered to their friends.

Q. Why were they allowed in?

A. Because security staff were not warned in advance by police or ambulance crews and access to the department was not monitored and controlled.

Q. Why did they become so aggressive?

A. Because of the seriousness of the injuries sustained to their friends, because they were uninhibited whilst under the influence of alcohol and drugs and due to a lack of security officers situated within the A&E department.

Q. Why were security staff not warned in advance?

A. Because there are no communication protocols between healthcare security staff, police and ambulance crews. The injured from rival groups were not separated before arriving at hospital and the police did not appreciate the capabilities or role of the security staff.

Control Measures

For the purposes of this guidance we will consider three levels of control measure:

Primary controls refer to action that can be taken to prevent conflict situations arising or reduce their likely frequency. Primary controls tend to be planned and address the root causes of frustration and conflict.

At an organisational level this includes establishing policies, communication protocols and safe systems of work, carrying out risk assessments, delivering good service, addressing architectural and environmental design, access controls, staffing levels and providing staff with necessary training.

At an individual level primary controls involve understanding the risks, delivering positive service, complying with safe practice guidance and putting training and learning into practice. Preventative action also includes reporting and recording incidents so as to learn from what happened and prevent recurrence. Preventative action is a continuous process of improvement rather than a finite work project. In therapeutic settings where an ongoing relationship exists with a patient/service user, the individual care plan is a key element in the prevention and management of violence and aggression.

Secondary controls focus on action taken by staff to prevent conflict escalating to violence. It typically involves the use of communication and conflict management skills, defusing and calming strategies, or team tactics to de-escalate and normalise a conflict situation.

Tertiary controls refer to action taken when violence is occurring and after it has occurred to prevent or reduce the potential for physical and psychological harm. Typically this will involve disengagement or other physical intervention tactics, invocation of emergency procedures or implementation of exit and containment strategies. Tertiary response



includes providing post incident support for the victims and managing the situation through to recovery. Incident reporting, review and learning will provide feedback for review of primary preventive measures in a continuous improvement cycle. Tertiary measures will be needed less often if effective primary and secondary controls are in place.

Returning to the 'five whys' example above:

The **primary response** to tackle the root cause of the incidents in the accident and emergency department waiting area could include ensuring that formal communication protocols are established with the police and ambulance services. Helping the security staff to control access, for example, to a limited number of those associated with the injured. Improved physical access controls to treatment areas will also help considerably and should be developed in conjunction with clinical staff.

The **secondary response** would involve staff being proactive in service delivery, for example communicating with relatives and friends by updating them on the condition of their friends and assisting security and Police in dispersing them.

A **tertiary response** could involve training staff in skills for protecting against assault and ensuring incidents are reported and followed up.

'Five whys?' assist in identifying the root cause(s) of the problem and helps identify primary and secondary strategies for reducing the risk. Primary exposure to risk should be reduced as far as reasonably practicable. If for example most assaults occur when intervening in disputes or ejecting problem visitors, one needs to understand why these situations are arising and identify ways of preventing them.

When the root cause of a problem is tackled through non-physical preventive controls, incident frequency can be reduced. Where a significant 'residual risk' remains, tertiary level controls may be needed and should be prepared for.

Key Messages

- Front line staff and where possible patients and service users, should be consulted during the risk assessment and actively involved with the development of ideas on how things can be improved
- Underlying causes of conflict should be identified and eliminated so far as is practicable
- Where violence risks cannot be controlled through primary and secondary measures alone, staff may require physical intervention training supported by emergency response procedures

Policy and Guidance

Policy formation

Where work related violence is a significant risk it is important that an employer has policy and guidance on its prevention and management. The policy needs to set out the employer's commitment to tackling this issue and in supporting staff, and should consider primary, secondary and tertiary controls. It should clarify expectations upon managers, staff, patients and visitors as to their contribution towards a safer environment. It should outline the measures required for physical or clinical intervention involving the elderly, the mentally ill, those with learning difficulties and other vulnerable adults and children and young people while in care.

The NHS SMS have produced policy templates for NHS bodies in England, for preventing and managing violence and aggression and for lone workers. These templates can aid NHS bodies in the development of their own local policies. The NHS Litigation Authority also request that specific areas are addressed within policies.

Incident and post incident management

In addition to setting out responsibilities for the assessment and reduction of risk, the policy will need to cover the eventuality of a violent incident and any harm caused, whether deliberate or otherwise. It is important that this possibility is acknowledged, prepared for and rehearsed to ensure an incident can be contained and its impact on all stakeholders minimised.

For these purposes, policy needs to be supported with specific guidance on incident management. Incident management protocols should establish emergency communications (internal and external) and leadership and support roles. Medical emergencies need to be planned for, safe havens identified as well as sources of support.

As for fire evacuations and major incidents, it is important to rehearse and test violence incident management procedures. This will ensure understanding among staff in their specific roles and test that communications are working and that plans are realistic. Others such as Nurse Managers, EPOs and the emergency services should be consulted and involved.

Positive relationships with local Police and Crown Prosecution Service are important in terms of reducing crime, disorder and anti social behaviour. It is also important that staff and local police know what is expected of each other should an incident occur. A positive relationship will reduce problems and help ensure successful sanctions and prosecutions. The NHS SMS have overarching concordats with the Association of Chief Police Officers and the Crown Prosecution Service, and it is important that protocols are developed at a local level to ensure collaborative working.

Supporting employees, patients and visitors post event

Individuals respond differently to violence and assumptions should not be made about their resilience, no matter how confident they normally appear. Sustained exposure to low-level abuse and intimidation can cause stress and an assault or serious threat of assault can traumatise the most experienced of staff.

It is therefore vital that staff receive support following a violent incident from their peers and managers and that they have access to independent and professional help where needed, for example, through their occupational psychologist or counselling service. Patients and visitors may also be traumatised through experiencing or witnessing such an incident and the healthcare body needs to consider its duty of care towards them.

Line managers are a key source of support following an incident and should facilitate support in the immediate aftermath and mid to long term. Support should focus on an individual's needs and care should be taken to avoid creating further anxiety, for example, through inferring blame, or not acknowledging the impact of the incident on the individual. Victims of violence and their colleagues or relatives will remember how managers supported them and this is a test of leadership. Colleagues/relatives are another important source of support and managers can encourage this.

The employer's policy should set out roles and responsibilities post incident and establish support during any absence and on return to work. Support whilst off work and on return to work are critical to aid rehabilitation and the return of confidence.



Sanctions and prosecution of violent individuals

The healthcare body needs to define the levels of expected behaviour and the sanctions available when these are broken. Employers need to be aware of the legal remedies and powers available for dealing with harassment and anti-social behaviour. The police and local authorities have specific responsibilities and in some areas powers with regard to crime and disorder and community safety, and these should be utilised.

Identification and successful prosecution of those that commit offences depends in part on securing intelligence, evidence and witnesses. Staff and managers should ensure that incident scenes are managed and evidence professionally presented. Consideration must be given to clinical opinion where this indicates that the behaviour was directly caused by a medical condition, treatment or adverse reaction to treatment as such cases may not be suitable for criminal sanction.

For the NHS in England, advice may be sought from local security management specialist and the NHS SMS legal protection unit.

Policy should set out responsibilities in terms of prosecution and the level of support that will be provided to staff in terms of legal advice, financial support and personal support during any investigation or proceedings.

Reporting and learning from incidents

There may be a legal requirement to report certain serious violent incidents to other organisations. For dangerous incidents, or those that result in three or more sick days from work, the incident should be reported to the HSE under RIDDOR regulations.

Other serious incidents involving violence may need to be reported to other agencies including the NHS National Patient Safety Agency, Care Quality Commission and NHS Strategic Health Authority. There is also a requirement for English NHS bodies, under Secretary of State's directions, to report physical assaults to the NHS SMS. Non-physical assaults will also need to be entered in the security incident reporting system (SIRS) when directed by NHS SMS.

It is important that employers capture information on all violent incidents so that these may be learnt from. Incident reports will inform the ongoing risk assessment process and may also provide added protection for staff and the employer in any subsequent legal action. Incidents are commonly underreported and there are a number of reasons offered for this including the perception that:

- Violence comes with the job
- You never get any feedback
- Nothing will change so it's a waste of time
- Reports are confusing and time consuming
- Budgets are tight, no money is available.

These perceptions need to be overcome and simple steps include:

- Challenging beliefs. Violence is not acceptable and should not be regarded as part of the job
- Emphasising the importance of reporting incidents and the benefits to staff
- Learning how to complete reports during training
- Designing a simple and relevant reporting mechanism that can provide important management information
- Ensuring managers at local and corporate level actively encourage reporting and provide tangible support and feedback to staff and are equipped to play their part in a detailed review of an incident and subsequent follow through
- Promoting successful actions and changes that have resulted from staff reports.



Multi purpose incident reports are naturally limited in terms of gathering specific information on violent incidents. In an area of work where conflict and violence are major issues it makes sense to have a reporting and monitoring process designed for purpose. Security staff should ensure that incidents are reported in line with their organisation's reporting policy.

Balancing Roles: Support and Investigation

In the immediate aftermath of an incident there is much to do and remember and emotions run high. Prompt support should be provided to the department concerned as key managers, staff, patients and visitors may have been involved and/or were affected by the incident. The security manager / local security management specialist will support this process. This balance will be easier to manage if problem staff attitudes and behaviours are addressed proactively by managers – before it goes wrong. Managers may benefit from training in these challenging areas of their role.

Key Messages

- It is vitally important for organisations to have an effective policy to address work related violence. This should be supported by executives and reviewed on a regular basis
- Good policy formation will involve consultation with everyone who is affected by the issue. It will clearly outline the organisation's stance on violence and send a powerful message to staff that the business is committed to their safety and welfare
- From this strategic level policy, departmental or team procedures must be developed for specific areas. For example, an accident and emergency department or mental health ward should have developed and implemented their own specific procedures, highlighting their local risks
- Employers need to prepare for potential incidents to help ensure they are managed professionally and staff are supported in the aftermath
- Preparation should include rehearsing incident responses and involving other agencies in this such as police and ambulance personnel.

Assessing Training Needs

Where security functions are provided under a contract, it is a legal requirement for security staff to hold a valid SIA licence. Training to deal with conflict will have been provided as part of the training for the licence. This sets a minimum requirement and should be supported by company and healthcare / site specific inductions. Conflict resolution training (CRT) and promoting safer and therapeutic services (PSTS) training (for mental health environments) are mandatory for all front line NHS staff in England.

The SIA has also set a requirement for security personnel applying for a door supervision licence to undertake a level 2 qualification in physical intervention that is approved by an SIA endorsed Awarding Body. This will be an optional unit for private security officers.

All private security personnel supplied to NHS trusts must hold a valid SIA licence. The NHS Security Management Service strongly recommends that such individuals also achieve the SIA endorsed Level 2 Unit of Qualification 'Physical intervention skills for the Private Security Industry'. This qualification along with training in the NHS SMS CRT syllabus will provide a basic foundation that can be enhanced as required by specific employer/service based risk assessments and training needs analysis. The latter may identify a need for additional training to ensure that security and clinical staff have a consistent approach where they are likely to operate together during restraint.

Some Hospitals employ security staff directly in-house. In these circumstances where risk assessments dictate that training in physical intervention is necessary, NHS SMS recommends that the NHS body should ensure that their security staff undertake training that is equivalent, as a minimum, to the SIA licence linked level 2 training in physical intervention. It is preferable that such training is accredited by an awarding body, or relevant professional body such as BILD in the case of a learning disabilities setting. This will again provide a basic foundation that can be enhanced as required by specific local needs. It is acknowledged that training for in-house NHS security teams, may be delivered either by the NHS bodies own in-house clinical physical skills training department, or by an external training provider.

Relevance

Training has to be relevant and commensurate with the risks faced. It should identify and address common risks, such as preventing assaults related to a patient's clinical condition and not just focus on malicious threats from patients and visitors as 'Breakaway' training traditionally has. This may require the teaching of different strategies, as skills that can contain a confused patient may not be appropriate or effective when applied to an individual that is able and intent on harming themselves or others, and vice versa. Where security officers are expected to restrain individuals, for example, under clinical direction to allow essential treatment or rapid tranquilisation, training should cover appropriate input on procedures and techniques. The risk assessment process described in this guidance will provide key information to underpin training needs analysis. Training itself carries a risk of injury, further reinforcing the need for an objective basis to decide which staff need training in physical intervention and to what level.

It is important for employers to understand that training is one of a range of control measures in reducing work related violence and will have limited impact if introduced in isolation. Training must be supported by policy and safe practice guidance. It is not uncommon for reported incidents to increase following training as staff better understand the need to report and how to do so.

Support roles

This guidance focuses upon the role performed by security officers, whether employed in house or under contract. All employees have a part to play in reducing risk and roles and responsibilities need to be clear. It is therefore important not to examine the learning needs of security officer in isolation. Different functions and roles need to be clear as to what can be expected from each other in relation to the prevention and management of violence. Care must also be taken to ensure consistency in training messages and skills sets. Staff inductions, coaching and training must reinforce the roles and responsibilities and safety issues. Loneworking should be considered from a personal safety perspective and appropriate training and lone worker communications established.



Training needs analysis (TNA)

Factors that need to be considered in a TNA for violence include:

- Risk assessment findings
- Employer and healthcare provider policy
- National Guidance from organisations including the NHS SMS, SIA, National Institute of Clinical Excellence (NICE), National Institute of the Mental Health Environment NIMHE) and member organisations such as Unison, NAHS and the Royal College of Nursing. Additional guidance is provided in the member countries of the United Kingdom and by the European Council.
- Specific tasks and activities performed
- Service user / patient considerations
- Analysis of reported incidents
- Existing knowledge base and skills of staff

This process will highlight the knowledge and skills gap, which will then identify the training need. For healthcare security officers, these are broadly divided into two areas of physical skills training:

1. Defensive skills: Non-restrictive physical skills to help avoid and protect (oneself or another) against unlawful assault and enable disengagement. Certain guiding skills may also be non-restrictive

2. Holding skills: Restrictive interventions that include escorting and restraint

Staff should not undertake training in physical skills unless they have first trained in primary and secondary prevention including conflict management skills. Within the NHS this should include the relevant NHS SMS CRT and PSTS training programmes.

Trainers need to have undergone the relevant NHS SMS familiarisation for the NHS CRT syllabus they are delivering and should be able to evidence continuing professional development. The British Institute of Learning Disabilities (BILD) accredits training in physical intervention and sets high standards for accredited organisations that provide this in learning disabilities settings. Research, standards and regulation of this area of training are constantly evolving and employers need to keep up to date to ensure compliance.

Where physical intervention training is necessary it needs to refresh and reinforce primary and secondary controls. The employer's training needs analysis will identify the specific emphasis required for such training and the following areas should be considered in this:

Underpinning knowledge

- Legal position on the use of force and how to report and account for actions
- Dynamic risk assessment and decision-making including impact factors, warning signs and danger signs
- Potential medical implications of physical intervention including restraint
- Medical emergency protocols including First Aid and Basic Life Support
- Alternatives to physical intervention; refresh primary and secondary controls
- Incident management and emergency communications and protocols
- Positive communication, de-escalation and exit strategies
- Teamwork, leadership and communications

Defensive skills

- Positioning and movement skills
- Skills for avoiding identified risks of assault
- Protection against most likely blows and kicks



- Releases from most likely grips (disengagement / breakaway skills)
- Rescue and separation skills.

Holding skills

- Non-restrictive interventions i.e. guiding and escorting skills
- Restrictive interventions can include:
 - Restrictive escorting
 - Standing holds
 - Seated holds
 - Ground or horizontal holds e.g. on a trolley or bed.

The selection of skills will be influenced by numerous factors including policy, role expectations, task analysis, service user considerations and risk assessment findings. It is important that techniques are kept to the minimum and chosen because of their relevance to the tasks undertaken and risks actually faced.

Additional areas to be considered in training needs analysis:

- Awareness of potential weapons including edged and concealed weapons
- Searching procedures and safe methods
- Training and guidance on equipment used, for example, communications equipment, protective equipment and mechanical restraint e.g. hand cuffs – if issued
- Training in the management of specific patient/service user groups, for example, children, older people or vulnerable adults
- Skills sets used by other staff groups within the same service

Duration of training

The duration of physical intervention training will be influenced greatly by:

- Level/extent of the training required i.e. just disengagement, or full restraint training
- Skill set taught i.e. complexity and number of techniques
- Training methodology i.e. is delivery solely course based
- Group size / supervision ratio
- Existing knowledge, skills and abilities of staff i.e. previous training in conflict management
- Pre course study e.g. of underpinning knowledge

These factors can influence the duration of training that can range between one and five days. SIA Licensed security officers and many in house staff will have had previous training in communication and conflict management and in some cases physical intervention. It should be noted that SIA competency requirements relating to physical intervention do not include horizontal restraint skills and risk assessments may identify a need for training and guidance in these. In other words it should not be assumed that holding an SIA Licence constitutes sufficient training for the role and setting.

Additional training in physical intervention should refresh and build upon primary and secondary skills and strategies in reducing the need for intervention.

Refresher training

Physical skills can fade over time with potentially serious consequences, so it is important to ensure that competency is maintained. Employers need to establish a training process and plan that ensures staff refresh their skills regularly, for example, through workplace practise and coaching. Staff should also undergo formal assessment and recertification of knowledge and skills within a pre-set period to ensure competency is maintained, this is typically undertaken during tutor led training courses.



The frequency and duration of staff refresher and recertification training will be influenced by factors including:

- The type of skill set taught in terms of complexity, number of techniques, associated risk levels and training method
- The frequency with which skills are used and practised in the workplace

This training should be planned ahead and form an integrated part of the employer's continuing professional development process for staff. It is vital that trainers also refresh and revalidate their knowledge and skills and the SIA requires this to be undertaken on an annual basis.

Employers need to provide guidance on workplace practice of skills, as risks can increase if a trainer is not present. The guidance will consider, for example, safety considerations, supervision, recording and monitoring of such activity. Injury rates during initial, refresher and revalidation training need to be continuously monitored and acted upon, as does any operational use of physical intervention.

Medical implications

Reference is made throughout this document to the potential medical implications surrounding physical intervention, which can include restraint related death. Staff need to be informed of the risks associated with any physical skills they are taught and how these can be minimised.

Even where training focuses on less aversive skills, it should provide an understanding of the potential risks of intervention and especially those of restraint related death associated with restrictive intervention. Additional input should be provided where it is foreseeable staff will come into contact with vulnerable groups, for example, children and young people, and older people. Physical intervention techniques should be taught that are appropriate for such groups. The physical fitness and risk of injury to the staff being trained should not be overlooked.

Use of force

Many security staff will have covered use of force and citizen's arrest in their training either as private security officers towards their licence-linked training, or through employer based training.

Understanding of these areas of law should be refreshed and expanded during any training in physical skills, particularly how to justify such action. The statutes (and common law) governing use of force must be read in conjunction with the Human Rights Act and amongst others the principles of proportionality and necessity. For example, are there viable alternatives to using force and if it is necessary is the force used proportionate to the wrong that it seeks to avoid or the harm it seeks to prevent? Is the use of force chosen the least intrusive or damaging practicable option? The higher the level of force the greater the justification required.

In clinical settings staff often operate within Common Law out of necessity to prevent a patient/service user coming to harm. In such circumstances staff should work closely with clinical colleagues and consider the best interests of the patient and staff safety.

Employers must provide policy and guidance on matters such as citizens arrest and use of force, but this should not affect the lawful rights of employees to protect themselves or others from imminent harm.

Staff may have to account for any use of force in the courts. They will need to know the legal authority for their actions and be able to explain why these were necessary, reasonable and proportionate in the circumstances. Staff training should focus on the principle of using the least forceful intervention practicable in achieving the desired objective.



Key Messages

- Training must be relevant to and commensurate with the risks faced, which may range from managing a confused patient to dealing with an aggressive individual intent on harm. The risk assessment process described in this guidance will provide key information to underpin training needs analysis
- Staff should not undertake training in physical skills unless they have first trained in primary and secondary prevention including conflict resolution training relevant to the specific sector in which they operate. Staff should be encouraged to apply these skills throughout physical intervention training
- Physical intervention training should cover the legal and medical implications of use of force and especially the risks associated with restraint
- Training needs to respond to the needs of vulnerable groups staff will come into contact with for example, children and young people, older people, and individuals with mental health problems or learning disabilities
- Training itself carries a risk of injury, further reinforcing the need for an objective basis to deciding which staff need training in physical intervention and to what level
- The learning needs of staff in non security roles should be established to ensure they are clear on their important preventive and supporting roles. Cross training may be required to ensure that staff in security and clinical roles have a consistent approach where they may need to work together during restraint
- Physical intervention skills must be refreshed regularly and training formally assessed and recertified at set intervals
- Training is an important control measure that needs to be part of an integrated violence risk management strategy

Selecting and delivering physical intervention training

Approaches to physical intervention

There are many models and approaches to physical intervention, as there are training providers. It is not the remit of this guidance to set training standards or recommend specific approaches to physical intervention.

The quality of training will vary and it is important that the employer chooses its provision with care. Physical skills vary in complexity and risk and there is limited research and much debate on the relative merits and effectiveness of approaches.

A highly aversive intervention carries substantial risk to all parties, for example, a strike or ground restraint. These may be lawful in extreme circumstances and where such restraint is foreseeable staff need to be taught safe methods and awareness of risks. Training should also however equip staff with lower risk options including less aversive strategies for disengagement, escorting and holding.

Areas that an employer can consider when selecting a training approach include:

Relevance: The relevance of the skill set to the role, tasks and activities performed

Flexibility: The balance and problem solving potential of the programme of skills in responding to day-to-day working practices and occasional high-risk incidents

Simplicity: The ease with which the skill set can be learnt and recalled under stress, based upon a minimum of techniques

Philosophy: The ethos and emphasis of the training, trainer and provider

Safety: The potential medical risks associated with both staff training in the skills and with their operational use. The appropriateness of the techniques for use with vulnerable groups

Effectiveness: The operational effectiveness of the skills applied by both male and female staff of varying experience and aptitude. An effective reporting process will help provide such information

If staff are likely to manage events involving children and young people it is important to establish that the skill set taught is appropriate for use.

Selecting trainers and providers

When selecting trainers and/or choosing an external provider it is important to consider their:

- Understanding and emphasis on primary and secondary controls
- Track record, experience and specialism in this field
- Knowledge of the healthcare sector
- Trainer qualifications and professional development process
- Quality assurance process
- Service commitment, resilience, reliability and safety record
- Rigour in training needs analysis and training evaluation
- Credibility and experience as expert witnesses
- Risk assessments of physical skills, including medical and legal reviews
- References and evidence of tangible results with other employers, for example, in reduction of complaints, assaults and restraints

Certification of training by awarding bodies is increasingly important, especially in this area of health and safety training where it adds further rigour and credibility. BILD as a professional body also provides a voluntary physical intervention accreditation scheme that expects high standards from providers.

The SIA has set specific requirements for trainers and training programmes concerned with the delivery of licence-linked qualifications:



1. Trainers must hold recognised qualifications in training delivery i.e. a teaching or training qualification equivalent to PTLLS accredited by Ofqual, SQA or endorsed by the HE Academy. They must also hold a Level 3 qualification (or above) in the delivery of conflict management training. If delivering the SIA related unit of qualification in physical intervention trainers need to hold a Level 3 Unit of Qualification in the delivery of physical intervention training, or an approved equivalent
2. Trainers can only deliver a physical intervention training programme that has been approved by an SIA endorsed Awarding Organisation to an SIA approved criteria

NHS bodies or security contract companies must ensure that they seek assurance on the qualifications of the individual providing the training.

NHS SMS recommends that all trainers delivering training in relation to conflict resolution and physical intervention outside of SIA requirements, for example, to 'in house' security staff, hold relevant nationally recognised training qualifications, such as those outlined above required by the SIA

Trainers should also possess relevant experience of healthcare environments and be covered by insurance and indemnity measures that explicitly cover the type of training delivered.

Employers need to check that their insurance and that of any provider covers the specific training provided. It is also important that employers and training providers keep individual training records on participation and completion of training to the required standard and record any injuries. These records may form a vital part of the audit trail at a later stage in any legal action.

Delivering safer training

There is always a possibility of injury during physical intervention training and this should be reduced through a range of controls, including:

- Provision of an appropriate, risk assessed training environment
- Focus on less aversive/forceful skill sets
- Risk assessment of both skill sets and training methodology
- Strict, well documented safety controls before and during training
- Ensuring staff are fit to participate in physical skills training
- Appropriate preparation for the activity being undertaken
- Use of experienced and responsible trainers
- Adequate supervision and trainer/delegate ratios

Each of the above factors can affect safety and learning/skill acquisition and in turn influence the choice of training method and trainer to delegate ratio. The SIA stipulates a maximum of twelve delegates being supervised by a single trainer for SIA Licence related training in physical intervention. Other bodies such as BILD, the ICM or General Services have similar standards.

It can be difficult to add realism to training without compromising safety. One straightforward way to achieve this is to have access to the workplace or similar area during training, for example, a confined space, waiting area or ward. This allows realistic but tightly controlled problem solving scenarios where staff can be guided/walked through situations they experience at work considering the skills they could use.

The trainer may want delegates to experience the skills with a degree of resistance to enhance confidence and technique. This should be done through tightly controlled exercises stipulating the level of resistance to be offered and safety boundaries. For added control the trainer may adopt the role of the subject being controlled.



Generally speaking, simulations or role-plays where situations are acted out under high levels of resistance should be avoided, due to the high risk of falls and/or injury. If such training is provided, it should be regarded as an advanced level with suitable control measures in place.

Trainers should continually examine and reinforce primary and secondary responses i.e. alternatives to physical intervention, during any problem solving or role play (if used).

Evaluation

Employers need to consider at the outset how training will be evaluated so that key baseline data can be gathered and goals and measurements established. If for example a desired outcome of the training is a reduction in the use of physical intervention and restraint, there needs to be a way of monitoring these activities. The training evaluation will typically consider the safety of any interventions taught and review injuries and near misses in both training and operational use. It may also consider the operational currency/relevance and effectiveness of the training and specific physical intervention skills taught. Information can be drawn from a combination of quantitative data, such as incident reports, and qualitative means such as staff surveys.

Key Messages

- Select a credible, appropriate and balanced training approach/skill set that responds to the training needs analysis
- Balance realism with safety and ensure safety guidance and control measures are followed and evaluated
- Choose internal trainers carefully to ensure they are positive and responsible role models
- Establish the expertise, qualifications, credibility and track record of external training providers
- Ensure employer and provider insurance covers the specific type of training provided
- Ensure training maps to relevant standards and best practice and that trainers hold current certification to deliver the specified programme and relevant qualifications
- Ensure that training is evaluated on an ongoing basis in the workplace to establish its operational effectiveness, currency and safety

Additional Information

Personal Protective Equipment (PPE)

PPE sits at the end of this guidance as it is the last step in the HSE Hierarchy of Controls. The priority of an employer should be on reducing exposure to risk and in providing appropriate training and other controls.

The Personal Protective Equipment at Work Regulations (PPE) 1992 governs assessment, suitability, deployment and use of protective equipment. The Provision and Use of Work Equipment Regulations (PUWER) 1998 consider matters such as training and maintenance of PPE. In general terms equipment provided for use at work needs to be:

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

PPE can include items such as protective vests and infection control items such as gloves, masks and safety glasses (spitting). Protective vests are increasingly being considered by employers for staff in higher risk security and enforcement roles. This equipment can be worn overtly or under clothing and provides protection against blows (trauma) and varying degrees of protection against edged weapon and ballistic threats. The down side is that such equipment does not provide full protection, is expensive to buy and maintain, and can have negative connotations in terms of staff image and perceptions.

Before considering PPE it is important to undertake a thorough assessment of the risks and to explore a wide range of potential controls. Once these controls are in place there will be a clearer picture of any residual risk and an informed decision on PPE can be made.

The danger in starting with an assumption that specific equipment such as protective vests are needed is that simple preventative measures can be overlooked. The use of protective equipment should be regarded as the “last resort” where risks cannot otherwise be controlled. It is essential to identify and tackle the root causes of incidents and to reduce primary exposure to risk. Protective equipment may be necessary but may only provide partial protection and it should be considered after other controls have been evaluated as described in PPE regulations.

Mechanical Restraints

It is an offence to carry an offensive weapon in a public place. The law prohibits the possession of batons and other equipment carried for the purposes of self-defence, for example, a long heavy torch.

Mechanical restraints are occasionally used by clinical staff, in certain settings such as forensic or high security services, under strict policy and guidance, to prevent a patient or service user harming themselves or others. Straps are also used, under clinical direction, in sectors such as learning disabilities and within acute medicine to permit, for example, critical medical procedures.

Mechanical restraint is the broad term to cover various types of equipment used to restrict an individual's movement and it is covered in this guidance as its use is increasing across the security business sector and wider policing family. The decision to use such equipment should not be taken lightly and employers have a duty to provide adequate training and guidance in its use. Staff must use such equipment lawfully and account for their actions. Mechanical restraints should not be trained in isolation, but rather as part of a holistic programme of conflict management.

Security staff must only use these types of equipment, in line with the policies and procedures of the NHS body.

An individual needs to be under a reasonable level of control to allow mechanical restraints to be applied and staff would therefore need to be sufficient in number and have had comprehensive training in restraint and its associated risks prior to being permitted to use such equipment.



Useful Sources and References

The following list is not exhaustive but provides valuable sources of information and support:

Project Chair Bill Fox: Bill@maybo.com

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