

Reducing restrictive interventions (RRI) policy

DOCUMENT CONTROL:

- **Version:** 7.1
- **Unique Reference number:** 311
- **Approved by:** director of corporate assurance
- **Date approved:** 28 October 2026
- **Document Author:** reducing restrictive interventions lead
- **Title of Accountable Director:** chief nursing officer
- **Date issued:** 29 October 2026
- **Review by date:** 31 January 2029

Contents

1. Document summary	4
2. Introduction and aim	5
3. Procedure	6
3.1 The duty of care	6
3.2 The duty of candour	6
3.3 Risk assessments	6
3.4 On admission to a mental health ward or learning disabilities service	7
3.5 On admission to other services	8
3.6 Advance statements and advance decisions	8
3.7 Physical interventions	8
3.8 Physical care and observation of the patient or national early warning score (NEWS2), observations during or following restraint or physical interventions	11
3.9 Seclusion	12
3.10 Rapid tranquillisation	12
3.11 Observation	13
3.12 Mechanical restraint	13
3.13 Incidents where weapons are present	13
3.14 Debriefing or post-incident reviews	13
3.15 Colleagues considerations	14
3.16 Visiting	14
3.17 Incident reporting and recording	14
3.18 Responding to complaints	14
3.19 Pursuing criminal proceedings	15
3.20 Gender or sexuality	15
3.21 Patients with disabilities	15
3.22 Pregnant patients	15
3.23 Managing patients with human immunodeficiency virus (HIV) or other communicable diseases	15
3.24 Patients brought in by the police who may have been restrained or searched	15
3.25 Colleagues who undertake domiciliary visits or work alone	16
3.26 Persons under 18 years of age on adult wards	16
4. Responsibilities	16

5. Training	18
6. Monitoring Arrangements	21
7. Related documents and associated references	22
8. Appendices	24
8.1 Appendix A Restrictive practice	24
8.2 Appendix B action following a serious assault	26
8.3 Appendix C safety pod guidance and information	26

1. Document summary

1.1 What this policy is about

This policy is about keeping people safe while using as few restrictions as possible. A restriction stops a person moving freely, making a choice or doing something they want to do.

The policy applies mainly to colleagues working in mental health and learning disability inpatient services, but its principles support safer practice across the Trust.

1.2 Prevent problems first

Listen to the patient. Know what may upset them and what helps them feel safe. Use their care plan, positive support and calm communication. Try to reduce distress before a crisis happens.

1.3 Use restriction only when needed

Restrictive practice means doing something that limits a person's movement, freedom or ability to make choices. It includes physical, chemical and psychological restraint, seclusion, clinical holding, enhanced observation, blanket rules and other restrictions.

Use a restrictive intervention only when there is a real risk of harm and safer options have not worked. Use the least restrictive option for the shortest time. Never use restriction to punish someone.

1.4 Keep checking safety

During and after restraint, check breathing, consciousness and the other required observations. Stop or reduce the restriction as soon as it is safe. Get medical help quickly if there are concerns about the patient's physical health.

1.5 After an incident.

Record and report what happened. Offer support to the patient, colleagues and witnesses. Talk about what led to the incident and what could be done differently. Update the care plan when needed.

1.6 What colleagues must do

Complete the training for your role. Follow risk assessments and care plans. Use only approved techniques. Protect the patient's dignity, privacy and communication needs. Ask for help when you need it.

1.7 Where to find more detail

The full policy explains responsibilities, training, monitoring and reporting. The appendices explain the types of restrictive practice, what to do after a serious assault and how to use Safety Pods safely.

2. Introduction and aim

This policy helps colleagues understand the restrictive practices used in mental health inpatient services and the effect these can have on patients. Services can only reduce restrictive practice when colleagues recognise every form of restriction, understand what contributes to it and report it accurately. This approach supports the [Culture of Care Standards for mental health inpatient services](#). These standards describe how services can create a positive culture where people can thrive through trauma-informed, autism-informed and culturally competent care.

This policy applies to all NHS-funded mental health inpatient services for people of every age and background. This includes older adults, children and young people, people with a learning disability and autistic people. Colleagues must also follow the [Mental Health Act \(1983\) Code of Practice](#) and other required guidance. This policy does not replace those requirements. Restrictive practices can happen in many care settings, so the policy also supports wider awareness and reduction across the Trust.

Restrictive practices are different forms of restraint and may also be called restrictive interventions. In this policy, restraint means an action intended to limit a person's movement, liberty or ability to act independently. Restrictions may be used on mental health wards to keep people physically safe, but they can also increase conflict or cause harm and trauma. When restraint is necessary, colleagues must always use the least restrictive option.

Being admitted to hospital places some limits on a person's freedom. In mental health settings, ward routines and ways of working also place colleagues in a position of authority. Restrictions may be intended to improve physical safety, but they can also raise tension and increase conflict. Colleagues must recognise this power difference and use restrictions only when necessary.

This policy describes eight types of restrictive practice used in mental health, learning disability and autism inpatient services. Appendix A gives definitions and examples. The types reflect the practices identified by the [Restraint Reduction Network](#). The appendix explains how restrictive practice can affect a person's rights and cause harm or trauma. It also directs colleagues to information that can help them reduce its use.

1.1 Restriction intervention statement

The Trust is committed to high-quality, person-centred care that protects each patient's dignity and treats them with respect. Colleagues must use early support, prevention and de-escalation wherever possible. This helps prevent crisis situations, reduces the use of force and supports patients in a proactive way.

There may be times when colleagues need to use restrictive interventions, including physical interventions. These must be used only as a last resort, for the shortest possible time and in a way that is proportionate to the risk. Care must be trauma-informed, person-centred and focused on maintaining a safe and therapeutic environment.

This policy has been developed using the current national requirements, standards and professional guidance that apply to NHS mental health services.

This policy covers both physical and non-physical violence and aggression, including:

- physical violence and assault
- self-harm
- antisocial, offensive, or disruptive behaviour
- verbal abuse
- threatening language or behaviour
- harassment
- damage to personal or trust property

Most of this policy applies to colleagues working in the Trust's mental health and learning disability inpatient services. Colleagues must also follow the relevant Trust policies listed in section 7.

3. Procedure

Everyone involved in preventing or managing distressed, aggressive or violent behaviour must understand their role and follow this policy, relevant Trust policies, current professional guidance and required training. Colleagues must:

- complete the required training and keep their knowledge and skills up to date
- make a full and accurate record of any intervention, including the reasons for clinical decisions
- help monitor how distressed or violent behaviour is managed and make sure concerns or required actions are passed to the person responsible
- consider their duty to the patient, other patients, colleagues and visitors throughout an incident
- never use care, treatment or restrictions as punishment
- report suspected criminal behaviour through the correct process

3.1 The duty of care

Colleagues have a duty of care to patients, themselves and other people. They must provide suitable care and treatment that is in the patient's best interests, is needed to protect or improve health and reflects accepted professional practice. Colleagues must be trained and competent in any treatment or intervention they use.

3.2 The duty of candour

Duty of candour means openly sharing relevant information with a person who has been, or may have been, harmed by the care provided. Colleagues must do this whether the person has asked for the information or made a complaint. See the [being open policy \(incorporating the duty of candour\)](#).

3.3 Risk assessments

- Risk assessment is essential to prevent and reduce aggressive or violent behaviour. Use accurate, relevant information to complete the appropriate FACE risk assessment and plan how identified risks will be managed.
- Every work area must have an environmental risk assessment that reflects its service and setting. Review it promptly when circumstances change and in

line with the Trust's [health and safety policy](#), [fire safety policy](#) and [ligature risk reduction policy](#).

- When a patient may present a risk of violence or aggression, the nursing team and multidisciplinary team must assess physical presentation, early warning signs, triggers, environmental factors and protective factors. They must agree a restraint reduction plan to prevent and reduce risk.
- Colleagues working alone or in remote locations must follow the [lone working policy](#).

If violence or aggression causes a colleague stress, they should complete the stress questionnaire and discuss it with their supervisor or line manager. They should agree suitable support in line with the [healthy workplaces staff support and stress at work policy](#).

3.4 On admission to a mental health ward or learning disabilities service

The Trust promotes positive behavioural support plans, or Dialog+ management plans, for all patients admitted to its services. Plans should use proactive, person-centred care, with primary and secondary strategies used first and the least restrictive approach always followed. Patients and, where appropriate, their family or carers must be involved. The plan must record any physical health condition that could affect the safe use of a restrictive intervention.

3.4.1 Primary strategies and prevention

Primary strategies are part of everyday care. They aim to improve quality of life and reduce the chance of behaviour that may cause concern. They must be person-centred and based on what matters to the patient.

Plans must record known or likely triggers and explain what colleagues should do if they occur.

3.4.2 Secondary intervention

Secondary interventions are used when early warning signs appear. They aim to reduce distress, stop the situation from escalating and support the patient through person-centred de-escalation.

3.4.3 Non-restrictive tertiary strategies

Non-restrictive tertiary strategies are used when behaviour that may cause harm is already happening. They aim to bring the situation under safe control quickly through person-centred de-escalation without restricting the patient.

3.4.4 Restrictive tertiary strategies

Restrictive tertiary strategies are used only when behaviour is happening and there is an immediate risk of harm. They may include physical restraint, chemical restraint, seclusion or enhanced observation. Use them only when de-escalation and less restrictive options have not worked and stop or reduce them as soon as it is safe.

Colleagues using a restrictive procedure must understand its risks and the precautions needed to reduce harm. Training must cover these risks and the relevant ethical and professional requirements.

These interventions manage immediate risk; they are not primary treatment. Colleagues must continue trying to de-escalate the situation and must never use an intervention as punishment.

3.5 On admission to other services

During admission, colleagues must look for behaviour that may indicate a higher risk of violence, aggression or abuse. If a risk is identified, they must develop an individual positive behavioural support plan and seek advice from the Reducing Restrictive Interventions team when needed.

3.6 Advance statements and advance decisions

- Patients who may be at risk of distressed or violent behaviour should be offered the opportunity to record their views and wishes in an advance statement.
- They should be encouraged to state clearly which interventions they would or would not want colleagues to use. Review these wishes regularly. See the [advance statements and advance decisions to refuse treatment policy](#).
- When choosing an intervention, colleagues must consider clinical need, the safety of the patient and others, the positive behavioural support plan and any recorded preferences or decisions. Where possible, the chosen approach should reflect the patient's wishes.

3.7 Physical interventions

Use physical intervention only as a last resort in an emergency when there is a real risk of harm. Always use the least restrictive approach. If a prone descent is used, colleagues must log roll the patient into the supine 'T' position as soon as possible to reduce the risk of positional asphyxia.

The most common reasons for needing to consider such interventions are:

- physical assault
- dangerous, threatening, or destructive behaviour
- extreme and prolonged over-activity that is likely to lead to physical exhaustion and risk to health
- attempts to abscond (where the patient is detained under the Mental Health Act)
- searching of a patient, please see [searching of a person or their property policy](#)

The purposes of intervention where de-escalation has failed are to:

- take immediate control of a dangerous situation
- end or significantly reduce the danger to the patient or others around them
- contain or limit the patient's freedom for no longer than is necessary

Any physical intervention used must be:

- reasonable, justifiable, and proportionate to the risk posed by the patient
- using the least restrictive approach at that moment in time, which should be reduced as the patient de-escalates
- used for only as long as is absolutely necessary

- involve a recognised technique that does not depend on the deliberate application of pain
- be carried out by colleagues who are appropriately trained and compliant with the training

One colleague should lead the response. Where possible, they should ask the patient to stop the behaviour and explain what may happen if the risk continues. Colleagues must consider communication and sensory needs. Approach a deaf or hearing-impaired person within their field of vision.

During physical intervention one team member should be responsible for protecting and supporting the head and neck, where required. They should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.

The Safety Pods should be utilised wherever possible and used as a primary strategy to reduce distress and behaviours that challenge

[Reducing restrictive interventions physical interventions comprehensive \(high Level\) techniques \(staff access only\)](#) may require the use of head protection to reduce the risk of injury to the patient and, or colleagues. This role is given to number one (please see 3-person team set up in [physical interventions, core techniques \(staff access only\)](#) and [physical interventions, comprehensive \(high Level\) techniques \(staff access only\)](#) techniques both can be found on the RDaSH intranet). They should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.

Use techniques that do not deliberately cause pain wherever possible. A pain-based technique has no therapeutic purpose and may be used only to rescue a patient, colleague or other person from immediate harm. Use no more colleagues than the technique requires. During prolonged restraint, colleagues may need to change because of clinical duties, injury, tiredness or difficulties within the team. The table below gives the required number of colleagues for each technique.

Intervention	Classification	Number of colleagues required
Passive hold	Standing, escorting	Three people (including number one at the front)
Figure of four	Seated, standing, escorting	Three people (including number one at the front, knelt at eye level in seated)
Back-to-back	De-escalation only	Three people (including number one at the front)
Reverse passive to the pod	Supporting, de-escalating	Three people (including number one at the front knelt at eye level)
Reverse passive to the pod with extra-large (XL) cushion	Supporting, de-escalating	Two people utilising cushion (1 person can be the number one from reverse passive to the pod)
Sit Back in Passive with head protection	Supporting, floor	Three people (number one protecting the patients' head on the floor)

Intervention	Classification	Number of colleagues required
Double wrist hold with head protection	Standing, escorting	Three people, (number one on head protection)
Finger and thumb hold with head protection	Standing, escorting	Three people, (number one on head protection)
Sit back in finger and thumb with head protection	Supporting, floor	Three people (number one protecting the patients' head on the floor)
Prone decent to supine 'T' via log roll	Supporting, floor	Three people (number one protecting the patients during the prone decent and protecting the head on the floor)
Prone decent to supine 'T' via log roll with leg management	Supporting, floor	Four people (number one protecting the patients during the prone decent and protecting the head on the floor number 4 on leg management)
Assisting to stand from supine 'T'	Supporting, floor	Three people (number one protecting the patients head on the floor and head protection throughout assistance to stand)
Assisting to stand from supine 'T' with leg management	Supporting, floor	Four people (number one protecting the patients' head on the floor and head protection throughout assistance to stand)
Seclusion exit with head protection	Supporting, kneeling	Three people, (number one on head protection)

It is important that restraint through the use of physical intervention is seen within the overall spectrum of approaches for dealing with violence and aggression.

Disengagement from a violent or potentially violent situation is preferable. Occasions may occur when the safety of self or others may supersede this.

Colleagues will develop a clear understanding of factors that may contribute to disturbed behaviour and dealing with violence and aggression through local induction procedures, advice, and instruction from managers on the policy and through their attendance on mandatory reducing restrictive interventions training.

Colleagues likely to be involved in restraint through the use of physical interventions must be suitable trained by attending the relevant course as set out in section 9 of this policy.

If violence happens suddenly and there is no time to de-escalate or call for help, colleagues may need to intervene immediately. Any intervention must use no more force than is needed to stop the attack or prevent injury.

3.7.1 Clinical holding

Clinical holding means using a planned physical hold so that colleagues can safely assess a patient or provide care or treatment when the patient cannot cooperate.

It may involve holding part of the body so that a procedure can be completed safely. For example, a colleague may hold an arm during a blood test to prevent sudden movement, pain, distress or injury.

Clinical holding interventions are planned interventions and therefore must be carefully planned using the appropriate documentation.

Clinical holding interventions should not routinely be reported on the incident reporting system unless something untoward occurs (for example, an injury to patient or colleague).

Clinical Holding should not routinely require a full early warning score (NEWS2) to be completed unless there is a clinical need.

3.8 Physical care and observation of the patient or national early warning score (NEWS2), observations during or following restraint or physical interventions

Physical monitoring must start during every restraint. It is especially important:

- during and following a prolonged or violent struggle
- if the patient has been subject to rapid tranquillisation
- if the patient is suspected to be under the influence of alcohol or illicit substances
- if the patient is clinically obese
- if the patient has a known condition which may inhibit cardiopulmonary function, for example, Asthma

At the point of restraint and every 5 minutes during the restraint the following observations should be recorded:

- respiratory rate
- central nervous system (CNS) (alert newly confused voice pain unconsciousness) (ACVPU) level
- oxygen saturations (O2 saturations)
- pulse

If oxygen saturation and pulse cannot be measured, colleagues must record respiratory rate and CNS level using ACVPU as the minimum. The patient record must explain why the other observations could not be taken.

Record these observations on the NEWS2 physical observation chart and calculate the NEWS2 score.

It is also important to monitor for any verbal or non-verbal signs of pain or discomfort.

If after release from restraint observations do not improve further medical assistance should be sought via the ambulance service particularly if:

- the patient is struggling to breathe
- there is noted flushing and redness to the face and neck
- there is marked expansion of the veins in the neck
- changes in behaviour

- reducing level of consciousness

Once the restraint has been released the following observations must be recorded every 15 minutes for the first hour and every 30 minutes for the next three hours:

- respiratory rate
- CNS (ACVPU)

Record these observations on the NEWS2 physical observations chart and calculate a NEWS2 score. Respiratory rate and ACVPU can be checked without the patient's cooperation, so they must be recorded after every restraint.

The following observations should be taken only if there is clinical indication of deterioration or change in the patient's physical condition and only then, if it is safe to do so:

- O2 saturations
- blood pressure
- pulse
- temperature

These observations must be documented on the NEWS 2 physical observations chart and a NEWS calculated.

If at any time, there is cause for concern for the patient's physical health a doctor must be contacted.

Rationale for the level of physical observations taken should be recorded in the nursing notes, not on the chart.

See also section 3.24 patients brought in by the police who may have been restrained.

For more information on the national early warning score (NEWS2) please see the [resuscitation manual](#).

3.9 Seclusion

Seclusion is the supervised confinement of a patient in a specifically designed and approved room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others. It has a place to play in the spectrum of least restrictive interventions available to support the management of violence and aggression. See [secluded or segregated policy](#).

3.10 Rapid tranquillisation

Rapid tranquillisation should only be considered once de-escalation and other strategies have failed to calm the patient and should be considered as a management strategy and not a primary treatment technique. See [rapid tranquillisation policy and guidelines \(pharmacological management of violence\)](#).

Physical intervention may be used to give medication to a patient who does not agree only when there is clear authority to provide treatment without consent.

Colleagues must follow the rapid tranquillisation policy and the patient's agreed care plan.

3.11 Observation

Increased levels of observation may be used both for the short-term management of disturbed behaviour and to prevent suicide or serious self-harm. See [supportive therapeutic observation policy](#).

3.12 Mechanical restraint

The use of mechanical restraint is not permitted.

Mechanical restraint includes tying or strapping a patient to an object, fixing a tray to a chair to stop the patient standing, placing a chair against a wall to prevent movement, or using clothing or furniture to keep the patient in place. The Trust does not allow these practices.

3.13 Incidents where weapons are present

Colleagues must not try to disarm a hostile person who has a weapon or an item that could be used as one. Call the police urgently when patients, colleagues or other people are at risk.

3.14 Debriefing or post-incident reviews

In line with the Restraint Reduction Network (RRN) standards, the trust recognises the need for thorough post incident review procedures to ensure:

- attention is given to the physical and emotional wellbeing of those involved
- post-incident reflection and learning

Post incident review must therefore:

- evaluate the physical and emotional impact on all involved including witnesses
- identify if there is a need, and if so, provide counselling or support for any trauma that might have resulted
- help patients and colleagues to identify what led to the incident and what could have been done differently to ensure lessons are learnt from each incident
- determine whether alternatives including less restrictive interventions were considered
- determine whether service barriers or constraints make it difficult to avoid the same course of action in future
- where appropriate recommend changes to the service philosophy, policy, care environment, treatment approaches, colleague education and training
- patients should not be compelled to take part in debrief, they should be offered the right to talk about the incident independently

If required, the Reducing Restrictive Interventions team can be available to assist in the debrief process.

3.15 Colleagues considerations

- A review of whether colleagues require medical treatment, sick leave or temporary relief from duty must be carried out by the manager and appropriate arrangements made. Colleagues may wish to be referred for counselling via the relevant occupational health department or alternatively could choose to access the colleague counselling service.
- A review and assessment of working practices and security measures must be carried out, and appropriate changes made where required. Where changes are required, but cannot be implemented, these must be reported to the director or senior manager immediately.
- The manager should discuss the issue of pursuing a prosecution against the assailant and offer to accompany the colleague to the police if necessary. Advice and support can be provided by the local security management specialist.
- If the colleague requires sick leave, then please refer to the [supporting health, wellbeing and managing attendance policy](#). Advice and support can be sought from the human resources department as appropriate.

3.16 Visiting

- Trust colleagues are responsible for the health and safety of any visitors who are on trust premises. If visitors are in the vicinity when an incident occurs, they should be removed to a safe area immediately.
- Witnessing a violent incident can be distressing. Colleagues should offer support and reassurance, and explain why the visitors are being removed, and when it is safe for them to return to the area from which they have been removed.
- See [visiting patients on inpatient areas policy](#), and [children visiting inpatient and residential units within the trust policy](#).

3.17 Incident reporting and recording

Colleagues must report all incidents of restrictive interventions as soon as possible after the incident by completing and submitting an electronic incident form (IR1) via the electronic safeguard incident reporting system. See [incident management policy](#).

For reporting of incidents in ward settings, the [mental health units \(use of force\) policy](#) must also be followed (section 3.5.3, data collection requirements).

These incident reports are reviewed by the local security management specialist (LSMS), Reducing Restrictive Interventions team and resuscitation service and reviewed with the relevant Manager as appropriate.

It is a requirement that all incidents of physical and non-physical assault are reported whether intentional or not.

3.18 Responding to complaints

Any complaint made against colleagues because of a violent incident will be dealt with quickly and fairly and investigated as per the [listening and responding to concerns and complaints policy \(formally complaints handling policy\)](#). Colleagues are

also encouraged to consult their own professional association or trade union for advice.

3.19 Pursuing criminal proceedings

Following a serious assault, the process set out in appendix A must be followed. The local security management specialist will provide advice and support to managers and colleagues as required.

3.20 Gender or sexuality

A responding team may not include a colleague of the same sex as the patient. This can create privacy, dignity or personal safety concerns during an intervention.

Where possible, a colleague of the same sex as the patient should be present to observe how the situation is managed.

Do not change the responding team simply to create a mixed-sex team unless it is safe and the colleague joining the response is trained in physical interventions.

3.21 Patients with disabilities

If a patient has a physical or sensory impairment or communication need, their positive behavioural support plan must explain the preferred way to manage an incident and any specific intervention needed. The plan must clearly state each colleague's responsibilities.

3.22 Pregnant patients

Where it is known that a patient is pregnant, advice should be sought from the Reducing Restrictive Interventions team, resuscitation service, obstetrics and gynaecology, and special provisions made where interventions may be required. The agreed interventions must be documented in the patient's care plan.

3.23 Managing patients with human immunodeficiency virus (HIV) or other communicable diseases

If colleagues are aware that a patient has a potentially infectious condition, the advice of the infection prevention and control team should be sought. Colleagues will utilise transmission and respiratory precautions accordingly and wear appropriate personal protective equipment. Any special provisions to be implemented with patients should be clearly written up in their management plan

In the event of a blood or body fluid spillage refer to the quick guide to blood and body fluid spillages contained in the [infection prevention and control manual](#).

Advice relating to contamination injuries involving blood and body fluids are contained in the quick guide section of the [infection prevention and control manual](#). These events must be reported via the digital reporting system.

3.24 Patients brought in by the police who may have been restrained or searched

Where patients are brought in by the police, colleagues must establish if the police have physically or mechanically restrained the patient, and if so, or if colleagues are

unsure a physical observation should commence as per section 5.7 of this policy. The discussion with the police should be recorded in the patient's clinical record and body map completed. Colleagues must establish if the patient has been searched prior to arrival at the unit, if not or colleagues are unsure, they should follow the direction in the trust's [searching of a person or their property policy](#).

3.25 Colleagues who undertake domiciliary visits or work alone

Colleagues who visit patients at home or work alone may be at greater risk. Managers and colleagues must follow the [lone working policy](#) and use the agreed safety arrangements for every visit or lone-working activity.

3.26 Persons under 18 years of age on adult wards

In the exceptional circumstance that a person under 18 years of age is admitted to an adult ward, due consideration should be given to the involvement of parents or carers in the planning of care and treatment to maintain the therapeutic relationship

4. Responsibilities

The Trust Board is responsible for making sure the Trust reduces restrictive interventions and manages violence and aggression safely. The Trust must use the least restrictive option needed to protect patients, colleagues and other people.

4.1 All colleagues

All colleagues are required to:

- promote early recognition, prevention and de-escalation so that restrictive interventions are reduced and incidents are less likely to happen again
- follow and support positive behavioural support plans
- follow this policy and all agreed risk management measures
- respect equality, diversity, privacy and dignity
- help identify environmental and clinical risks linked to violence and aggression, contribute to risk assessments and take part in writing patient plans
- take reasonable steps to protect themselves and others from harm
- complete mandatory reducing restrictive interventions training and use only the techniques taught, unless an agreed bespoke plan is in place, as set out in the [mental health units \(use of force\) policy](#)
- report all incidents and take part in post-incident reviews
- ask for advice and support promptly when needed

4.2 Managers

Managers will:

- explain the policy to colleagues through local induction and regular communication
- help colleagues understand and follow the practice requirements in this policy and related Trust policies
- support and monitor attendance at mandatory reducing restrictive interventions training and keep accurate training records
- promote equality, diversity, privacy and dignity
- promote early recognition, prevention and de-escalation, with primary and secondary strategies used wherever possible

- support open reporting, learning and ongoing improvement in safe, therapeutic care
- make sure all incidents of violence and aggression are reported using the electronic incident form (IR1)
- make sure a restraint or physical intervention monitoring form and body restraint chart are completed in SystmOne after any physical intervention
- arrange a timely debrief with the patient to provide support, understand what happened and review or develop the positive behavioural support plan
- arrange timely reflection and learning with colleagues, the patient or service user, carers and other people involved

4.3 Resuscitation service

The resuscitation service will:

- advise services on planning and providing physical healthcare during and after restrictive interventions
- support patient areas and the Reducing Restrictive Interventions team when concerns arise about a patient's physical health

4.4 Reducing Restrictive Interventions (RRI) team

The Reducing Restrictive Interventions team will:

- promote evidence-based practice that prevents and reduces restrictive interventions through early recognition, proactive support and de-escalation
- help services learn from incidents and place greater emphasis on prevention rather than restrictive tertiary strategies
- plan, coordinate and approve all reducing restrictive interventions training in line with national guidance and local risk assessments
- keep complete and accurate records of training delivered
- advise managers on risk assessments, positive behavioural support plans and training needs
- support implementation and monitoring of this policy
- support patients, colleagues and managers with incident reviews and debriefs when appropriate
- provide person-specific advice and bespoke training when an assessed need is identified
- advise services on the least restrictive way to manage an identified intervention
- work with estates and facilities colleagues so that building design supports safe and positive risk management

4.5 Directors

Through their managers the directors will:

- make sure the policy is implemented and monitored effectively in their services
- promote early recognition, prevention and de-escalation to reduce restrictive interventions and prevent incidents happening again
- support the use of individual positive behavioural support plans when needed
- promote open reporting, learning and ongoing improvement in the management of violence and aggression
- work with estates and facilities leaders so that building design supports positive risk management

- assess violence and aggression risks in their areas, including risks involving patients, visitors and colleagues, and seek advice from the health and safety lead when needed
- agree local procedures following risk assessment and make sure colleagues understand them
- explain policy requirements through local induction, team meetings, supervision and post-incident reviews
- support and monitor attendance at mandatory reducing restrictive interventions training

4.6 Local security management specialist (LSMS)

The local security management specialist (LSMS) will:

- work closely with clinical services to promote early recognition, prevention and de-escalation and reduce repeat incidents
- promote evidence-based security practice and support services to put it into place
- lead local security management work and advise services on required safety arrangements
- provide advice and support to managers and colleagues after a serious assault
- monitor violence and aggression reports and advise on sanctions, police reporting and prosecution where appropriate
- work with the Reducing Restrictive Interventions team and managers to improve security practice and organisational learning
- work with the police when an investigation is needed
- provide the health and safety forum with an annual report and forward plan on preventing and managing workplace violence

5. Training

In line with the Restraint Reduction Network standards an annual review of the training needs analysis and training offer is carried out in relation to this policy. These documents are formulated based on data from across the trust to ensure that training remains relevant to colleagues and patient groups. The training needs analysis (TNA) for this policy can be found in the trust's [mandatory and statutory training policy](#).

5.1 All inpatient adult mental health wards or older persons mental health or forensic service, bank colleagues

- How often should this be undertaken: annually.
- Length of training: 3 days.
- Delivery method: face to face.
- Training delivered by whom: 3-day comprehensive update, immediate life support, learning and development.
- Where are the records of attendance held: colleagues electronic staff record (ESR).

5.2 Physical health wards except Magnolia Lodge, community colleagues who are patient facing, support service assistants, estates, catering

- How often should this be undertaken: annually.
- Length of training: 3 hours.
- Delivery method: face to face.
- Training delivered by whom: disengagement update.
- Where are the records of attendance held: colleagues electronic staff record (ESR).

5.3 Magnolia bespoke training

- How often should this be undertaken: annually.
- Delivery method: face to face.
- Training delivered by whom: 2.5 days comprehensive update, immediate life support, learning and development.
- Where are the records of attendance held: colleagues electronic staff record (ESR).

5.4 All new starters at the following, inpatient adult mental health wards or older persons mental health or forensic services, bank colleagues

- How often should this be undertaken: once.
- Length of training: 4 days.
- Delivery method: face to face.
- Training delivered by whom: 4-day induction comprehensive reducing restrictive interventions.
- Where are the records of attendance held: colleagues electronic staff record (ESR).

5.5 All new starters at the following, physical health wards, community colleagues who are patient facing, support service assistants, estates, catering

- How often should this be undertaken: once.
- Length of training: 1 day.
- Delivery method: face to face.
- Training delivered by whom: 1 day induction disengagements reducing restrictive interventions.
- Where are the records of attendance held: colleagues electronic staff record (ESR).

5.6 All colleagues

- How often should this be undertaken: 3 yearly.
- Length of training: 1 hour.
- Delivery method: e-learning.
- Training delivered by whom: conflict resolution.
- Where are the records of attendance held: colleagues electronic staff record (ESR).

5.7 Reducing restrictive interventions (RRI) team

All colleagues must have a comprehensive understanding of reducing restrictive interventions (RRI).

The trust provides the following training in relation to this:

- conflict resolution, e-learning
- reducing restrictive interventions, disengagement (annual)
- reducing restrictive interventions, comprehensive (annual)
- bespoke training, delivered to specific colleague teams in relation to a specific patient referral

An individual's training matrix will identify at which level training should take place.

Colleagues working in any in-patient settings (ward based), must only use the applicable physical intervention techniques taught on training, specific to a given ward area, in line with the [mental health units \(use of force\) policy](#).

If colleagues have concerns about supporting individual patients and feel the taught physical interventions will not adequately support that patient, then they must make a request for bespoke training and, or bespoke physical intervention training to the Reducing Restrictive Interventions team.

The Reducing Restrictive Interventions team will then, working in conjunction with nursing teams and the multi-disciplinary team, gather additional information and formulate a bespoke package of training. Any bespoke person-centred physical interventions will be fully risk assessed and signed off by the delegated responsible person for the use of force, prior to implementation.

In line with the Restraint Reduction Network (RRN) training standards, upon attendance to either of the reducing restrictive interventions courses, facilitators can ask colleagues to re-attend on the basis of language and attitude displayed on the course this can be either towards other colleagues or facilitators, they can also be asked to re-attend if they have not been deemed competent by the end of the training. A letter will be sent out to the manager to inform them of re-attendance.

5.8 Resuscitation, life support

All clinical colleagues involved in restraint or the administering and prescribing of rapid tranquilisation or monitoring patients who have received rapid tranquilisation or restraint must receive training in immediate life support (ILS) to a level equivalent to the resuscitation council immediate life support course. See the trust's [resuscitation manual](#).

Regarding persons under 18 years of age (see 6.7 above), from puberty a child is considered to be an adult in a life support situation.

5.9 Rapid tranquilisation

All colleagues involved in rapid tranquilisation must be trained to the level of immediate life support prescribers and those who administer medicines must receive

training in rapid tranquilisation including the properties, risks and titration of medications used in rapid tranquilisation. See the trust's [rapid tranquillisation policy and guidelines \(pharmacological management of violence\)](#)

6. Monitoring Arrangements

6.1 How the trust carries out risk assessments for the prevention and management of violence and aggression

- How: local security management specialist work plan and security report.
- Who by: head of health, safety and security.
- Reported to: Quality Assurance Sub Committee.
- Frequency: annual report and half yearly update report.

6.2 Timescales for review of risk assessments

- How: local security management specialist work plan and security report.
- Who by: head of health, safety and security.
- Reported to: Quality Assurance Sub Committee.
- Frequency: annual report and half yearly update report.

6.3 How action plans are developed as a result of risk assessments

- How: local security management specialist work plan and security report.
- Who by: head of health, safety and security.
- Reported to: Quality Assurance Sub Committee.
- Frequency: annual report and half yearly update report.

6.4 How action plans are followed up

- How: local security management specialist work plan and security report.
- Who by: head of health, safety and security.
- Reported to: Quality Assurance Sub Committee.
- Frequency: annual report and half yearly update report.

6.5 Arrangement for making sure lone workers are safe

- How: local security management specialist work plan and security report.
- Who by: head of health, safety and security.
- Reported to: Quality Assurance Sub Committee.
- Frequency: annual report and half yearly update report.

6.6 How the trust trains colleagues, in line with the training needs analysis

- How: report.
- Who by: head of learning and development.
- Reported to: individual care groups.
- Frequency: monthly.

6.7 Audit of positive behavioural support plans

- How: report.
- Reported to: environmental risks in clinical areas steering group.

- Frequency: annually.

7. Related documents and associated references

- [Clinical risk management system policy](#)
- [Data protection regulations policy](#)
- [Freedom to speak up policy: raising concerns \(whistleblowing\) policy](#)
- [Healthcare record keeping policy](#)
- [Healthy workplaces staff support and stress at work policy](#)
- [Infection prevention and control manual](#)
- [Information risk management policy](#)
- [Listening and responding to concerns and complaints policy \(formally complaints handling policy\)](#)
- [Mental Capacity Act \(2005\) policy](#)
- [Respect, civility and resolution \(formerly bullying and harassment\) policy](#)
- [Safer manual handling operations policy](#)
- [Security policy](#)
- [Taser or irritant spray on inpatient guidelines](#)
- [Being open policy \(incorporating the duty of candour\)](#)
- [Care and treatment of children under the age of 18 on adult acute mental health inpatient areas policy](#)
- [Care Quality Commission \(2015\) The fundamental standards](#)
- [Children visiting inpatient and residential units within the trust policy](#)
- [Fire safety policy](#)
- [Crisis Prevention. Meeting needs and reducing distress, Guidance on the prevention and management of clinically related challenging behaviour in NHS settings](#)
- [Department of Health \(2004\) Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision \(Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health in-patient settings\)](#)
- [Department of Health \(2005\) Race Equality Action Plan: a five-year review \(Delivering Race Equality in Mental Health Care: An action plan for reform inside and outside service, and the Government's response to the independent inquiry into the death of David Bennett\)](#)
- [Department of Health \(2015\) Code of Practice: Mental Health Act \(1983\)](#)
- [ECHR \(1953\), European Convention of Human Rights](#)
- [England NHS UK \(2021 and 2022\). Metric Definitions: Restrictive Practice Tier 4 Child and Adolescent Mental Health Services \(CAMHs\) \(General Adolescent Services including Specialist Eating Disorders Services\) Quality Dashboard 2021/22](#)
- [Gov UK \(1977\). Criminal Law Act \(1977\)](#)
- [Gov UK \(1998\) Human Rights Act \(1998\)](#)
- [Gov UK \(2018\). Mental Health Units \(Use of Force\) Act 2018](#)
- [Gov UK. Deprivation of liberty safeguards: resources](#)
- [Gov UK. Positive and safe: reducing the need for restrictive interventions: Department of Health \(20150\)](#)
- [Health and Safety Executive \(HSE\) website provides further information and resources](#)

- [Health and safety policy](#)
- [Incident management policy](#)
- [Intranet. Advance statements and advance decisions to refuse treatment \(staff access only\)](#)
- [Intranet. Physical Interventions Core Techniques \(staff access only\)](#)
- [Intranet. Physical Interventions Comprehensive \(High Level\) Techniques \(staff access only\)](#)
- [Legislation Gov UK \(1854\). Common Law Procedure Act \(1854\)](#)
- [Legislation Gov UK \(1974\) Health and Safety at Work Act \(1974\)](#)
- [Legislations Gov UK \(1983\) Mental Health Act \(1983\) as amended by the Mental Health Act \(2007\)](#)
- [Legislation Gov UK \(2005\) Mental Capacity Act \(2005\)](#)
- [Ligature risk reduction policy](#)
- [Lone working policy](#)
- [Mandatory and statutory training policy](#)
- [Medical devices management policy](#)
- [Mental health units \(use of force\) policy](#)
- [Ministry of Justice \(2008\) Mental Capacity Act \(2005\) Deprivation of liberty safeguards, Code of Practice to supplement the main Mental Capacity Act \(2005\) Code of Practice](#)
- [National Patient Safety Agency \(2006\) With safety in mind: mental health services and patient safety, Patient Safety Observatory Report 2](#)
- [NHS Counter Fraud Authority \(NHSCFA\)](#)
- [NICE \(2004\) Clinical Guideline 16 Self-harm. Self-harm in over 8s, short term management and prevention of recurrence \(updated July 2016\)](#)
- [NICE \(2015\) Clinical Guideline NG10. Short term management in Mental Health, Health and community settings \(May 2015\)](#)
- [Patient Safety Incident Response Framework \(August 2022\)](#)
- [Rapid tranquillisation policy and guidelines \(pharmacological management of violence\)](#)
- [Restraint Reduction Network](#)
- [Resuscitation manual](#)
- [Royal College of Psychiatrists \(2018\). Restrictive interventions in inpatient intellectual disability services: How to record, monitor and regulate](#)
- [Searching of a person or their property policy](#)
- [Secluded or segregated policy management of a secluded or segregated patient](#)
- [Secretary of State Directions. Tackling Violence Against NHS Staff \(2011\)](#)
- [Supporting health, wellbeing and managing attendance policy](#)
- [Supportive therapeutic observation policy](#)
- [Visiting patients on inpatient areas policy](#)

8. Appendices

8.1 Appendix A Restrictive practice

This appendix defines and gives examples of eight types of restrictive practice used in mental health, learning disability and autism inpatient services. The types reflect those identified by the [Restraint Reduction Network](#). It explains how restrictive practices can affect a person, including the risk of harm and trauma, and directs colleagues to information that can help reduce their use.

In mental health units in England, the recorded use of force includes physical, mechanical and chemical restraint, and the use of seclusion or isolation. These events must be recorded and reported to the [NHS England Mental Health Services Data Set](#). Colleagues may easily recognise restraint, seclusion and segregation as restrictive practices. They must also recognise less obvious restrictions, such as blanket rules or cultural and psychological restraint. Colleagues should consider the effect of all these practices and work to reduce their use.

Restraint includes using force, threatening to use force or limiting a person's freedom of movement. This appendix aims to help colleagues recognise all forms of restraint and think carefully about their own practice.

This appendix uses the word 'patient' for the person affected by a restrictive practice. This helps make the difference in power between patients and colleagues clear. The word 'people' includes patients, colleagues and visitors.

8.1.1 Protecting human rights

Colleagues must protect each patient's rights, dignity, privacy, safety and freedom as far as possible. Any restriction must have a clear reason, be proportionate to the risk and be the least restrictive option available.

Restrictive practice can affect a person's physical and emotional wellbeing, independence, privacy and relationships. Colleagues must consider these effects before, during and after any intervention and must never use a restriction to humiliate, distress, punish or degrade someone.

Before using a restrictive practice, colleagues must consider whether it is necessary, whether a safer and less restrictive option is available and whether the likely benefit outweighs the risk of harm. The reason, decision, intervention, monitoring and outcome must be recorded clearly.

8.1.2 Definitions or explanations of terms used

Term	Definition
Clinical Holding	A definition of clinical holding as taken from the Mental Capacity Act is "The use of restrictive physical interventions that enable colleagues to effectively assess or deliver clinical care and treatment to individuals who are unable to comply".
Clinical holding	As the proactive holding of part of the body to allow a procedure to be carried out, for example, holding an arm while

Term	Definition
	blood is being taken in order to prevent reflex withdrawal and consequent unnecessary pain, distress or injury to the patient, colleagues or accompanying persons.
De-escalation	The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression (NICE).
Duty of candour	Refers to the volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether the information has been requested and whether a complaint or a report about that provision has been made.
Non-physical assault	The use of inappropriate words or behaviour causing distress and or constituting harassment.
Physical assault	The intentional application of force to the person of another without lawful justification resulting in physical injury or personal discomfort.
Positive behavioural support plan (PBS, HEE)	PBS is a person-centred framework for providing long term support to people with a learning disability, and, or autism, including mental health conditions, who have, or may be at risk of developing, behaviours that challenge. It is a blend of person-centred values and behavioural science and uses evidence to inform decision-making.
Restrictive intervention	Interventions that may infringe a person's human rights and freedom of movement, including physical restraint, chemical restraint, rapid tranquillisation, psychological restraint, seclusion, clinical holding, mechanical restraint (RDASH does not use mechanical restraint)
Restrictive practices	Restraint Reduction Network (RRN) defines restrictive practices as "making someone do something they don't want to do or stopping someone doing something they want to do. In service settings this can be linked to the use of blanket rules which apply to everyone regardless but may have a tenuous for application or are only necessary because of a specific individual risk".
Using restraint	Mental Capacity Act Code of Practice, section 6(4) states that someone is using restraint if they: "Use force or threaten to use force to make someone do something that they are resisting or restrict a person's freedom of movement whether they are resisting or not".
Violence and aggression	Refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether violence or aggression is physically or verbally expressed, physical harm is sustained, or the intention is clear.
Work-related violence	The health and safety executive (HSE) defines it as any incident in which a person is abused, threatened, or assaulted in circumstances relating to their work. This can include verbal abuse or threats as well as physical attacks.

8.2 Appendix B action following a serious assault

Serious assault on a:

- colleague
- service user
- visitor

Senior colleague to:

- contact service matron or senior manager on call
- contact clinical director (if medic assaulted)
- ensure the colleague that has been assaulted has reported it to the police (with support if needed)
- inform local security management specialist (LSMS)

For any serious assault against a medic, the medics decision-making responsibility will be immediately suspended, and responsibility temporarily handed to the duty consultant, who will make any immediate decisions required for the service user's care.

Arrangements will then be made for the service user's long-term care to be allocated to another consultant via the pre-agreed rota.

8.2.1 Report to police

Anyone can report an assault if the person who was assaulted cannot do so. The police will decide what action to take. If the person is arrested and removed from the service, their immediate care and discharge arrangements must be managed safely. Mental health colleagues will assess the person in custody and arrange further assessment or care if needed.

8.2.2 Arrested by police

- Criminal justice system procedure to take its course.
- Return to service only after full risk assessment by consultant psychiatrist (new consultant for service user if appropriate)

8.2.3 Not arrested

- Remain in service.
- Clinical review.
- Risk assessment by consultant and victim informed of risk management process by the consultant managing the situation.
- Movement of colleagues if required.
- Change of medic if appropriate.
- Senior manager to raise the incident with police at senior level if felt to be required.

8.3 Appendix C safety pod guidance and information

Using Safety Pods in inpatient areas supports the Trust's commitment to safer care for patients and colleagues.

A Safety Pod is a large, supportive seat similar to an oversized bean bag. It meets safety and infection prevention requirements. It is designed to support the patient

and colleagues when physical intervention is needed. Instructions for reverse passive to the pod and seated techniques are available in [physical interventions, core techniques \(staff access only\)](#) and [physical interventions, comprehensive \(high Level\) techniques \(staff access only\)](#) on the Trust intranet.

The Trust encourages colleagues to use Safety Pods as part of primary and secondary prevention and as a therapeutic aid during de-escalation. If a situation continues to escalate, the Safety Pod may also be used as a tertiary strategy. Using a Safety Pod does not require extra colleagues.

Safety Pod training is part of mandatory reducing restrictive interventions training and is not a separate course. Colleagues must show that they can use the pod safely. Further information about use and maintenance is available from UK Pods and in the [medical devices management policy](#).

8.3.1 UK Pods Limited

UK Pods Limited supplies Safety Pods for use as part of person-centred approaches that aim to reduce restraint.

The pod is intended to provide a safer alternative to restraint on the floor when a situation becomes difficult to manage.

8.3.2 Medical review

The manufacturer arranges regular medical review of the Safety Pod and its use during physical interventions.

If you would like a copy of our latest medical review, please contact info@ukpodsltd.co.uk.

Services using a Safety Pod must explain how it will support primary, secondary and tertiary interventions and how it will help reduce restraint. Colleagues who may use the pod must read this guidance and include its planned use in local procedures and individual care plans.

8.3.3 Training

Colleagues expected to use a Safety Pod must receive approved training on physical intervention techniques, safe use, procedures and risks. This training must form part of the Trust's system for preventing and managing violence and aggression.

This training is likely to be Restraint Reduction Network (RRN) certificated.

The use of the Safety Pod should be fully recorded for review and planning purposes.

All colleagues using the Safety Pod should be in-date for their training.

It is best practice that the planned use of the Safety Pod be fully documented in an individual's support or crisis plan where its use can be carefully reviewed and approved by a multi-disciplinary team.

It is always good practice to include clients in any such consultation.

8.3.4 Guidance

The Safety Pod offers many opportunities for positive and proactive working, to mitigate rising distress and avoid the use of restrictive interventions altogether. It may also be used to keep people safe from harm in the event action needs to be taken to limit harm.

The following shows examples of ways in which the Safety Pod has been used by clients and represents some recommended uses. Primary uses:

- adjunct in therapy-based sessions
- as object of comfort
- to facilitate relaxation
- also to support general supervised activities

Secondary uses:

- de-escalation aid
- as object of comfort and, or to facilitate relaxation within context of co-regulation and self-regulation
- deep pressure therapy support tool.

Tertiary uses:

- physical intervention aid
- enhance safety and support as well as restraint reduction or minimisation efforts

Restrictive interventions, physical intervention holds in particular, may be used in the context of secondary and tertiary measures. The additional scope for reduction in the use of restrictive interventions may include, but are not limited to, the following:

- fewer colleagues involved in responses to challenging behaviour
- less likelihood of injury to client or colleagues
- shorter periods of physical intervention
- less restrictive holds
- less likelihood of undignified and unsafe interventions, for example, takedowns to ground level
- reduced time spent in potentially unsafe positions, for example, on the floor

When a Safety Pod is included in a personal support or crisis plan, the plan must explain why it may be used and how colleagues should use it. Complete an individual risk assessment and review every use.

8.3.5 How to set up the Safety Pod

Take hold of the hood next to the logo and shake the Safety Pod until the hood is empty of inner contents.



Place the hood of the Safety Pod and rest it onto the body of the Safety Pod as shown below.



8.3.5.1 Moving and handling

The Safety Pod weighs approximately 15kg. It is advised that the Safety Pod is set up for use and placed upright on its side when moving.



Physical Intervention Training team support is recommended before using the Safety Pod, for more information please contact info@ukpodsltd.co.uk.

Ensure the Safety Pod is set up before each use (see set up instructions).

It is recommended that the Safety Pod should be placed in supervised areas at all times.

It is advised you check the Safety Pod on a regular basis to check for damage (see maintenance guide).

We advise a refill, if the Safety Pod appears flat or low to the ground. A refill service is available nationally please contact info@ukpodsltd.co.uk.

To achieve the best results, it is advised your Safety Pod is checked and maintained on a regular basis. Please refer to maintenance log provided.

Do not use the Safety Pod on a wet or slippery surface.

8.3.6 Health and safety

8.3.6.1 Advised use of the Safety Pod position



The person should be sitting upright with head on hood support:



We recommended you **do not**:

- do not place a person face down in the Safety Pod or any surface
- do not place the Safety Pod on top of a person





8.3.7 Contact information

UK Pods LTD
6 Wallis Road
Skippers Lane Industrial Estate
Middlesbrough
TS6 6JB

Company number: 10414909

- [01642 453 777](tel:01642453777)
- info@ukpodsltd.co.uk

8.3.8 Safety Pod refill guide

We recommended that your Safety Pod maintains an even level from front to back and across to each side as shown below in the Safety Pod position.



In the hood of your Safety Pod passes the halfway seam as seen below, or if you do not have an even surface when the Safety Pod is in the set-up position your Safety Pod may require a refill or service.



Please contact a member of our team if you require any further information regarding a service and refill, contact info@ukpodsltd.co.uk.

Your Safety Pod will reduce in volume over time; to maintain good performance, it is advised your Safety Pod is checked on a weekly basis. Please find overleaf a maintenance log for your reference. If you require further information on this, please contact manufacturers at info@ukpodsltd.co.uk.

It is advised your Safety Pod is serviced annually.

We advise if any damage appears or if you have any questions about your Safety Pod condition, please contact info@ukpodsltd.co.uk.

For guidance on cleaning your Safety Pod please refer to cleaning guidance.

It is advised that risk assessments are carried out regarding the safe use of the Safety Pod and that this is done on an individualised basis.

UK Pods Ltd accepts no responsibility for damage or faults to a Safety Pod that does not carry a clear record of consistent maintenance

We highly recommend that your Safety Pod is regularly maintained. It is the user's responsibility to ensure regular maintenance is carried out and evidenced.

A maintenance log is provided with every Safety Pod as a guide.

It is recommended that you check your Safety Pod after each use and once a week for damage or faults.

We advise that you do not attempt to remove or add any filler to your Safety Pod, if you have any queries regarding the fullness of your Safety Pod please contact a member of our team.

8.3.8.1 Maintenance log

Maintenance log				
Date checked	Check by	Safety Pod location	Check by	Further action required

8.3.9 Cleaning

Safety Pods are made from stain-resistant material designed for regular cleaning. Clean the pod after use and follow the Trust's infection prevention and cleaning procedures.

Our Safety Pods can be cleaned using all current NHS approved cleaning solutions such as Chlor-Clean, Haz-tab, Milton and Tristel.