SAFE TRANSPORT OF PATIENTS POLICY

Introduction

This policy is designed to clarify the procedures relating to the transport of patients deemed to be at risk of attempting to abscond whilst being transferred to and from Ravenswood House and other institutions.

The policy sets out a number of measures designed to reduce the likelihood of absconding including: ratio of staff to patient, type of vehicle used, planning of the transfer and use of handcuffs. The following document sets out how they are used in on the very rare occasions when the other measures are not thought to be adequate to contain the risk of abscondion. Handcuffs are only to be used to facilitate unavoidable escorted journeys in those deemed to pose a high risk of absconding. If the journey is non-essential then it should not be undertaken.

Assessment of Risk of Abscondion using the Flowchart (Page 2)

This policy is to be read in conjunction with the accompanying flowchart (see over leaf) which links risk of absconding to management plans related to safe transportation of the patient in the community. The level of perceived absconding risk is to be recorded in the patient’s notes (nursing section).

In office hours
Wherever possible concerns regarding risk in relation to patients leaving the unit should be anticipated by the Multi Disciplinary Team (including the RMO and the clinical staff on the ward) and the Multi Disciplinary Team should draw up the care plan so as to ensure the safe transport of the patient. This process should be guided by the flowchart. The decision to use handcuffs would need to be sanctioned by the Director of Operations, Specialised Services Directorate or his deputy.

Out of Office Hours
If such a scenario has not been anticipated and it does arise out of office hours the person in charge of the ward in conjunction with the unit coordinator must refer to the flow chart in order to establish whether the patient falls into the medium or high risk absconding categories and therefore requires special measures relating to community transfers. The level of perceived absconding risk is to be recorded in the patient’s notes (nursing section).

If the person in charge believes that the patient’s risk profile might be such that he requires the use of handcuffs then they should contact the on-call consultant and senior nurse on call for them to decide if this is merited. If the decision to use handcuffs is made then this decision would also need to be sanctioned by the Adult Mental Health Directorate On-call Manager. The Unit Coordinator will record these verbal authorisations and sign the record of use of handcuffs (appendix 1). If any one of these three senior members of staff do not agree with the use of handcuffs then the escorted leave should not go ahead.
INITIAL ASSESSMENTS
Assessments of risk of absconding based upon the risk profile

CONTEMPORANEOUS INFORMATION
Any new information indicating an increase of absconding risk should be fed into the assessments.

Factors that indicate patient of low risk of absconding
• Multi Disciplinary Team assess low risk of absconding (no recent history or threats to abscond or escape).
• No immediate danger to self or other if abscond or escape.
• Current mental state stable.
• Currently receiving community leave.
• Compliance with treatment.

Factors that indicate patient of medium risk of absconding
• Multi Disciplinary Team assess risk of absconding as medium (some historical factors or threat to abscond or escape).
• Some impulsivity.
• Behaviour that may pose a risk to self or others if he were to abscond or escape.
• Current mental state fluctuating.
• Currently not receiving unescorted community leave.

Factors that indicate a patient of high risk of absconding
• Multi Disciplinary Team assess risk of absconding as high (historical and recent history of absconding or escape or threat to do so).
• Thought to pose an immediate risk to self or others if absconds or escapes.
• Exhibits acute symptoms of mental illness and/or challenging behaviour.
• Has no community leave.
• Patient detained under Section 35, 36, 38, 47, 48 and 49.
• Patients with a high degree of political or media interest.

Management: low risk
• Escort according to current leave entitlement.
• Transportation negotiable with what is available.
• Routine observation and report as per procedure.

Management: medium risk
• Number of escorts to be agreed by the Multi Disciplinary Team and Clinical Ward Manager (in office hours) or by the on-call RMO and senior nurse on-call (outside office hours).
• Care plan to be formulated and agreed prior to escort.
• Transport in secure van/hospital transport.
• Briefing session to take place before and after the escort.

Management: high risk
• Consult Multi Disciplinary Team, Clinical Ward Manager and RMO (in office hours) or on-call Consultant and senior nurse on-call (after hours).
• Is the trip necessary?
• Can the procedure/event take place on the unit?
• Minimum three escorts required (at least one registered nurse).
• Secure transport, with additional driver that remains with the escort.
• Care plan formulated by the Multi Disciplinary Team and Clinical Ward Manager (in office hours) or the on-call RMO and senior nurse on-call (outside office hours).
• Briefing session to take place before/after escort.
• Are handcuffs necessary? Refer to the Safe Transport Policy.
Care plan for patients thought to be of medium or high risk of abscondion should include:

1. Nature of the escorted leave (planned or emergency).
2. Need for escorted leave—can the procedure or event take place on the unit?
3. Duration of the escort leave
4. Legal status of the patient
5. Leave status of the patient
6. Patient’s current physical state, particularly conditions or circumstances which will be relevant to the possible use of restraint or handcuffs (e.g. muscular skeletal injuries and cuts).
7. Patient’s current mental state
8. Risk to the public, staff or patient. This would include risk of violence or aggression during the escort.
9. Is the patient likely to be co-operative during the escort?
10. Past and recent history of absconding
11. Previous recommendations and implications for future escorting events made in post-escorted leave analysis.
12. Decision regarding what type of vehicle should be used: hospital transport, secure van or ambulance (in the case of a medical emergency). Some individuals would require transfer by secure van but not require handcuffs.
13. The number of escorting staff required their skill mix, trained or untrained, and gender.
14. Staff to be involved in the escorted leave and their specific roles during the leave, including any strategic staff positioning at various points of the journey and whilst escorting the patient in the vehicle
15. Risk of accomplice assisting the patient to abscond
16. Communication arrangements between base and destination throughout the journey.
17. A risk assessment of the area to which the patient is to be escorted. This would include the lay out, exits, availability of waiting room, and the ability to accommodate patient and escorts. This should ideally be conducted prior to the escorted leave, although if this is not possible then it may be undertaken by one of the team on arrival whilst the patient remains in the vehicle.
18. Where the escorted leave is to a general hospital a member of the ward team should ring prior to the escort to request specific accommodation which might reduce the risk of absconding, e.g. a single room with ensuite facilities, or a request for speedy service at Outpatients or the Accident and Emergency Department.
19. Precise arrangements regarding, transfer from Ravenswood House to the secure vehicle and from the secure vehicle to the destination.
20. Route
21. Use of handcuffs
HANDCUFFS

1. The handcuffs used by Ravenswood House are Hiatt ratchet bracelets (general use). For long distance journeys heavy duty Chubb handcuffs are used. They will be applied so as to bring the wrists close together in front of the patient. In each case the handcuff will be linked to by means of a short chain to a single handcuff attached to the staff member’s arm.

2. The use of handcuffs would always be considered an “exceptional event”. They are never to be used routinely. They are to be used as one of a number of options to reduce the risk of absconding, detailed above.

3. Handcuffs limit the ability of the patient to run quickly. They also limit the individual’s dexterity and might reduce the risk of inappropriate or harmful behaviour. They reduce the risk of the patient striking out.

4. It is noted that once a patient is wearing handcuffs they are more likely to hurt themselves should they fall over. Over-tightening of the handcuffs may cause discomfort and soft tissue damage and handcuffs themselves may increase the risk of assault by strangulation if the patient so restrained is sat directly behind a member of staff.

5. If a patient is assessed (by the RMO and Multi Disciplinary Team during office hours or the senior nurse on-call and on-call consultant outside office hours) as posing a high risk of violence then the escorted leave outside the unit should be cancelled unless it is essential. If the patient is required to be escorted for a court appearance or transfer to another hospital, then they should be escorted to the secure vehicle (under restraint if necessary) and be placed in the seclusion area of the vehicle for the duration of the journey.

6. Handcuffs should not be used in medical emergencies where they would interfere with any treatment required (to ensure that those with physical illness are not adversely affected by the application of the handcuffs). They should not be used in order to overcome staff shortages. They are only to be used outside the medium-secure environment.

7. The availability and use of handcuffs within Ravenswood House would not normally be discussed in the presence of patients or visitors.

Possible Situations when Handcuffs Might be Used

a) Court hearing, particularly if it is a hearing related to disposal.
b) Transfer of prisoner under Section 47 being returned to prison\(^1\)
c) General hospital assessment or treatment in an emergency, which can not be delayed.

\(^1\)It is noted that there is no specific guidance as to who is responsible for the transfer of individuals back to prison and that in some circumstances it may be appropriate to ask the prison service to do it.
PROTOCOL FOR THE USE OF HANDCUFFS

1. The decision to use handcuffs is made after a risk assessment based upon the accompanying flow diagram (page 2) to establish escort status.

2. The decision to use handcuffs must not be based upon prejudice on the grounds of race, gender or age.

3. If it is deemed necessary for handcuffs to be used then the accompanying Record of Use of Handcuffs form (appendix 1) should be completed.

4. A minimum of three escorting staff (excluding the drive) should make up the team. All three members of the team should be trained in care and responsibility (C and R).

5. The number of escorting staff, their level of training and gender should be determined by the assessed risk of absconding.

6. Handcuffs must be used in such a way so as to cause the least possible discomfort for the patient. The patient’s hands must not be handcuffed behind them. The patient’s hands will be cuffed with their hands in front of them and then be linked by a short chain to a member of the escort team by a single cuff. Once inside the secure vehicle the handcuffs maybe removed based on the risk assessment.

7. The escorting staff should then dial 999 to summon police assistance in the event of a security problem which they are not able to deal with.

8. If the vehicle was unable to complete the transfer or return to the unit the staff should
   a. Contact the person in charge of the relevant ward at Ravenswood House.
   b. Handcuff the patient (if not already) and seek a suitable place to wait for help either from Ravenswood House if possible or from the police.

9. Unless there are exceptional circumstances male patients should be handcuffed to male staff.

10. The lead member of the escorting team must be qualified: they will provide leadership. They will not be handcuffed to the patient. They will control the application and removal of handcuffs as set out in the approved handcuff training. They will be the only member of the team to have keys for the handcuffs.

11. A full briefing identifying risks and details of the escort must the undertaken before the escorted leave. This should include all the escorting team and the driver of the vehicle. The briefing should be led by a senior member of staff with knowledge of the patient and the risk assessment.

12. Consideration should be given by the clinical ward manager or senior nurse on-call/modern matron as to where to apply the handcuffs. This would either be in the airlock at the front of the building or in ICA with the patient leaving through the rear entrance.
13. Before the handcuffs are applied staff must clearly inform the patient what they are about to do. At this point the patient will undergo a metal detector and rub down search. The patient should be informed of the risk of falling over should he try to run whilst cuffed.

14. When the handcuffs are removed the patient’s wrists should be examined and/or photographed with a digital camera. If there is any concern that the cuffs have caused injury then the duty doctor should be called to see the patient within the next 12 hours.

15. A debriefing session must be undertaken on return from the escorted leave. This session must be led by a senior member of staff with knowledge of the patient and the risk assessment. This should include feedback from the patient.

16. The Multi Disciplinary Team should carry out an evaluation of the escorted leave at the earliest opportunity to inform future escorted leaves. The lead of the escorting team would be invited to attend this meeting. The findings of this meeting should be recorded details recorded on the post escorted leave analysis form (appendix 2).

17. In the case of transfer via paramedic ambulance in a medical emergency, it may be accepted the use of handcuffs may not be appropriate if this is likely to hinder procedures to be undertaken by the paramedic staff in the case of a life-threatening condition.

18. The care plan should detail any circumstances in which the patient’s handcuffs can be removed and reapplied while they are outside the secure unit. This would include circumstances relating to certain treatments, examinations or when appropriate to allow the patient to use the toilet.

19. On some occasions it may be deemed necessary to take handcuffs with the escorting staff as a form of contingency, e.g. if the behaviour of the patient indicated that their risk of absconion had increased after receiving a court’s decision to dispose of them either to prison or hospital. In such a case it will be essential that there was a record of the contingency plan laid out in the patient’s notes prior to the escorted leave. Such a transfer would have to be staffed by a team who met the criteria for the use of handcuffs.
EQUIPMENT SPECIFICATION, STORAGE AND ISSUE

1. The handcuffs are to be securely stored in a satchel with the three sets of keys in a locked cupboard in reception. The contents of the handcuffs satchel will be checked by reception staff on a monthly basis. A record of this check will be made on a recording sheet (appendix 3). If any items are missing a report should be made immediately to Clinical Risk and Security Liaison Nurse.

2. Handcuffs will only be issued to qualified nurses/mental health practitioner who have undergone the handcuffs training. A pair of handcuffs with two keys will be issued at any one time. The escort lead and senior nurse on-call would sign out the handcuffs and keys at the beginning of the escorted leave and sign them back in on return.

3. If handcuffs have been used the out of hours the senior nurse or clinical ward manager will inform the Director of Operations the next working day.

4. The Clinical Risk and Security Liaison Nurse will monitor the use of handcuffs and report on a six monthly basis to the Clinical Governance Group.

STAFF TRAINING

1. All members of staff acting as lead escort or handcuffed to the patient must have undergone the handcuff training. A training programme will be delivered and staff will be required to attend refresher training on an annual basis. Only staff that have up-to-date care and responsibility training will be eligible for handcuff training.

2. A core group of staff will undergo handcuff training. These would be volunteers. It is anticipated that handcuffs will seldom be used and therefore regular training for a small group of staff will be vital to ensure the necessary expertise when the circumstance arises.

Policy Equality Impact assessment (point 6 page 3, Points 2 and 9 page 4) 11th April 2008
Policy originally drawn up May 2008
Review date May 2011
Appendix 1
SECURE SERVICES
RECORD OF USE OF HANDCUFFS

<table>
<thead>
<tr>
<th>Name of patient:</th>
<th>Ward:</th>
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<tbody>
<tr>
<td>Date of Intended use:</td>
<td>Legal status:</td>
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<tr>
<td>Purpose of Leave to include destination:</td>
<td></td>
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<tr>
<td>Careplan for safe transfer of high absconding risk patient completed:</td>
<td>Yes/No</td>
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**During Office Hours**

<table>
<thead>
<tr>
<th>Authorised by RMO (or nominated deputy)</th>
<th>Signature</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Authorised by Director of Operations, Specialised Services Directorate or his deputy</td>
<td>Signature</td>
<td>Date</td>
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**Outside Office Hours**

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<tr>
<th>Authorised by oncall consultant</th>
<th>Name</th>
<th>Date</th>
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<tr>
<td>Authorised by oncall senior nurse</td>
<td>Name</td>
<td>Date</td>
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<tr>
<td>Authorised by oncall manager for the Adult Mental Health Directorate</td>
<td>Name</td>
<td>Date</td>
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<tr>
<td>The above 3 verbal authorisations received by Unit Coordinator</td>
<td>Signature</td>
<td>Date</td>
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*Outside office hours the Senior Nurse on-call should record that this authorisation has been received verbally once the matter has been discussed with the oncall consultant, senior nurse and AMH Directorate on-call manager.*

**TO BE COMPLETED IMMEDIATELY PRIOR TO ESCORT**

| Assessment of need for handcuffs carried out? | Yes/No |
| Assessment indicates handcuffs still required? | Yes/No |

**Names of escorting team:**

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<th>Handcuffs issued by:</th>
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<td>Handcuffs applied by:</td>
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<td>Handcuffs removed by:</td>
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**Appendix 2**

**POST-ESCORTED LEAVE ANALYSIS OF USE OF HANDCUFFS**

(To be completed by MULTI DISCIPLINARY TEAM at next Ward Round Meeting following High Risk Escorts where handcuffs are applied)

<table>
<thead>
<tr>
<th>Patient's Name:</th>
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<tbody>
<tr>
<td>Date of Escort:</td>
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<td>Purpose of Leave, to include destination:</td>
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<th>Date of the meeting:</th>
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<td>In attendance:</td>
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<td>Evaluation of escorting arrangements:</td>
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<tr>
<td>Comments from service user immediately prior to the event (include date and time comments obtained):</td>
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<tr>
<td>Implications for future escorting events:</td>
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<tr>
<td>Signed RMO (or nominated deputy):</td>
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With reference to the Safe Transfer of Patients Policy, the handcuffs kept in reception at Ravenswood House, have been subject to a monthly review. The condition of the handcuffs has been reviewed and the safe function of the ratchet and key mechanism has been checked.

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<th>Date:</th>
<th>Signatures:</th>
<th>Action Taken:</th>
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