### MANAGEMENT OF SELF STRANGULATION INCIDENTS

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<td><em>To provide for all the quality of services we would expect for our families and ourselves</em></td>
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Mental Health and Disability Services

Operational Policy

The Management of Self Strangulation Incidents

November 2008
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1.1 Background

Suicide is not a new phenomenon in psychiatry (Cutcliffe, 2002) and was identified as a major cause of premature death in the Health of the Nation document (Dept of Health, 1992) particularly in people with a mental illness.

In psychiatric hospitals hanging is the most common method of suicide. The Department of Health (2001) found one quarter of completed suicides in Britain had been in contact with psychiatric services and 10% of suicide inquiries in Northern Ireland were psychiatric in-patients. These suicides were the most likely to be by hanging, and commonly occurring in the evening and at night.

Nursing staff are required to predict and manage reasonably foreseeable risks in the provision of care to patients (NMC 2002). Premature death by self-strangulation is a “reasonably foreseeable” occurrence for the nurse so there must be guidance on how to act in the event of strangulation incidents. None of the literature or guidance addresses what to do if first on the scene, and this is why there is a need for an evidence based policy (Millar & Esler 2005).

1.2 Policy aim

The aim of this policy is to inform nursing staff of action to be taken and their responsibilities, if first on the scene at a self-strangulation.

- This policy is to be read in conjunction with the following:
  - Management of Cardiac Arrest
  - Management of Deliberate Self Injury
  - The Management of Accidents/Incidents
  - Breaking Bad News Regional Guidelines – HPSS 2000

1.3 Policy

- Staff will manage the immediate first-aid of a self-strangulation incident until paramedic assistance arrives. The management includes –
  - Lowering the patient from hanging
  - The removal of a ligature from the patient’s neck
  - Resuscitation of the casualty
- Staff will participate in training provided by the Trust.

- Staff will follow the accompanying procedural guidelines when managing self-strangulation incidents.

- Staff will undertake and review individual and environmental risk assessments of acute psychiatric patients.

- Action will be promptly taken to manage potential risks.

- Necessary equipment will be provided by the Trust and made accessible.

1.4 Policy Team

Mrs E Millar, Back Care Advisor  
SN A Brown, Assistant Ward Manager  
Mrs D Lewis, Nursing Services Manager  
Sr A Esler, Community Psychiatric Nurse

1.5 Consultation

Mental Health Hospital Management Team  
Mr Alex Lynch, Clinical Governance Department  
Regional Paramedic Training Officer
1.6 Date Policy Agreed 10 April 2009
This Policy will be reviewed in April 2012
Policy accepted and agreed by:
Director Mental Health and Disability
Signature Oscar Donnelly Date 10 April 2009
Clinical Director
Signature Dr G Lynch Date 10 April 2009
1.7 References

Cutcliffe, JR (2002) Suicidal mental health inpatients: principle approaches to care. Mental Health Practice. 5(9), pp 32-37


Prevention

- Individual and environmental risk assessments of acute psychiatric patients will be completed and reviewed.

- Ward Managers will make sure that necessary action is taken promptly to identify potential risks.

Managing an incident

- For incidents of self-strangulation inpatient psychiatric facilities will be provided with equipment (ligature cutters, non-sterile gloves, and resuscitation face shields) to manage an incident. Equipment will be stored in an area, which is easily accessible by staff within the emergency cardiac bags at Noble House and the main hospital reception.

- Staff will initiate the emergency procedure in an incident of self-strangulation relevant to their clinical area. The appropriate assistance should be summoned via 6666 as required. The first member on the scene, after establishing patient status, will contact Ambulance Control (9) 999 and request the cardiac ambulance. A staff member who has been instructed in the use of the ligature cutter will attend the scene.

- In the event of a suspended strangulation, staff that are available will elevate the patient to reduce any tension on the ligature in order to prevent further injury. This also applies to instances of kneeling, sitting, and lying strangulation. Principles of safe manual handling will be applied, so far as is reasonably possible (see appendix 1).

- If the patient is hanging from a height that the staff will find difficult to reach, every reasonable effort will be made to reduce the tension on the ligature.

- In the event of a suspended strangulation, available staff will assist the lowering of the patient when the ligature has been cut from the point of suspension.
• Available staff will control the patient’s head (see appendix 2), into a supine position onto the floor/ground maintaining in-line mobilization (see appendix 3). If the ligature remains in situ then it will be removed from the neck. **Do not cut the knot as it may be important forensic evidence.**

• Contact the PSNI

• In all instances of self-strangulation:
  
  Assess the patient’s
  
  - Airway
  - Breathing
  - Circulation

  Assess the patient’s neurological status

  - Consciousness/Unconsciousness
  - Response to pain
  - Orientation

  Immediate CPR to commence if required

**Action following an incident**

• Responsible Medical Officer to make immediate contact with person identified in ‘contact in emergency section’ of patient’s case notes.

• All patient’s involved in incidents of Self Strangulation requiring the use of ligature cutter as an intervention, **will be medically examined.**

• An incident form will be completed regarding the use of the ligature cutter. The position and location of surrounding furniture, the placement of the knot, and type of ligature used will be identified.

• The ligature will be kept in an envelope marked with the patient’s name for forensic purposes if required.

• All witnesses, including staff and patients will participate in a critical incident review.

• The patient’s nursing care plan will be reviewed following an attempted self-strangulation.
• Disposal of the ligature will take place when the Multidisciplinary Team has ascertained its retention is no longer required.

• Safely dispose of ligature cutters if you believe they have become blunt or contaminated undertaking this procedure.

• Liaise with Line Manager to source and replace ligature cutter immediately.

1.9 Equality Statement

This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote Equality of opportunity.

This policy has been screened to identify any adverse impact on the 9 categories. Following consultation it has been agreed that the policy does not require an Equality Impact Assessment.

If at any stage of the life of the policy there are any issues within the policy which are perceived by any party as conflicting with his/her rights, that party should bring these to the attention of the Director of Mental Health or raise a complaint to the Chief Executive through the published complaints procedure.

1.10 Principals of safe manual handling

• Keep the person to be transferred as close to your body as possible:

• Make sure of a good handgrip;

• Try to work as close to your natural, erect spinal posture as possible;

• Bend the knees when transferring – not the back;

• Ensure a good base of support is adopted.
1.11

Appendix 1

Lowering a patient from a suspended strangulation

This is a high-risk activity, where no other option is available.

Complete, suspended strangulation

- It is essential the patient is brought down immediately.
- Staff attending the scene will take hold of the patient’s thighs and elevate him/her to reduce tension on the ligature while help arrives to bring the patient down.
- If the patient is at a height that the staff find difficult to reach, every reasonable effort will be made to reduce the tension on the ligature e.g. place a table under the patient.
- A staff member will cut the ligature from the point of suspension;
- A member of staff will control the patient’s head, while other staff lower the patient into a supine position onto the floor/ground.
- Remove the ligature from the neck, using a ligature cutter if required.
- Do not cut the knot.
- Assess vital signs.
- Commence CPR if indicated.

Incomplete strangulation kneeling and semi-seated

- Staff will lower the patient to the ground immediately be removing the ligature.
- This may require the ligature to be cut from the point of suspension. DO NOT pull on the ligature to remove it (ie – from over a tap, bedpost).
- Staff must control patient’s head when ligature has been cut.
- If staff are not available to cut the ligature immediately, it is important that an attempt is made to elevate the patient by grabbing around the
thighs, hips, or by using the patient’s belts or clothes, to reduce the tension on the ligature.

- In a kneeling or semi-seated strangulation incident, this will be difficult due to the close proximity of the patient to the ground. All reasonable efforts must be made to save the patient in this situation.

Staff must use the principles of safe manual handling, as far as is reasonably practicable.

Lying Strangulation

- Staff will slide the patient up towards the point of suspension, to reduce the tension on the ligature before removal.

Dangers

- The weight taken by the staff will exceed the numerical guidelines, for lifting and lowering, (HSE1992), increasing the risk of injury to the staff.

Precautions

- Patient will have a medical assessment immediately – even if conscious.

- A full review of the patient’s risk assessment/care plan will be undertaken.

- A staff debrief will be held.

An audit will be initiated to:

- Investigate if best/safe practice was followed.

Implement any preventative measure indicated with hindsight, how can the ‘first on the scene’ incident be improved.
The following apply in instances of suspended strangulation

- Maintaining in line mobilisation of the spine is crucial in this emergency.

- Carry out Danger, Response, Airway, Breathing and Circulation (DRABC) check.

- Ongoing assessment of the patient’s neurological status, consciousness/unconsciousness, response to pain, orientation. Neurological deficits are often reversible with intervention, depending on how long the brain was without oxygen.

- Immediate CPR to commence (jaw thrust manoeuvre to be used for resuscitation purposes).

- Continue resuscitation until medical assistance arrives.