Policy:
Managing Substance Misuse and Harmful Substances on In-Patient Wards

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<thead>
<tr>
<th>Executive or Associate Director lead</th>
<th>Dr Mike Hunter, Medical Director</th>
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<tr>
<td>Policy author/ lead</td>
<td>Sharon Ward, Ward Manager / Vin Lewin, Clinical Risk Manager</td>
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<tr>
<td>Feedback on implementation to</td>
<td>Vin Lewin, Clinical Risk Manager</td>
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<tr>
<th>Target audience</th>
<th>All clinical staff working in in-patient wards</th>
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<td>Keywords</td>
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Policy Version and advice on document history, availability and storage

This is version 3.0 of this policy and replaces version 2 (November 2009). This version was reviewed and updated as part of an on-going policy document review process.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust’s website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version (V2) should be destroyed and if a hard copy is required, it should be replaced with this version.
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Flowchart A: Harmful Substances – Suspicion

**SUSPICION**

**Concern Relating to Harmful Substances**
- Evident
  - Refer to Flow Chart B
- Suspicion
  - Visitor
  - Challenge and ask visitor to leave
  - Consider further action
    - Management Review
    - Police Involvement for suspected illegal substances
    - Complete Incident Form.
  - Service User
  - Review with Nurse in Charge
    - Are there good grounds for concern?
      - No
        - Discontinue approaches
      - Yes
        - Review with Service User
          - explain grounds
          - give advice
          - define outcomes
          - No
            - Concerns Remain
              - Review in MDT*
                - Or with RC* at next opportunity
                - No
                  - Consider further Options
                    - further monitoring/ information needed
                    - consider room search
                - Yes
                  - Suspicion confirmed
                  - Refer to Search Policy
            - Yes
              - Concerns Remain
Flowchart B: Harmful Substances – Evident

Concern relating to Harmful Substances

Suspicion

Evident

Refer to Chart A

Service User

Confirm with Service User

Have substances been found

Contact Police

No

Service User gives to staff freely

Yes

Contact Police

Staff disposal following advice

Obtain Police advice re disposal of suspected illegal substances

Police arrange disposal

Incorporate into Service User’s treatment plan

Is there a need to break confidentiality?

Consider Class of Drug/substance and Intent

No

Record disposal

Maintain Service User Confidentiality

Record in ‘Drop box’ Record Book

Appropriate disposal

For suspected illegal substances place in secured ‘drop box’

Record disposal

Appropriate disposal

Legal substances as household waste

Obtain Police advice re disposal of suspected illegal substances

Incorporate into Service User’s treatment plan

Is there a need to break confidentiality?

Consider Class of Drug/substance and Intent

Possibly

Review with Consultant and Manager before proceeding

Visitor

Challenge and ask visitor to leave

Consider further action
- Management Review
- Police Involvement for suspected illegal substances
- Complete Incident Form.

EVIDENT

Appropriate disposal

For suspected illegal substances place in secured ‘drop box’

Record in ‘Drop box’ Record Book

Record disposal

Maintain Service User Confidentiality

No
1. **Introduction**

1.1 The Trust has clear responsibilities for providing an environment and culture that is best able to meet the health care function. Given this remit, the Trust and its employees have an obligation to provide a structure and guidance to promote behaviours and attitudes of healthy living and decrease behaviours and attitudes which are likely to be detrimental to the health of service users, staff and others.

1.2 The misuse of substances may be detrimental to the health of the individual and is, in some circumstances, illegal. As a health care provider, the Trust is concerned that substance misuse may reduce the positive prognosis of an individual's treatment.

1.3 The Trust has a legal responsibility to ensure that the wards are free of illegal substances.

1.4 The policy avoids taking a moral viewpoint and aims to guide staff on the correct course of action to take if they suspect a service user is in possession or under the influence of a harmful substance. It will also provide the reassurance to staff that they are not breaching their duty of care to the service user while fulfilling the legal obligations they may have under the Misuse of Drugs Act 1971, in relation to substances that are illegal.

2. **Scope**

This policy has been written to give staff confidence and guidance to help deter the use of harmful substances within the Trust's in-patient services and enable them to take appropriate action where such use is suspected.

The policy aims to promote a thoughtful response to the misuse of harmful substances on all in-patient Wards.

**For prescribed Controlled Drugs** – Staff should refer to the Standard Operating Procedures for Controlled Drugs.

3. **Definitions**

**Service User** – any service user, patient, client, resident

**Nurse-in-charge** – the person with overall responsibility for the shift on a ward at the time of the event

**Harmful Substances**

Harmful substances, for the purpose of this policy, are defined as:

- Those drugs falling under Class A, B and C of the Misuse of Drugs Act 1971, which are supplied/used without prescription and/or outside of an individual's treatment plan.

  NB: The Misuse of Drugs Act now includes khat (2014), Novel Psychoactive Substances (NPS) also know as legal highs (2016) or ‘fungus (of any kind) which contains psilocin or an ester psilocin’

- Other drugs or substances which, although not illegal, are taken, outside of prescription, in order to alter mental state, for example glue.

- Alcohol taken contrary to a prescribed plan of treatment or the ward’s policies.
Suppliers
A supplier (for the purpose of this policy) is anyone who gives or sells harmful substances to other persons. Within our services it is possible that service users may be suppliers to other service users or that service users may be given/sold harmful substances by visitors.

Users
A user (for the purpose of this policy) is anyone who uses harmful substances and continues their habit despite the negative impact on their physical and/or mental illness or social problems. The individual may use a harmful substance for a variety of reasons, which can include culture, effect experienced, behaviour, etc. The user may or may not be aware or accept the possible unhealthy effects of the substance s/he is using and the possible negative affect the substance may have on their treatment plan.

4. Purpose
For the purpose of this policy, substances that are commonly misused are, for example, illegal drugs including khat, NPS (legal highs) also alcohol, glue and non-prescribed drugs.

The misuse of drugs/substances may be detrimental to the mental and/or physical health and may have an effect on the behaviour of individuals and is, in some circumstances, illegal. As a health care provider, the Trust is concerned that substance misuse may further reduce the positive prognosis of an individual's treatment.

The Trust also recognises that the unchallenged misuse of substances by individuals receiving treatment from our services, can and will have an impact on other service users in relation to their individual feelings of safety, wellbeing and confidence in the services in general.

Tobacco is not included but all health evidence would state that tobacco is a harmful substance – See Nicotine Management and Smoke Free Policy (NM&SF)

Intended outcome
• To give information and guidance to staff in providing information to service users.
• To provide guidance to staff in dealing with harmful substances on in-patient areas.

5. Duties
Ward Managers
• Ensure that this policy and guidance are applied within their sphere of responsibility
• Ensure that staff are aware and comply with their responsibilities (i.e. aware of what to report and how to report it)
• Ensure corrective actions are implemented
• Provide support or access to support for staff, service users or others involved in incidents as appropriate.

Nurse-in-charge
• Ensure corrective actions are implemented
• Provide support or access to support for staff, service users or others involved in incidents as appropriate.

Individual Ward Staff
• Ensure all incidents are reported before going off duty.
• Follow the guidance in this policy
• Ensure the immediate safety of persons and environment
• Support improvements to work processes following incident investigations
• Raise concerns as appropriate

**Multidisciplinary Team**
• Review individual incidents and wellbeing of service users
• Review all incident data regularly as part of governance discussions

6. Process

6.1 GUIDANCE FOR STAFF

6.1.1 Promotion of Policy Approach – Advice upon Admission

As part of the admission process all service users will receive an explanation about issues related to substance misuse and use of harmful substances in line with this policy. Information should also be contained in ward handbooks.

6.1.2 Service Users

All service users should, on admission, be informed that they are required to hand in all prescribed and non prescribed medications (including substances, alcohol and tobacco) to the nurse in charge. All service users should be advised by their named nurse that they are strongly advised not to take any substances during their treatment, other than those prescribed, as they can have a detrimental and serious effect.

Any medications will be stored in the ward medicine cupboard for disposal by Pharmacy.

Suspected illegal substances will be disposed as described in Section 6.8 of this policy. Harmful (legal) substances and alcohol on admission – will be kept for 48 hours for relatives, etc to collect and remove from the ward. After 48 hours alcohol/substances will be disposed of. Also refer to Section 6.9 of this policy.

NM&SF policy advocates asking service users either not to bring tobacco in or ask relatives/friends to take it back home or we store it for return on discharge (see policy)

6.1.3 Visitors

All wards encourage visitors to enable service users to maintain relationships with family and friends. While staff should not be intrusive while observing visitors they should be aware of the interactions and may need to take action if there is suspicion of use/supply of harmful substances. As such, the observation can be made less obtrusive if staffs make themselves known to a service user’s visitor.

6.2 PROFESSIONAL RESPONSIBILITIES

6.2.1 All health care staff have a duty of care to act in the best interests of service users. The following areas are of prime consideration:

- The welfare of the service users
- Acting in the best interests of service users
- To maintain confidentiality.

**NB if a service user is supplying harmful substances to other service user(s) our duty of care is greater to the other service users and not the supplier.**

6.2.2 All professional bodies clearly state that the professional responsibilities in this area are not transferable and are not abrogated by delegation to another professional. The professional
must at all times act in the service user’s best interest and the law.

6.3 MAINTAINING SERVICE USER RELATIONSHIPS

It is acknowledged that an increasing amount of service users have dual diagnosis issues (i.e. mental health problems and substance misuse problems) and this issue can be integral to the lives of the service user we are caring for. The multi-disciplinary team must therefore recognise and own the issue of dual diagnosis being integral to service user care and that we have a duty of care to help.

However, if the help offered is refused or counter-therapeutic behaviour persists, or if behaviour compromises the safety of other service users then it may be necessary to review whether the current in-patient setting is appropriate.

6.4 SUSPICION OF SUBSTANCE MISUSE (Service Users)

Given the legal and health issues surrounding substance misuse the following guidance aims to assist staff in taking action where use/supply is suspected. While such guidance cannot be expected to cover every eventuality, it is expected that staff will act in the best interests of the service user and the law.

6.4.1 If staff have any suspicion or concern about the use or possession of harmful substances then these should be recorded and included in clinical decision making and always reported to the nurse in charge of the ward.

6.4.2 There should be good grounds for the suspicion, such as concerns raised by other service users and/or observations of service user’s behaviour or appearance. The grounds of concern should be confirmed by the nurse in charge.

6.4.3 Care should be taken not to accuse the service user of possessing or using harmful substances on the basis of suspicions only. However the apparent concern should be explored and reviewed with the service user by the appropriate member of staff. In most cases this will be the service users named nurse, unless the nurse in charge feels that issue needs to be reviewed sooner.

6.4.4 The reasons for the suspicion should be explained to the service user. If appropriate, the service user should have the opportunity to discuss related issues with members of the clinical team. Staff will then take measures to obtain evidence to support the suspicion (e.g. urine drug screen). The basis of this discussion, and any advice given to the service user should be documented in their clinical record.

6.4.5 The initial suspicion, and the information gained from the review with the service user should be reviewed with the service users Responsible Clinician or Consultant, at the earliest opportunity.

6.4.6 The conclusions drawn at this stage should be documented in the service user’s clinical record.

6.4.7 If suspicion still remains, consideration may be given to undertaking a search of the service user’s property, possessions and room in accordance with guidance provided in the Search Policy.

6.4.8 Flow Chart A at the beginning of this policy summarises action to be taken.
6.5 ACTION TO BE TAKEN WHERE THERE IS EVIDENCE OF SUBSTANCE MISUSE (Service Users)

6.5.1 Any service user known to be using illegal drugs or harmful substances, on Trust premises, will be actively discouraged from doing so. The service user should be informed that continued use, or intent to supply will result in the involvement of the Police. The Trust’s incident reporting procedure should be followed. Where a service user is misusing substances and this is clearly significant in their care and treatment, this needs to be reflected in their collaborative care plan. Consideration should also be given to referral to, or liaison with, the Substance Misuse Service where the service user meets the criteria for Dual Diagnosis (Mental Health and Substance Misuse) Protocol.

6.5.2 A full explanation of the (possible) adverse effects of behaviour associated with illegal or harmful substance use should be given to the individual in terms which s/he is able to fully comprehend. Associated concerns regarding the feelings and wellbeing of fellow service users should also be reviewed with the service user. Information regarding services available may need to be discussed with the service user. Staff should also be mindful of complications that could arise from a service user being intoxicated with substances and the possible physical effects this can have.

6.5.3 Where possible, the individual should collaborate in the writing their care plan with their named worker and the multidisciplinary team, to address concerns identified through their behaviours.

6.5.4 Where it is impossible to write the collaborative care plan with the individual, a suitable plan should be drawn up by the multidisciplinary team, until such time as the individual is able to fully participate.

6.5.5 Contracts may be included within the collaborative care plan, to which the individual agrees to abide. Should the individual not agree the possible repercussions should be explained to them, and fully documented in the service user’s clinical record.

6.5.6 Where behaviour in relation to repeated use of harmful substances persists, the following approaches should be considered;

a) That the individual service user is demonstrating behaviour that is deemed to be inconsistent with accepting and engaging in the treatment plan in place

b) In light of this consideration should be given to the service users mental state and the appropriateness of detention under the Mental Health Act

c) If detention is not appropriate then consideration should be given to discharging the service user from the ward.

d) Should discharge be considered appropriate the clinical team must be clear that this does not mean an end to the provision of any necessary and appropriate support and treatment from other parts of the health and social care services as highlighted by the service user’s needs

e) Where discharge is implemented in these circumstances, all necessary and appropriate arrangements consistent with expected practice around discharge planning should be followed i.e. all service users should have a discharge plan and appropriate communication with the care coordinator, Community Mental Health Team and/or other agencies involved in their community care package

6.5.7 Flowchart B at the beginning of this policy summarises action to be taken.
VISITORS

6.6.1 The use or suspected use of harmful substances by non-service users on Trust premises will result in the person being asked to leave the premises by the nurse in charge. The grounds for such suspicion should have good cause.

6.6.2 If any difficulties are experienced, the person will be informed that the Police will be contacted to attend the ward. Should they not leave immediately or if they return and continue their suspected activities then Police assistance should be requested immediately.

6.6.3 Where the person is a service user’s visitor, the service user will be informed of the reasons why such action has been taken. The Trust’s incident reporting procedure should be followed. Other wards on the site should be informed of the incident. Should the persons be suspected of continuing such activities, during future visits, on the premises, the Police should be contacted. The Ward Manager and Responsible Clinician or Consultant should be informed about what is happening and a discussion regarding the situation in terms of being detrimental to the service users mental health should ensue. A decision as to whether the visitor should be banned from Trust premises needs to be made. Where this affects particular service user(s), the reasons should be fully explained to the service user(s), by a member of the multi-disciplinary team.

6.6.4 The individual concerned will be informed that they are banned from further visits until a review by the Ward Manager has been undertaken. The individual concerned will be informed of the outcome of this review, which may entail a continued ban, or supervised visits, or no further action.

SUPPLYING OF HARMFUL SUBSTANCES

6.7.1 If staff have any suspicion or concern about the supply of harmful substances then these should be reported to and reviewed with the nurse in charge of the ward. The Trust’s incident reporting procedure should be followed.

6.7.2 There should be clear and substantial grounds to support the belief and concern that a service user is supplying harmful substances to other service users. The grounds for concern should be confirmed by the nurse in charge.

6.7.3 Where it is evident that such concerns exist and are well founded, the service’s duty of care to other service users will be regarded as overriding the duty of care to the individual service user concerned. Such continued actions by a service user are considered to be seriously detrimental to the safety and wellbeing of other service users. The following two courses of action will be considered:

a) The active involvement of the Police will be considered as an appropriate means to provide for and safeguard the wellbeing and safety of other service users. Following the involvement of the Police, any consequential action arising for the service user concerned will be determined by the Police. Clinicians responsible for the service user concerned may undertake and seek to advise the Police as to the service user’s circumstances, however, decisions regarding legal implications will be for the police to address.

b) Discharge from the ward should also be considered. Outline guidance for the approach to be taken in response to this potential is contained within paragraph 5.6 of this Policy. It is acknowledged that discharge may not be an option due to detention of the service user. Where this applies the MDT need to formulate a plan of care that adequately addresses the problem.
6.8 DISPOSAL OF HARMFUL SUBSTANCES

NOTE: South Yorkshire Police have recommended that each site in the Trust should have available a drug ‘drop box’ for proper disposal of suspected illegal substances. The Police have undertaken to empty these boxes on request. The boxes are at the following sites; The Longley Centre, Michael Carlisle Centre and Forest Lodge. There is a record book for the purposes of recording appropriate information.

6.8.1 Following the location of any illegal substances, or suspected illegal substances, the substance should be retrieved and placed in the secured drop box. An entry should be made in the ‘drop box’ record book and signed by two qualified nurses.

6.8.2 If the service user declines to surrender the suspected substance, the nurse in charge of the ward will provide the service user with the option of surrendering the substance anonymously to the nurse, or directly to the Police.

6.8.3 Members of staff acting on behalf of the Trust are not authorised, under law, to possess illegal substances. This action is only supported pending appropriate and timely action to ensure that the suspicious substance is passed for safekeeping to an individual who is authorised to possess and arrange for its disposal.

6.8.4 Care should be taken not to directly handle any suspicious substances.

6.8.5 The appropriate Senior Manager and the service user’s Responsible Clinician or Consultant, should be informed that a suspected illegal substance has been found within the ward environment.

6.8.6 Substances which cannot be put in the ‘drop box’, e.g. large amounts. Members of staff are not authorised to dispose of large amounts unless it is done strictly in accordance with Police instructions and guidance.

6.8.7 Police personnel should be notified when the drop box requires emptying CONTACT SOUTH YORKSHIRE POLICE AND ASK FOR EXTENSION 4179 OR 4210 and an officer will attend to collect the substances. Staff should record in the record book when the box has been emptied.

6.8.8 There should be appropriate disposal of legal substances e.g. alcohol. If family members are not able to take them home these can be disposed of as household waste. The exception is tobacco which will be returned on discharge.

6.8.9 Service user confidentiality should be maintained in most circumstances. The exception to this will be influenced by the subsequent category of the illegal substance, and concerns relating to intent to supply. Any potential decision that over rides service user confidentiality, through informing the Police, can only be taken following consideration by the service users Responsible Clinician or Consultant and the Ward Manager or Senior Manager.

6.9 ALCOHOL MISUSE

It is Trust policy that alcohol is not consumed on Trust premises or grounds.

It is acknowledged that patients may consume alcohol while on leave from the ward. However, excessive use of alcohol is detrimental to patient’s physical and mental well-being. The issue of excessive use of alcohol should be addressed as outlined in Sections 6.1.2, 6.4, 6.5 and 6.7 of this policy.

On return from leave alcohol will be disposed of as in Section 6.8.8 of this policy.
7. **Dissemination, storage and archiving (Control)**

A copy of the policy will be placed on the SHSC intranet within 5 working days of finalisation and the previous version removed by Corporate Governance team. A communication will be sent out via the Communications Digest to all SHSC employees informing them of the revised policy. Managers are responsible for ensuring the hard copies of the previous versions are removed from any policy/procedure manually or files stored locally. Clinical and Service directors are responsible for ensuring that all their staff are aware of and know how to access all policies.

The Corporate Governance team will maintain an archive of previous versions of this policy, and make sure that the latest version is the one that is posted on the Trust intranet.

Where paper policy files or archives are maintained within teams or services it is the responsibility of the team manager to ensure that paper policy files are kept up to date and comprehensive, and that staff are made aware of new or revised policies. Older versions should be destroyed to avoid confusion. It is the responsibility of the team manager to make sure the latest version of a policy is available to all staff in the team.

8. **Training and other resource implications**

All teams providing care for service users should be familiar with the standards within this policy.

Training programmes for staff in these teams should refer to these standards.

Specific training is not required, but the standards should be referred to in other relevant training, e.g. Dual Diagnosis (Mental Health and Substance Misuse).

Also staff to be advised to add alcohol/substances as a ‘contributory factor’ to incident forms, where this is appropriate (see Section 9.1).
9. **Audit, monitoring and review**

9.1 All incidents where the presence of harmful substances are confirmed, are to be treated and managed as an incident under the Trust Incident Reporting & Investigation procedures. The relevant and associated documentation is to be completed in respect of this. Alcohol or substance will be recorded as a contributory factor where appropriate, e.g. substances found, where alcohol has been consumed prior to an incident, etc.

9.2.1 Monitoring of incident data via the Acute Care Forum Patient Safety sub-group and/or other Directorate meetings where incidents are reviewed.

9.2.2 Ongoing issues in respect of this policy will be reviewed through existing liaison forums established between the Trust and South Yorkshire Police.

9.3 Individual Directorates with responsibilities for in-patient care should consider the need to audit standards as part of their service improvement plans.

9.4 This policy should be routinely reviewed at least every three years, or before this if sufficient concern exists. The formal policy review will consider the appropriateness and effectiveness of the outlined approaches based upon:
   a) information regarding prevalence based upon incident reporting
   b) issues highlighted through existing liaison forums
   c) other sources of feedback, such as complaints, service user forums, national reports/ guidance subsequently published
   d) lessons learned from incidents

<table>
<thead>
<tr>
<th>Monitoring Compliance Template</th>
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<tr>
<td>Minimum Requirement</td>
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<td>Policy content including duties and process</td>
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## 10. Implementation plan

<table>
<thead>
<tr>
<th>Action / Task</th>
<th>Responsible Person</th>
<th>Deadline</th>
<th>Progress update</th>
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<tr>
<td>New policy to be uploaded onto the Intranet and Trust website.</td>
<td>Director of Corporate Governance</td>
<td>Within 5 working days of ratification</td>
<td></td>
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<tr>
<td>A communication will be issued to all staff via the Communication Digest immediately following publication.</td>
<td>Director of Corporate Governance</td>
<td>Within 5 working days of issue</td>
<td></td>
</tr>
<tr>
<td>A communication will be sent to Education, Training and Development to review training provision.</td>
<td>Director of Corporate Governance</td>
<td>Within 5 working days of issue</td>
<td></td>
</tr>
<tr>
<td>Make team aware of new policy, including the need to include alcohol/substance on incident forms, where it is a ‘contributory factor’</td>
<td>Ward Manager</td>
<td>30.11.2016</td>
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<tr>
<td>Check staff awareness through supervision</td>
<td>Ward Manager</td>
<td>Next session following issue.</td>
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11. Links to other policies, standards and legislation (associated documents)

- Incident Reporting & Investigation Policy
- Personal Search Policy
- Liaison with Police
- Dual Diagnosis (Mental Health and Substance Misuse)
- Waste Management
- Standard Operating Procedures for Controlled Drugs
- Nicotine Management and Smoke Free Policy
- Discharge Policy (In-patients)

12. Contact details

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Nurse – Patient Safety</td>
<td>Charlie Turner</td>
<td>22 63377</td>
<td><a href="mailto:charlie.turner@shsc.nhs.uk">charlie.turner@shsc.nhs.uk</a></td>
</tr>
<tr>
<td>Clinical Risk Manager</td>
<td>Vin Lewin</td>
<td>16379</td>
<td><a href="mailto:vin.lewin@shsc.nhs.uk">vin.lewin@shsc.nhs.uk</a></td>
</tr>
<tr>
<td>Police Liaison Lead</td>
<td>Richard Bulmer</td>
<td>16384</td>
<td><a href="mailto:Richard.bulmer@shsc.nhs.uk">Richard.bulmer@shsc.nhs.uk</a></td>
</tr>
</tbody>
</table>

13. References

- Misuse of Drugs Act 1971
### Appendix A – Version Control and Amendment Log

<table>
<thead>
<tr>
<th>Version No.</th>
<th>Type of Change</th>
<th>Date</th>
<th>Description of change(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.0</td>
<td>Review / ratification / issue</td>
<td>Nov 2016</td>
<td>Full review completed</td>
</tr>
</tbody>
</table>
### Appendix B – Dissemination Record

<table>
<thead>
<tr>
<th>Version</th>
<th>Date on website (intranet and internet)</th>
<th>Date of “all SHSC staff” email</th>
<th>Any other promotion/dissemination (include dates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0</td>
<td>Nov 2016</td>
<td>Nov 2016 – via Communications Digest</td>
<td></td>
</tr>
</tbody>
</table>

**Stage 1 – Complete draft policy**

**Stage 2 – Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If NO – No further action required – please sign and date the following statement. If YES – proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date)  

**Stage 3 – Policy Screening** - Public authorities are legally required to have ‘due regard’ to eliminating discrimination, advancing equal opportunity and fostering good relations, in relation to people who share certain ‘protected characteristics’ and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don’t know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

<table>
<thead>
<tr>
<th>Group</th>
<th>Does any aspect of this policy actually or potentially discriminate against this group?</th>
<th>Can equality of opportunity for this group be improved through this policy or changes to this policy?</th>
<th>Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DISABILITY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GENDER REASSIGNMENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREGNANCY AND MATERNITY</td>
<td></td>
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</tr>
<tr>
<td>RACE</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>RELIGION OR BELIEF</td>
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<tr>
<td>SEX</td>
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<td></td>
</tr>
<tr>
<td>SEXUAL ORIENTATION</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Stage 4 – Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)  

Please delete as appropriate: no changes made.

Impact Assessment Completed by (insert name and date)  

Sharon Ward 10/11/16
Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person’s Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf (Relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?
   - ☑ Yes. No further action needed.
   - ☐ No. Work through the flow diagram over the page and then answer questions 2 and 3 below.

2. On completion of flow diagram – is further action needed?
   - ☐ No, no further action needed.
   - ☑ Yes, go to question 3

3. Complete the table below to provide details of the actions required

<table>
<thead>
<tr>
<th>Action required</th>
<th>By what date</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose ‘Format Text Box’ and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.

Managing Substance Misuse and Harmful Substances on In-Patient Wards

1.2 What is the objective of the policy/decision? .......................................................... 1

1.3 Who will be affected by the policy/decision? .............................................................. 1

Will the policy/decision engage anyone’s Convention rights? 2.1 NO

YES

Will the policy/decision result in the restriction of a right? 2.2 NO

YES

Is the right an absolute right? 3.1

NO

Is the right a limited right? 3.2

NO

YES

Will the right be limited only to the extent set out in the relevant Article of the Convention? 3.3

YES

Policy/decision is likely to be human rights compliant

BUT

NO

4 The right is a qualified right

1) Is there a legal basis for the restriction? AND
2) Does the restriction have a legitimate aim? AND
3) Is the restriction necessary in a democratic society? AND
4) Are you sure you are not using a sledgehammer to crack a nut?

Policy/decision is not likely to be human rights compliant please contact the Head of Patient Experience, Inclusion and Diversity.

Access to legal advice MUST be authorised by the relevant Executive Director or Associate Director for policies (this will usually be the Chief Nurse). For further advice on access to legal advice, please contact the Complaints and Litigation Lead.

Get legal advice

Regardless of the answers to these questions, once human rights are being interfered with in a restrictive manner you should obtain legal advice. You should always seek legal advice if your policy is likely to discriminate against anyone in the exercise of a convention right.
Appendix E – Development, Consultation and Verification

This is version 3.0 of this policy and replaces version 2 (November 2009). This version was reviewed and updated as part of an on-going policy document review process. Part of this update included mapping the draft onto the current policy document template and updating the contents.

Consultation and verification took place via the Service Users Safety Group. The policy was verified by the Deputy Chair of SUSG on 11 November 2016, prior to being sent for ratification.
Appendix F – Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy Document Template which can be downloaded on the intranet.

1. **Cover sheet**
   All policies must have a cover sheet which includes:
   - The Trust name and logo ✔
   - The title of the policy (in large font size as detailed in the template) ✔
   - Executive or Associate Director lead for the policy ✔
   - The policy author and lead ✔
   - The implementation lead (to receive feedback on the implementation) ✔
   - Date of initial draft policy ✔
   - Date of consultation ✔
   - Date of verification ✔
   - Date of ratification ✔
   - Date of issue ✔
   - Ratifying body ✔
   - Date for review ✔
   - Target audience ✔
   - Document type ✔
   - Document status ✔
   - Keywords ✔
   - Policy version and advice on availability and storage ✔

2. **Contents page** ✔

3. **Flowchart** ✔ ✔

4. **Introduction** ✔

5. **Scope** ✔

6. **Definitions** ✔

7. **Purpose** ✔

8. **Duties** ✔

9. **Process** ✔

10. **Dissemination, storage and archiving (control)** ✔

11. **Training and other resource implications** ✔

12. **Audit, monitoring and review** ✔

   This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).
<table>
<thead>
<tr>
<th>Minimum Requirement</th>
<th>Process for Monitoring</th>
<th>Responsible Individual/group/committee</th>
<th>Frequency of Monitoring</th>
<th>Review of Results process (e.g. who does this?)</th>
<th>Responsible Individual/group/committee for action plan development</th>
<th>Responsible Individual/group/committee for action plan monitoring and implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Describe which aspect this is monitoring?</td>
<td>e.g. Review, audit</td>
<td>e.g. Education &amp; Training Steering Group</td>
<td>e.g. Annual</td>
<td>e.g. Quality Assurance Committee</td>
<td>e.g. Education &amp; Training Steering Group</td>
<td>e.g. Quality Assurance Committee</td>
</tr>
</tbody>
</table>

13. Implementation plan

14. Links to other policies (associated documents)

15. Contact details

16. References

17. Version control and amendment log (Appendix A)

18. Dissemination Record (Appendix B)

19. Equality Impact Assessment Form (Appendix C)

20. Human Rights Act Assessment Checklist (Appendix D)

21. Policy development and consultation process (Appendix E)

22. Policy Checklist (Appendix F)
Appendix G – Novel Psychoactive Substances (Legal Highs or Chemical Highs)

From 2016 these Substances are no longer legal and come under the Misuse of Drugs Act 1971.

Background
A new phenomenon for in-patient areas is the increased use of Novel Psychoactive substances (NPS) more commonly referred to as Legal Highs or Chemical Highs. They are used across all age ranges and there is currently no research as to the short, medium or long-term effects of the use of these substances.

NPS come in small brightly coloured packages with appealing and catchy names. There were 24 NPS appeared in 2009 and this has risen exponentially year on year to 251 in 2012.

More recently, NPS have been in a format that allows them to be used in electronic cigarettes. This is a new development and requires further exploration.

There has been a 35% increase in hospital admissions related to NPS (5 people in Sheffield) and 68 deaths in 2010 (non in Sheffield)

NPS are bought primarily from Headshops (42%) in which there are a number in Sheffield and the internet (45%). Recently a number of local shops and petrol stations have also been found to be selling NPS.

NPS are a group of psychoactive substances that mimic the effects of illegal substances; cannabis, ecstasy and cocaine being the most common. Users of NPS have described them as being compulsive and moorish.

They broadly are categorised into three main groups

| Stimulants | Hallucinogens | Depressants |

NPS are often not legal and are certainly not safe. NPS are illegal under current medicines legislation to sell, supply or advertise for ‘human consumption.’ To get around this sellers refer to them as research chemicals, plant food, bath crystals, alloy wheel cleaner, pond cleaner etc.

Current Concerns
- Dosing problems
- Circulatory or heart problems
- Membrane damage
- Over heating
- Compulsive re-dosing
- Insomnia
- Change from established culture of drug use

As previously stated there is no meaningful research as to the health effects of these substances. Research carried out by the Home Office in 2013 showed that 1/20 NPS also contained illegal drugs. Testing also showed that there was no consistency in the potency of NPS in those with the same name or bought at different times.

Service users have used ingenious means to bring NPS onto Trust properties. Headshops are selling adapted drinks cans, water bottles and possibly other reciprocals that have the weight of a full can/bottle but the lid or centre can be twisted off to reveal a compartment where the NPS packet can be placed whereby the reciprocal looks for all intent and purpose as its intended function.
**Health Risks**
The paucity of information on the pharmacology and toxicology of most NPS makes it hard to understand their possible dangers, or even to know what substances are contained in products.

Use of NPS (both alone and with other substances) can result in acute toxicity and serious harm. The use of NPS can also result in young people and adults putting themselves in situations where they may be vulnerable or at risk of other harms (e.g. through collapse, intoxication, etc) including accidents and being victims of crime (e.g. sexual or physical assault).

The clinical features seen in service users with acute toxicity associated with NPS include agitation, psychosis, delirium, tachycardia, hypertension, chest pain and seizures.

Previous experience of in-patient areas is that the first signs are that service users are physically unwell whereby their physical observations make no diagnosable sense or that there are behavioural disturbances that do not mimic previous patterns of behaviour.

Other effects can mimic drugs like cocaine, ecstasy and amphetamines. These can include

- Reduced inhibitions
- Drowsiness
- Excitement
- Euphoria
- Paranoia
- Coma
- Seizures
- Death

These risks increase with the use of alcohol and/or other substances.

In-patient staff have no means of knowing what chemicals have been ingested, smoked or inhaled thus making the risk of contraindications with prescribed medication and/or underlying physical health problem highly likely which leaves those who use NPS at risk of serious harm and/or death.

**Action**
Acute Toxicity should be treated through symptom management. Use the Early Warning Signs (EWS) form to monitor physical observations. Seek medical attention and if concerned call an ambulance.

If there is, suspicion or evidence that a service user is using NPS In-patient areas should follow points 6.4 and 6.5 of this policy.

If there is suspicion or evidence that a service user is using NPS in-patient areas medical advice should be sort regarding administration of prescribed medication. Pharmacy advice should be sort regarding prescribing psychotropic medication.

In-patient areas should follow point 6.8 regarding the disposal of NPS due to the evidence indicating that 5% of NPS also contain illegal substances.

Healthcare professionals can contact the National Poisons Information Service (NPIS) for support in managing service users with acute NPS toxicity. Alternatively health care professionals can access TOXBASE on line however there may be a delay in the NPS being added to the database.

NB: It has to be noted that due to a paucity of national and international research on NPS and the risks associated service users risk death as a result of there use.