

**POLICY & GUIDANCE FOR THE
RECOGNITION, PREVENTION, AND THERAPEUTIC
MANAGEMENT
OF VIOLENCE AND AGGRESSION**
(Requirement by the NHSLA Risk Management Standards)

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Policy Title	Recognition, Prevention and Therapeutic Management of Violence and Aggression
Purpose of Policy	The aim of the policy is to promote a consistent and positive approach to the therapeutic management of aggression, so as to reduce to a minimum level the number and severity of violent incidents. The policy applies to all staff.
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ASSURANCE STATEMENT

North East London Foundation Trust is committed to promoting the safety of service users, staff, contractors and visitors. The reduction of risk is a high priority and a variety of interventions and methods will be utilised to address this complex problem. This policy and guidance is intended to provide a framework for practitioners to practice in a safe, consistent manner. Its aim is to reduce to a minimum level the number and of severity of violent incidents.

1. INTRODUCTION

- 1.1 Violence and aggression is a problem in most health care settings – in a busy A & E Department, GP surgery, in-patient wards and can be directed from both patients and visitors. Repeated exposure to violent and aggressive behaviour can have a highly negative effect on staff moral and performance. It can leave staff feeling vulnerable, and undervalued by their senior manager. It can also be very costly to the organisation as it may also result in high levels of sickness and failure to retain staff (Nabb, 2000).
- 1.2 Violence and aggression may relate to incidents by:
- Service user to staff
 - Service user to fellow service user
 - Staff to service user
 - Visitor/carer to service user
 - Visitor/carer to staff
 - Staff to visitor/carer
- 1.3 People are often faced with the dilemma of caring for the person who has assaulted them, and the same may be said about the patient/user or visitor/carer who experiences an assault by a staff member, who may have to explore issues of trust and respect for the care team/care system.

2. DEFINITIONS

- 2.1 For the purpose of this policy, NELFT recognises the following definition of violence: *'an incident where an individual is abused, threatened or assaulted in circumstances related to their involvement with the organisation, which includes an explicit or implicit challenge to their safety, well being or health'* (adapted from DOH 2000).

Violent incidents may result in:

- Major injuries requiring medical assistance
- Minor injuries which may or may not require First Aid treatment
- Threat / fear of assault with or without a weapon where no physical harm is caused
- Verbal abuse
- Damage to personal or hospital property

Where appropriate, incidents involving violence between employees will be dealt with under disciplinary procedures.

3. AIMS AND OBJECTIVES

- 3.1 To promote a consistent and positive approach to the therapeutic management of aggression, so as to reduce to a minimum level the number and severity of violent incidents.

Key policy issues:

- The recognition, prevention and management of aggression and violence.
- How to provide a safe and therapeutic environment for patients, staff and visitors.
- The aggression management strategies that can be legally and ethically applied before during and after an aggressive/ violent incident.
- To provide staff with a framework of good practice
- To outline accountabilities and responsibilities for staff working at all levels within NELFT.

4 DUTIES AND RESPONSIBILITIES

It is the responsibility of every member of staff to prevent aggression and violence. In addition, there may be particular responsibilities associated with professional and managerial roles:

4.1 Organisation responsibility

NELFT promotes Safe and Therapeutic services initiatives. This means it does not accept violence or the threat of it as an inevitable part of daily routine. This policy is part of an overall 'zero tolerance' approach aimed at developing a culture where prevention and reduction of violence is the aim. This is achieved by partnerships at all levels within and outside the organisation.

NELFT recognises and accepts its responsibility in accordance with relevant legislation. Accordingly, this policy is specifically aimed at reducing the risk of violence, whether verbal or physical, to patients, staff and visitors.

NELFT will:

- Have in place systems for the review of violent incidents and authorise staff to make changes as a result of these reviews.
- Make initial training and refresher courses available to staff.
- Adhere to relevant legislation.
- Carry out risk assessments and act upon their findings.
- Provide systems that allow adequate staffing to prevent or manage violent incidents.
- Provide support for patients, staff and others who have been involved in violent incidents.
- Work in collaboration with the CPS and police to ensure prosecution for violence against staff in appropriate cases. Ensuring that mental disorder is not used as a label to avoid responsibility for actions carried out with capacity.

4.2 Responsibility of Medical staff

Medical staff must carry out a formal risk assessment at agreed intervals and when significant changes to the patient's situation occur, e.g. on admission, changing levels of observation, prior to commencing and returning from leave, discharge and after an incident of violence in conjunction with other staff. The outcome of the risk assessment must be recorded in the clinical notes on RIO and made known to the staff and people who need to know (e.g. relatives) as soon as possible. A management plan based on perceived and actual risks must be recorded and accessible to staff. Informal risk assessment will be made as part of ongoing mental state assessments.

A physical examination should always be carried out when a patient has been involved in violence. This should be as soon as is feasible. In addition, medical staff will:

- Be available to listen to concerns of staff regarding current or potential difficulties in caring for patients
- Carry out joint assessments with other staff where required and contribute to risk assessment and subsequent management plans
- On call staff must prioritise work and review same as new requests for input are received
- Liaise with carers as required

4.3 Responsibility of Nurses (R.N'S)

Nursing staff must carry out a formal risk assessment at agreed intervals and when significant changes to the patient's situation occur e.g. on admission, changing observation levels, prior to commencing and returning from leave, discharge, after a violent incident in conjunction with other staff. The outcome of the risk assessment must be recorded in the clinical notes and made known to other staff and people who need to know as soon as possible. Informal risk assessment will be made as part of ongoing nursing assessments.

All nursing staff will also:

- Maintain the physical environment to ensure safety, reporting ongoing problems to their line manager
- Be aware of signs of potential violence and take steps to reduce these at the earliest opportunity
- Carry out joint assessments with other staff where required and contribute to risk assessment and subsequent management plans
- Ensure staffing levels are appropriate to the level of actual and potential risk (RN's).
- Liaise with carers as required.

4.4 Responsibility of Allied Professionals, Psychologists and Social Care staff

- Design and implement suitable interventions to help reduce violence in conjunction with other staff
- Be aware of the signs of (potential) violence and intervene appropriately to reduce these should they arise
- Report significant information to other staff and people who need to know
- Contribute to formal risk assessments as required
- Contribute the psychological perspective to understanding the person/ situation and how best to intervene

4.5 Responsibility of Ward Managers

Ward Managers are required to have systems in place to ensure:

- The induction of new staff includes outlining their role in emergencies and how to summon assistance and make response calls
- Staffing is flexible enough to cover (potential) violence
- Communication systems allow appropriate individuals to be informed of risks associated with patients
- Damage to the environment is dealt with promptly
- Staff are released for the appropriate training and updates
- Systems for reducing violence such as personal alarms, panic buttons, mobile phones and pagers are checked regularly.

- De-briefing and other post incident support take place facilitated by suitably trained and/or experienced individuals
- Effective measures are taken to protect the staff and patients for whom they are responsible
- Ensure a regular review of risk assessments are carried out together with implementing a preventative strategy to ensure all practical measures are taken to avoid violent incidents. Appropriate action must be taken when significant risks are identified. Risk assessments must be reviewed where there is reason to believe that they may no longer be valid
- Learning from previous events is incorporated into practice
- Liaise with other departments and agencies as required
- Have an awareness of the dynamics occurring within the team and the effects on the potential for violence, intervening to reduce this where necessary
- Ensure relevant policies and procedures are available and known to staff
- Accurate reporting of incidents
- Are aware of the legal, ethical and professional aspects involved in the therapeutic management of violence

4.6 **Responsibility of Executive/Borough Directors, AOD'S, Professional Leads, Modern Matrons**

Good practice indicates that senior managers need to take a lead within organisations, to ensure a strategic approach and consistent approach is taken to encourage the therapeutic management of violence and aggression.

The NELFT Board/Directors have the responsibility to ensure that in line with other comparable business decisions, the resources and support necessary to adequately implement and maintain this policy is made available.

In addition, they should:

- Ensure structures within management systems allow concerns to be reported and dealt with quickly
- Respond in a timely fashion when requests for advice or action is required
- Are compliant to the legal responsibilities defined by the Health and Safety at Work Act, Human Rights Act and Criminal Law Act
- Show support to staff directly affected by a serious violent incident
- Support staff to move forward criminal proceedings in the event of a serious violent incident.

4.7 **Responsibility of Service User's**

- To adhere to standards of behavior which include not abusing others either verbally or physically
- To identify issues which may trigger aggression in themselves and work with staff to reduce these
- To be aware that the display of aggression and violence may lead to action by others such as additional medication, restraint and/or contact with the criminal justice system

4.8 **Responsibility of Carers**

- To communicate any concerns to the key worker/ named nurse and /or the multidisciplinary team
- Contribute to reviews such as CPA meetings and ward rounds

4.9 **Responsibility of Advocacy Providers**

- To work with patients on the basis of informed consent
- To work with patients, staff and managers to promote a safer and therapeutic service

4.10 **Responsibility of all staff**

- To actively take responsibility for health and safety issues within the work environment, alerting line managers to potential hazards, including the risk of violence

5. **PREVENTION OF AGGRESSION AND VIOLENCE**

5.1 **Causes of violence**

Many incidents of violence arise from the individual feeling vulnerable, disregarded or ignored and the attack becomes a means of defense. While the causes of violent outbursts are not always easy to ascertain, the following have been identified as being some potential contributing factors:

- Past experience of being 'rewarded' for violent behaviour
- Lack of meaningful activity
- Lack of personal space, possessions or places to store possessions securely.
- Inability to hold private telephone conversations
- An institutional rather than a homely environment
- Restrictions on freedom
- Inability to communicate effectively or feel understood
- The use of illicit drugs or alcohol
- Feeling one's person or property is being invaded
- Feeling threatened
- Misinterpreting communication or hearing voices
- Not feeling in control of one's own situation
- Not feeling respected
- Group/ peer pressure
- Feeling overwhelmed by information or a lack of information
- Fear and anxiety
- Temperature (usually too hot)
- Overcrowding and a lack of privacy
- Cramped smoking areas
- Noise levels
- Poor air quality
- Inadequate nutrition
- Too little/ too much stimulation
- Tensions between patients
- Staff are perceived as inaccessible or too controlling
- Staff responses are inconsistent
- Communication between staff is poor

It is known that health and social care workers are at increased risk of violence because they:

- provide care or advice
- exercise/represent authority
- provide (or withhold) a service

- deal with alcohol or drug misuse
- may work alone with patients
- work outside office hours
- handle medication or valuables
- work with people under stress

The likelihood of aggression increases when staff:

- have to intervene with patients
- refuse requests
- ask patients to perform some activity
- are perceived to ignore patients

By considering the situation in conjunction with the intervention and the patient's presentation, staff can start to anticipate the likelihood of violence and construct plans to reduce the risk.

5.2 Risk Factors

Certain factors can indicate an increased risk of physically violent behaviour. The following list is not exhaustive and these risk factors must be weighed on an individual basis

a) Demographic or personal history

- History of disturbed/violent behaviour
- History of misuse of illicit drugs or alcohol
- Carers reporting patient's previous anger or violent feelings
- Previous expression of intent to harm others
- Evidence of rootlessness or 'social restlessness'
- Previous use of weapons
- Previous dangerous impulsive acts
- Denial of previous dangerous acts
- Severity of previous acts
- Known personal trigger factors
- Verbal threat of violence
- Evidence of recent severe stress, particularly loss or threat of loss

b) Clinical variables

- Misuse of substances/alcohol and drug effects (disinhibition, akathisia)
- Active symptoms of schizophrenia or mania such as
 - delusions or hallucinations focused on a particular person
 - preoccupation with a violent fantasy
 - delusions of control (especially with a violent theme)
 - agitation, excitement, overt hostility or suspiciousness
- poor collaboration with suggested treatments
- antisocial, explosive or impulsive personality traits
- organic dysfunction

c) Situational variables

- Extent of social support
- Immediate availability of a potential weapon
- Relationship to potential victim (e.g. difficulties in relationship are known)
- Access to potential victim

- Limit setting (e.g. staff members setting boundaries for activities, choices etc.)
- Staff attitudes (aggressive, sarcastic, disrespectful, discourteous, disinterest, demeaning language and behaviour)

5.3 **Warning of imminent violence**

Some signs that aggression and/or violence are imminent are:

- dilation of pupils
- increased pitch and volume of voice
- abrupt answers to questions
- sudden shouting or silence
- depersonalising body language
- towering posture
- invading others' personal space
- tensing of limbs and facial muscles
- sustained/prolonged eye contact
- clenching (and unclenching) fists
- restlessness, agitation, making sudden movements
- throwing things, banging/kicking furniture
- threatening gestures, provocative behaviour
- repeating same thing over and over
- direct threats

5.4 **Prevention of violent incidents**

- All staff has a responsibility to prevent situations which increase risks to patients, staff and others. A multi-faceted approach is required to prevent violence, including being aware of both the physical and emotional environment, including staff self awareness.
- The provision of a 'homely' environment in terms of furnishings and the ongoing maintenance of its decoration is key to creating an atmosphere where violence is discouraged. This is balanced with security features such as appropriate lighting etc where required.
- The provision of an accessible smoking area with adequate space is important.
- Staff must be sensitive to patient's need for access to open space and fresh air. This should be balanced with consideration of actual or potential risk(s).
- The ongoing review and maintenance of equipment such as panic/personal alarms, mobile phones and pagers which allow staff to call for help, may stop violence from occurring or escalating.
- Staff must be sensitive to patient's desire for privacy, especially when attending to personal hygiene or conversing with friends and family either in person or by phone. Again, actual or potential risk(s) in facilitating this freedom need to be considered, recorded in care plans and any restrictions regularly reviewed.
- The provision of information such as signage, verbal and in leaflet form also contribute to a reduction in violence.
- Staff should routinely assess and identify any potential difficulties in their area and take steps, wherever possible, to reduce the likelihood of such an incident.

- The only reliable predictor of violence is a known history of violence including threats and near misses and contact with the legal system which did not result in conviction or prosecution. This history must be made known to all persons who need to know, and all relevant risk indicators must be updated on the RIO system.
- Staff should be aware of patients with a history of aggression and have a plan in place for dealing with the situation should it arise. Collaboration with the patient to develop crisis plans is recommended good practice.
- The named nurse will collate information and initiate reviews as necessary. The reviews allow the multidisciplinary team, the patient and carers a formal opportunity for the review of risk.
- Procedures for searching and removing items that are considered to be dangerous are in line with preventing violence to self or others. The trust search policy should be read in conjunction with this policy. Staff conducting searches should do so in a respectful and sensitive manner.
- Wherever possible, staff must facilitate the ability for patients to exercise choice in their care and treatment. This includes informing patients of their options and helping him/her to weigh the benefits and risks.
- The provision of appropriate meaningful activities balanced with time for rest should be facilitated by staff for individuals and groups.
- Staff should pay particular attention to the management of activities known to be associated with increased levels of violence such as mealtimes. The deployment of adequate and appropriately skilled staff should be present during these activities, being alert to the possibility of violence and using skills to prevent such incidents.

5.5 Staffing

The trust has a legal obligation (Health and Safety at Work Act, Human Rights Act) to ensure there is adequate staffing available to deal with potential and actual violence. Staffing levels should be based on anticipated future events, therapeutic staff: patient ratios and any recent adverse events.

Managers should take into account the risk of violence when making a decision regarding staffing levels. There should be:

- An agreed skill, gender and ethnic mix of staff and flexibility to meet ward/unit needs.
- Adequate staff cover for night, weekend duty and shift change over's.
- Staff should not be left for long periods on their own, particularly junior or inexperienced staff.
- Stable and consistent in-patient teams
- Multi-disciplinary consensus on clinical care
- Staff training and development, with annual PMVA updates.

5.6 Calls for assistance

Calls for assistance should be made in line with the local borough response protocol. Urgent assistance for emergency situations should be made via the alarms or the Psychiatric Emergency Team (PET) response pagers which are activated on the ward by putting out a PET 1 call to NELFT switchboard on extension 1100 (Emergency phone). Do not dial Switchboard on 0 to request a PET call. Staff making response calls should speak clearly, stating the unit and exact location where assistance is required. Any other calls for assistance should be made by telephoning each unit to obtain an adequate number and mix of staff to manage the situation.

Details such as the exact location, the nature of the incident or reasons for assistance should be given. A member of staff should be designated to meet those staff arriving to help and direct them to where they are required. Staff arriving should be given relevant information about the patient and incident to allow them to assist.

5.7 De-escalation of potential violence

Potentially violent confrontations may occur due to a number of factors and all staff should be sensitive to the causes in order to minimise the risk of situations / persons escalating.

Internal motivator's e.g. paranoid ideas, auditory hallucinations may impact on the patient's presentation and care plans should reflect the impact of such symptoms. Emotional responses e.g. fear or frustration can also lead to confrontation and staff must make every effort to positively engage with patients to minimise negative experiences. External motivator's e.g. loss of liberty, excessive noise, feeling ignored and a lack of meaningful activity can also contribute.

Every effort must be made to establish preventative interventions by carrying out a thorough risk assessment and ensuring care plans reflect individual needs. Where possible, collaborative care planning with patients and/or carers should be conducted to establish how patients would prefer to be cared for during a violent or potentially violent incident (advance directive). This care plan should be communicated to staff.

De-escalation is always the preferred intervention when confronted with potential violence. This should only be superseded when delaying the use of other interventions would result in physical harm. In order to de-escalate a violent or potentially violent situation staff should aim to present in a calm and interested manner and display empathy to the patient's perspective. Non threatening, open body posture and active listening skills can reduce the risk of a violent response. It is important for staff to feel confident in the use of de-escalation and communication skills when a patient presents with potentially violent behaviour. The following verbal skills should be employed:

5.8 Verbal skills

Attempt to convey that their situation is understood by helping the person to talk about whatever it is that is troubling them. Staff should adopt an unhurried approach and:

- address the person using their preferred name
- focus on the emotional content not their level of arousal
- maintain a calm voice
- only use facts and don't make promises that can't be kept to get out of a situation
- Ask the person to place any potential weapons in a neutral place if safe to do so. Never ask them to hand a weapon to you.
- The person's risk assessment should determine if it is safe to negotiate or withdraw self and others from a situation involving weapons.
- Help the person address the reasons for their anger step by step
- Offer alternative solutions to the problem and negotiate options
- Avoid making the person lose face and don't feel you have to win – the aim is for a win-win outcome for staff and the person.
- Build on the person's strengths to help them take control of their actions
- Remind them throughout the conversation that you are there to try to help them
- Always be prepared to compromise and apologise if staff have provoked the person in any way
- Do not resort to status issues or threats

5.9 **Non-verbal skills**

Along with the above verbal skills, the following non-verbal skills should be used:

- Avoid/ reduce 'audiences' e.g. ask the person if you can discuss their concerns with them in private.
- Be aware of exit opportunities in the environment (own and other person's)
- Be aware of potential weapons and obstacles in the environment
- Avoid sudden movements
- Avoid sustained eye contact and standing 'square on' to the person
- Avoid cornering the person or crowding them (too many staff present)
- Show warmth and continued support
- Maintain a safe personal space
- Adopt a 'side on' stance and an open posture
- Sit beside the person if possible (maintain a safe distance to allow exit should violence occur) - avoid towering over the person.

Physical intervention should be avoided if possible, but may be necessary if someone will otherwise be hurt. Any physical intervention must be necessary and proportionate to the harm it is intended to prevent.

(Adapted from NICE Guideline 25 2005, The Royal College of Psychiatrists 1998, NIMHE 2004)

5.10 **Sexual Safety**

Ensuring our service users dignity and respect is maintained is a key priority for the Trust. Although the preferred choice for in-patient care is single sex wards, some of the wards within NELFT remain mixed, with single sex bathroom, toilet, bedroom and female only lounge facilities.

Unfortunately this can put both genders at risk from inappropriate, and unwanted sexual harassment/advances which can be frightening, distressing and humiliating for the individual involved.

When completing the initial risk assessment for a new admission, staff should always be mindful of the need to highlight and care plan for the following identified risks:

- History of promiscuous sexual behaviour
- Sex offences
- Increased vulnerability as a result of mental state
- Predatory sexual behaviour towards opposite/same sex
- Effect of alcohol/drug use on sexual behaviour
- Psychosis with sexual content
- Increased sex drive due to mental state (e.g. in a manic episode)

If an individual complains of being sexually harassed by another patient, then staff need to address this as a high priority risk factor and put appropriate safety measures in place e.g. increasing levels of observations. It is also essential that staff are supported by the trust through accessing adequate training and supervision to assist in the effective management of sexual safety within the in-patient areas.

6. RISK ASSESSMENT AND MANAGEMENT

- 6.1 Risk assessment is one element in an organisation's overall management system for Health and Safety and this principle applies to the overall management system for users of mental health services who pose a risk to either themselves or others. For the purpose of this guidance, the focus is on the risk of dangerousness to others.
- 6.2 'Risk' has always been part of the overall assessment of an individual's needs by all mental health professionals. However, the now familiar formal structures that have been developed to assess 'risk' arose as a result of many inquiries into incidents of serious violence by those with a history of mental illness (DHSS, '88; Ritchie et al, '94). The Government's responses to such inquiries and the Care Programme Approach (CPA) (D.o.H. '90) have greatly influenced 'risk assessment' and 'risk management'.
- 6.3 A systematic approach to identifying hazards, assessing the risks against such hazards and, reducing and controlling the risks will inform and support risk management (Clough, '98). Risk assessment and risk management cannot be separated.
- 6.4 The British Psychological Society, '98 identified the following areas that:
- ❑ will demonstrate good quality risk assessment
 - ❑ it is an on-going exercise and not a "one-off
 - ❑ it is closely monitored over time
 - ❑ it involves other staff/disciplines who can share their knowledge of the individual
 - ❑ there is an identifiable framework for assessing risk
 - ❑ there is commitment to learn from critical incidents
 - ❑ there is clear guidance to respond to and reduce the risk.
- 6.5 Inquiries into serious and/or fatal incidents involving someone with a history of mental illness, such as the Clunis Inquiry ('94), the Jason Mitchell Inquiry ('96) have all highlighted specific deficits in the care and treatment provided.

They are:

- ❑ failure by clinicians to obtain sufficient knowledge about a service user's history
 - ❑ poor communication between disciplines
 - ❑ lack of collaboration between agencies
 - ❑ lack of resources
 - ❑ failure to adequately assess and manage risk
(Doyle, '98).
- 6.6 The Care Programme Approach was introduced in 1991 and provides a framework for the care of mentally ill people in the community (D.o.H.'90). Clinical risk assessment and management are implicit when planning care and are key elements of the CPA

Elements to the CPA are based on systematic arrangements for assessing the health and social needs of those accepted into specialist mental health services. Various mechanisms were introduced into the CPA to address the needs to those who pose a significant risk, i.e. Supervision Registers ('94) and Supervised Discharge ('96) and Section 117 after-care ('95). In order to determine whether these are applicable, high quality risk assessment and management are central to operating an effective CPA.

- 6.7 Risk assessment should include a structured and sensitive interview with the service user, and where appropriate, carers. Efforts should be made to establish the service users own views and their trigger factors, early warning signs of disturbed/violent behaviour and the management of these.
- 6.8 Risk assessment should be used to establish whether a care plan should include specific interventions for the short-term management of disturbed/violent behaviour.
- 6.9 When assessing for risk of violent/aggressive behaviour, care should be taken to ensure that negative assumptions are not based on ethnicity. Staff members should be aware that some cultural traits might manifest as unfamiliar behaviour that could be misinterpreted as being aggressive. The risk assessment should be objective, with consideration being given to the degree to which the perceived risk can be verified.
- 6.10 Special provision should be made for pregnant women in the event that short-term interventions for the management of aggression are required. These should be recorded in the service users care plan.
- 6.11 Individual care plans should detail staff responsibilities for de-escalation, rapid tranquilisation, physical intervention, and seclusion of service users who have disabilities, including those with physical or sensory impairment, and/or communication difficulties.
- 6.12 If staff are aware that a service user has HIV, hepatitis, or any infectious/contagious diseases, advice from the trust infection control lead should be sought.
- 6.13 The approach to risk assessment and management must be multi-disciplinary and Reflective of the clinical setting in which it is undertaken.
- 6.14 The finding of the risk assessment must be communicated across relevant care settings and agencies

7. MANAGING A VIOLENT INCIDENT

7.1 Managing a violent incident

If the above measures fail to prevent a violent or potentially violent incident from escalating, the use of physical interventions may become necessary. Skilled leadership and cohesive teamwork underpin successful management of violence.

Physical interventions may include the administering of medication, supervised confinement and the use of appropriate levels of physical force. Adequate assistance should be called where possible before attempting any physical intervention. Where physical intervention is necessary, the degree of force to be used must be proportionate to deal with the incident. The number of staff involved to manage a violent incident directly should be a reasonable number necessary to restrain the individual whilst minimising the risk of injury to all parties. Where a member of staff has been assaulted by a service user, they should be replaced as soon as possible and play no further active role in managing the incident.

A member of staff must be designated to direct the team and ensure the physical and psychological well being of the service user. The service user's head and neck must be protected and absolutely no pressure applied to the neck area. Continuous risk assessment is essential and the designated team member must interact with the patient to ensure the physical intervention applied is proportionate to the presenting risk. De-escalation skills must be used throughout the intervention.

The use of pain compliance is not acceptable as it has no therapeutic value. Similarly restraint positions that increase the risk of positional asphyxiation e.g. prone restraint must only be used if safer methods e.g. seated or supine are likely to fail. Prone restraint must only be used for the shortest period of time or up to three minutes, beyond which time the prone recovery position should be used

The service user's physical state must be monitored during and after such intervention.

Staff involved in physical interventions must be trained to a level of basic life support and be fully aware of restraint related risks and medical emergency procedures. Qualified nurses must undertake the trust AED, suction, airway training, and this must be mandatory for all nurses working throughout the in-patient areas.

7.2 Weapons

Where staff are threatened with a weapon attempts should not be made to disarm the individual. Those present should attempt to keep the situation contained and call the police for assistance. In situations involving weapons staff should evacuate patients, visitors and staff to a safe area and dial 9999 for the police or via Switchboard emergency phone on extension 1100 PET 2 Weapons police assistance required. Explicit information regarding the location of the incident, the weapon involved and a description of the assailant and the risks they present will assist the police risk assessment process and allow a prompt response. 999 calls receive a graded response and clear information is required. Reception staff should be advised of the call so the police can be directed to the area on arrival.

7.3 Sensitivity to patients

Violence can be a reaction to (perceived or actual) feelings of a lack of sensitivity to individual needs. Staff faced with potential or actual violence must bear in mind any physical, sensory or communication deficit the person is experiencing and takes this into account when managing the situation. Similarly cultural and gender issues must influence the staff response to (potential) violence e.g. ensuring where possible that staff responding to a situation are of both genders. Assumptions regarding an individual's likelihood to be aggressive or co-operative should not be made; each situation must be managed as it unfolds.

8. PHYSICAL INTERVENTIONS

8.1 Disengagement Techniques (breakaway)

Occasionally during an aggressive encounter, a member of staff may be grabbed and held by an aggressor. The aim of using a disengagement technique is to escape from the grip of an aggressor. Staff have a legal right to defend themselves and others from harm. The level of force used to escape from a threatening situation must be necessary and proportionate to the perceived threat.

Disengagement techniques taught in training cannot cover every possibility and may not always be successful. Section 3 of the Criminal Law Act (1967) allows citizens the right to use force that is reasonable in such a situation. PMVA training provides staff with information regarding legal rights and professional responsibilities with regard to the use of force.

8.2 Restraint

Restraint may take many forms and may vary in degree from a supportive hold to seclusion. The essence of restraint is to contain or limit another person's freedom.

The degree of force used should be necessary and proportionate in degree, duration and nature to the actual danger or resistance presented by the violent individual. Staff attending a violent incident will have to make a decision as to what level of restraint is required. This will always be underpinned by using a therapeutic not punitive response.

- **Level 1 Restraint:** involves 2-3 staff members using supportive holds up to a secure straight arm hold. The patient may be stood, sitting or kneeling.
- **Level 2 Restraint :** involves 2-3 staff members using restrictive bent arm holds. The patient may be stood, sitting or kneeling.
- **Level 3 Restraint:** involves 3-4 staff members, including restraint of the patient's legs. The patient is lying in either a prone or supine position on the floor or a bed.

(Not to be confused with level 1, L2, L3, L4 holds as taught on POMOVA training)

Staff working within the YPU (Brookside) will need to be shown specific techniques in order to safely manage their younger service users

The purpose of physical restraint

Physical restraint is used as a last resort and only when staff believe that not doing so would result in greater physical harm to the patient, staff or others.

Preparing for physical restraint

When staff are aware they may potentially be involved in restraint they should remove any items that may cause injury to themselves or others such as ID badges, pens, watches. When a decision to physically restrain is made staff must adhere to the following guidance:

- One staff member will direct the actions of all staff
- Staff will work together as a team
- Staff must ensure that the techniques used are proportionate to the risk that is being managed. Staff should utilise the level of restraint appropriate to the situation e.g. level 1, 2 or 3
- An ongoing explanation of staff actions will be given to the patient
- Staff will explain the actions required from the patient and allow sufficient time for these to be understood and carried out
- Other staff will remain on hand (and possibly out of sight of the patient) in case extra assistance is required
- At least one staff member will be allocated to remain with other patients if they are present within the ward/ department.

8.3 Methods of Physical Restraint

Methods of physical restraint are taught to relevant staff by contracted trainers. The training provided includes aspects of theory and practice as outlined in the NICE guideline 25 for the management of acutely disturbed behaviour/violence. The methods that have been taught to staff on these courses should be utilised during restraint. The use of agreed methods will avoid putting any pressure on the patient's chest, neck, back and stomach and equip staff with the knowledge to recognise factors contributing to the risk of positional asphyxia and other restraint related risks.

8.4 During restraint

The lead staff member should continue to speak to the patient even if there is no verbal response. Staff should observe the patient for difficulties in breathing, cyanosed mucous membranes, hands and feet, fits/seizures, vomiting and choking. If physical difficulties are evident, staff should proceed with the appropriate interventions immediately e.g stop and rest, reposition patient and medical emergency procedures as included in the physical intervention aspects of the managing violence and aggression training.

8.5 Release from Physical Restraint

Releasing a patient from physical restraint should occur as soon as it is considered safe to do so to prevent ongoing discomfort or distress. The patient should be informed of what is happening and what is expected of him/her after s/he is released. The lead staff member should obtain agreement on immediate future actions from the patient prior to release. The level of holding should be reduced prior to release.

9. RISKS ASSOCIATED WITH PHYSICAL INTERVENTIONS

- 9.1 The following is based on a systematic review exploring the frequency of deaths associated with restraint in health and care settings in the UK (Paterson, Bradley, Stark, Sadler, Leadbetter, and Allen, 2003).
- 9.2 Physical interventions are basically unsafe procedures and should be avoided if at all possible. Where it cannot be avoided, clear guidance must be available to help reduce risk of injury and restraint related death.
- 9.3 Four distinct 'clusters of death' were identified through the review by Paterson et al. These were:
- ❑ **Neck holds** - pressure exerted on the carotid arteries can rapidly induce unconsciousness but carries a significant risk that death rather unconsciousness will result;
 - ❑ **Mechanical restraint-related deaths** – generally these involved older people experiencing confusion, garments specifically designed for restraint purposes and in the persons attempts to escape the garment can effectively act as a ligature;
 - ❑ **Prone restraint related deaths** – the most predominate identified from the review and describes a wide range of variations in which a person is held on the floor, generally 'face down'. These included –
 - 'hobble tying' (associated with restraint-related deaths in American police custody) where the individual is in a face down position and both arms and legs are pinned behind the individuals back. To achieve this legs are bent and shoulders are pulled back. It is suggested that this and similar positions may significantly compromise the bellows aspect of respiration, forcing the chest wall into a hyper-expanded position and seriously limiting chest wall relaxation and expansion. This may be exacerbated if pressure is applied downwards on the patient's back to hold the person more securely, particularly while administering medication.
 - other restraint positions include where the individual is in a position in upper torso is hyper flexed (i.e. leaning forward, bent over at the waist while seated or kneeling). Respiration is severely compromised, particularly if the individual is obese.

- obesity was a factor present in nearly all restraint-related deaths reviewed as was,
 - positive testing for recreation drug use, particularly cocaine intoxication. Cocaine has been reported in association with agitated/excited delirium syndromes and offers a credible explanation for a number of deaths ascribed to 'restraint asphyxia'. Among the physical symptoms were increased psychomotor activity, insomnia, dehydration, fatigue and elevation of temperature, and a fall in blood pressure.
 - In addition to recreational drugs, potential adverse effects of neuroleptic medications such as cardiac arrhythmia and respiratory failure have been linked to restraint-related deaths particularly where there has been a violent struggle and by impairing the individual's ability to swallow or expectorate effectively leading to an increased risk of the inhalation of vomit.
- **A typical restraint-related deaths** – these serve to draw attention to the need to recognise the potential dangers involved in all restraint positions where respiration may be compromised. For example, being restrained in a kneeling position, securing the arms and lying with the torso face down across a bed, chair etc, or being restrained in a 'side lying' position on a bed when a person lays across the torso to secure the individual on the bed, whilst others hold onto the arms and legs is clearly without its own risks.
 - **Physical health needs** – must be assessed using current RIO tool, and based on PMVA risk assessment (appendix 1). This should include :
 - Risks associated with positional asphyxia (see appendix 1)
 - Excited delirium
 - Sickle cell
 - Compartment syndrome
 - Cardiac problems
 - Hypertension

10. MEDICAL PROCEDURES AND RAPID TRANQUILISATION

Rapid tranquilisation is not to be regarded as a primary treatment technique. If employed:

- Should only be considered when de-escalation and other strategies have failed
- Clinical need – safety of service users – safety of others and advanced directives to be taken into account
- The intervention must be reasonable and proportionate to the risk presenting

10.1 Equipment

A resuscitation trolley should be available within 3 minutes:

- Automatic external Defib
- Bag valve mask
- Oxygen
- Cannulas
- Fluids
- Suction
- First line Resus Med's
- Checked weekly
- Doctor on scene within 30 minutes

10.2 Legal

- All staff to work within MHA Code of Practice
- Any departures from this guidance to be clearly recorded and justified as being in the best interests of the service user.

10.3 Service User Concerns

- Ensure Service Users' dignity is maintained
- Explanation of why procedure was carried out at the earliest possible opportunity
- Review of Service Users' Treatment Plan ASAP
- Reintegration of Service User to Ward Milieu ASAP
- Opportunity to document their account in their notes

NICE (2005)

All nursing staff must use care plan for rapid tranquilisation (appendix 2) and observation chart for rapid tranquilisation (Appendix 3) in all cases when RT is administered.

11. STAFF PERSONAL SAFETY

- Every member of staff has a responsibility for enhancing his/her own safety and that of others and assisting as necessary.
- All staff has a responsibility to contribute to a culture of respect, encouraging all to express any concerns and feelings.
- Good communication underpins all aspects of enhancing safety. All staff must familiarise themselves with local communication systems.
- No member of staff, finding themselves alone faced with a potentially violent incident should attempt physical intervention before adequate assistance has been obtained. The exception would be a situation where such inaction would endanger themselves or others and there is no opportunity to remove them from the situation. In clinical areas, staff should use the personal alarm system or two-way radios to summon assistance. Staff must weigh the impact of removing themselves from the immediate vicinity of an aggressor with their duty to care and therefore protect patients by taking appropriate steps to minimise risks to them.
- Additional assistance should be sought as soon as possible in an emergency situation. Staff should not wait to report the incident to the person in charge before calling for assistance.
- All incidents of actual or potential violence must be reported and documented as soon as possible (clinical / non-clinical incident reporting and Appendix 4 if physical restraint used).
- Staff must inform other members of the team of their whereabouts at all times.
- If a member of staff does not feel able to carry out their role in emergencies, he/she must discuss this with their Line Manager as soon as possible to allow appropriate steps to be taken.
- Joint clinical risk assessments are good practice and should be completed in all instances.
- Any intervention utilised must be necessary and proportionate to the harm they are intended to prevent.

12. POST INCIDENT MANAGEMENT

12.1 Post incident management

A senior staff member on duty will co-ordinate the activities of others post incident. At least one staff member should remain with the patient after release. A review of the patient's Mental Health Act status and observation level should take place. The patient's care plan and risk assessment should be reviewed and updated and communicated to the staff team. A doctor must be in attendance within 30 minutes of a level 3 or prolonged restraint occurring or if requested to attend by the nurse in charge to assess/ review the patient and agree the future management plan and physical monitoring. Any physical observations must be carried out as agreed and reported if outside expected limits. If a patient refuses to have their vital signs monitored this must be reported to the responsible doctor and documented in the patient's notes.

12.2 Potential consequences of violence

The prevention of violence is the main aim of this policy as the consequences can be far reaching for staff and patients alike. These include:

- During the incident and for some time after, there are reduced numbers of staff available to work with other patients
- Short term reduction in staffing levels due to sickness
- Increased stress for staff who are available
- Reduced morale
- Reduction in permanent staff may lead to reduced quality and consistency of care and poor communication
- Lack of confidence in staff (from peers and patients)
- The progress of other patients may be halted or decline having witnessed a violent incident.

12.3 De-briefing

Facilitators of post incident reviews should invite all staff involved to attend. Participation must be left to personal choice. Facilitators of reviews must have appropriate skills and access to supervision. The post incident review process should be used to establish the facts surrounding the events with consideration to the antecedents, behaviour displayed and consequence. Assumptions should not be made with regard to the cause hence the patient must be asked separately for his/her views as to the reasons why events occurred. When factual events are established the information can contribute to the future prevention planning process. Post incident review should not focus blame – it is a learning experience. An opportunity for those involved to acknowledge and discuss their feelings should also be allowed.

The patient involved and any witnesses to events must be given the opportunity to de-brief and understand why the intervention occurred in order to contribute to future prevention.

It may be necessary to review an individual's MHA status, including section 17 leave following a violent incident and this should be incorporated in a full risk assessment and MDT review of care. This may also include a PICU assessment if it is found the individual's risks remain high following the incident review.

Having received a copy of the restraint report (Appendix 4), a Modern Matron Bleepholder in conjunction with the member/s of staff involved will make arrangements for any further group or individual de-briefing that may be required. Where appropriate the Serious Untoward Incident Policy will be implemented. The debrief must be documented in the patient's RIO notes.

12.4 Staff issues

A review of whether staff members require medical treatment, sick leave or temporary relief from duty must be carried out by the line manager, deputy or nurse in charge and appropriate arrangements made. When a member of staff has been involved in an incident, the line manager should ensure the staff member has the contact details of the appropriate staff support services. The line manager should discuss the issue of potential prosecution and offer to support the staff member should they choose to report the incident to the police. NELFT will support staff throughout the prosecution process.

Incident Report (IR1) will be completed and forwarded to Governance & Assurance. If it relates to an assault on staff the Incident Reporting Officer notifies Parkhill (Security Management Service) using a PARS form. A letter is also sent to the staff member and their manager outlining services provided to support them.

If the staff member requires sick leave, the manager should establish how frequently the staff member would like to be contacted. Staff may feel very isolated if they are away from work and unable to discuss the events. Managers should also check how staff are feeling when they return, at the return to work interview and at intervals following the incident. Staff who's condition is such that it requires them to be absent from work should not be financially compromised. Each individual injury resulting from the use of approved restraint techniques will be reviewed. Managers must liaise with Human Resources and Payroll to ensure that the agreed salary payment is paid to the staff member during their period of absence.

13. PROCESS OF IMPLEMENTATION

13.1 Reporting and Documentation

Staff must report all instances of violence or potential violence. All incidents should be fully and correctly recorded as soon as possible after the event. Datix (DIF1) incident forms should be completed (if incident involved damage to property, injury to staff, patients or others and theft). Appendix 4 'Report for patients requiring restraint Level 1, 2 and 3' should be completed where physical restraint has been used. A copy of this is then forwarded to the Governance & Assurance department, and Modern Matron (if acute in-patient). The original is filed in the patient's clinical notes. Additional records such as clinical notes, observation record sheets and risk assessment reviews must be completed as soon as possible after the event.

The Bleepholder should be notified of violent incidents, the use of physical restraint, and administering rapid tranquillisation. Any level 3 restraint or serious violent incident should be reported to the senior manager on call.

13.2 Complaints

Any complaints made against staff as a result of violent incidents will be investigated as per NELFT complaints policy, and an advocate should be offered to the service user making the complaint. Staff are also encouraged to consult their own professional association or trade union for advice.

13.3 Audit

A quarterly report of restraint incidents will be produced for each borough, and this should be undertaken by the Modern Matron. The information collated should be forwarded to the Associate Operational Director and this should be incorporated into relevant borough business plan.

14 TRAINING

14.1 Training

NELFT is required to provide such training as is necessary to ensure, as far as is reasonably practicable, the health and safety at work of its employees. A programme of training is in place that should meet the recommendations from NIMHE, NICE and NHS Security Management Services. Training courses encompass all clinical specialties and are based on needs assessment. Appropriately qualified instructors working within a code of conduct to promote safer and therapeutic services deliver training

Any staff directly involved in the use of physical restraint should receive basic life support training annually. Registered nurses and medical staff involved with the administration of rapid tranquillisation and aftercare should receive AED/suction/airway training annually and be familiar with NELFT resuscitation and policy.

Staff who cannot complete PMVA training due to pregnancy or medical problems should be referred to Occupational Health. A risk assessment should also be carried out to ascertain whether the person will be able to continue working in that specific area or whether a tailored programme can be provided that meets their individual needs.

14.2 Damage to personal property

NELFT will consider reasonable claims for compensation in respect of damage caused to personal property as a direct result of a violent incident involving the employee who is the owner of the property provided

That all reasonable precautions to avoid the damage were taken. All claims should be made to the line manager as soon as is reasonably possible after the incident. Individual staff members will not be held liable for damage to hospital property incurred during a violent incident provided that the employee has taken all reasonable precautions in the circumstances at the time of the incident to avoid the damage.

14.3 Assistance from non physical restraint trained staff and non-clinical Staff

Only in exceptional circumstances and as a last resort will employees, bank or agency staff who have not received PMVA training be expected to apply physical restraint interventions. Their involvement will be at the direction of the staff member responsible for managing the violent incident. As soon as is practicable, staff should be replaced by appropriately trained staff.

15. EQUALITY STATEMENT

15.1 The Trust's vision is to have in place a sustainable people driven service system of care which is best of class, and values based on hope inspiring environments and embracing diversity. When implementing this policy, no groups of people will be treated differently because of their race, gender, age, disability, sexuality or belief systems.

16. RELEVANCE TO OTHER NELFT POLICIES

- Observation & Engagement
- Safeguarding adults
- Clinical risk assessment and management
- Serious Untoward Incidents
- Rapid Tranquilisation Policy

- Advance Directives
- Complaints
- Safeguarding children
- Searching (property & personal)
- Psychiatric Emergency Response Team (PET)
- Resuscitation
- Sickness Policy
- Lone Workers Policy

17. REFERENCES

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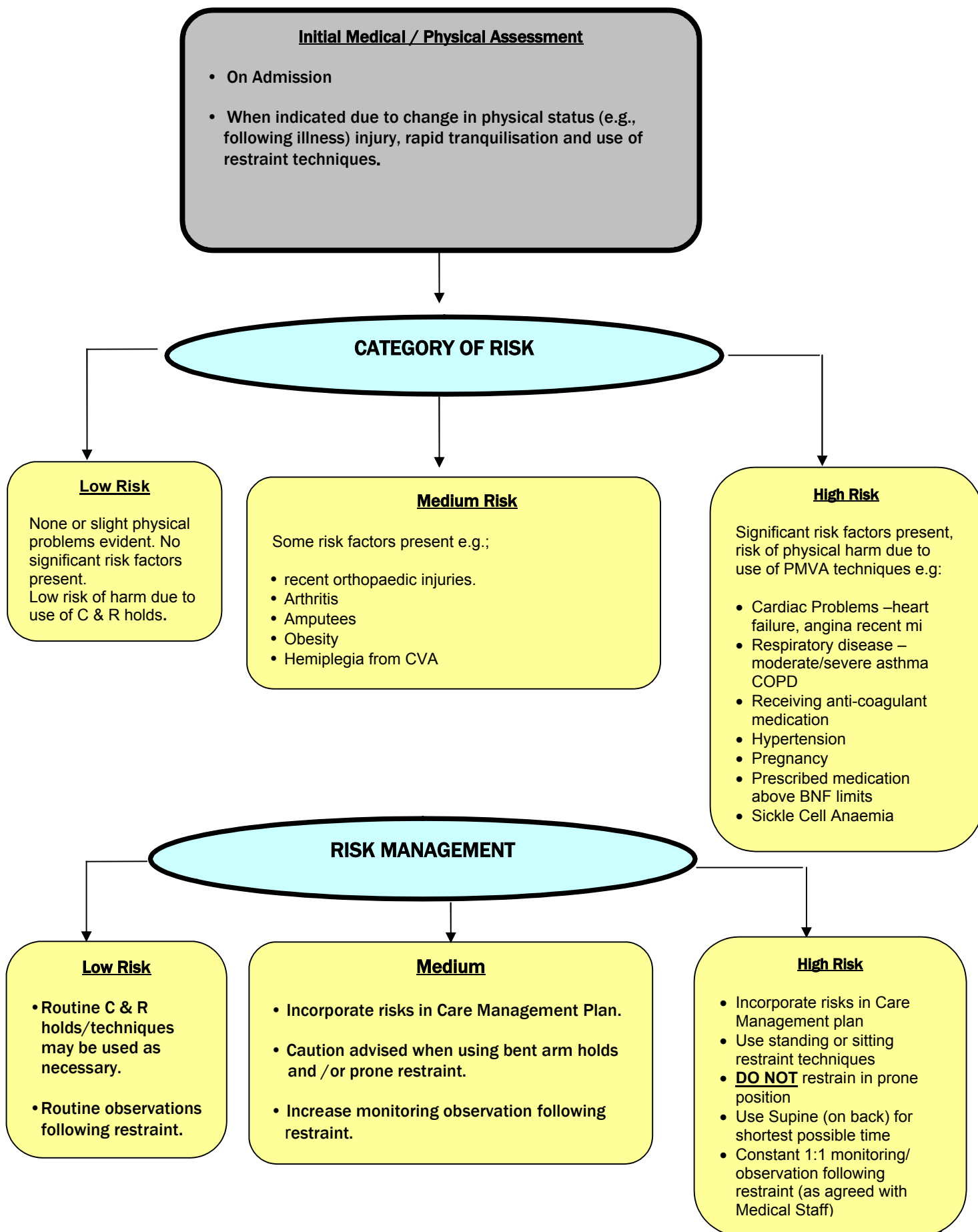
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CORE CARE PLAN (Physical aftercare of patient following RT)

Patient's Name:

Date and Time:

Patient's Date of Birth:

Ward:

	Objective(s)	Nursing Intervention(s)	Evaluation(s)
1.	To ensure physical well-being and safety of patient, following administration of rapid tranquilisation.	The following should be implemented if patient is conscious/responsive to verbal communication: <ul style="list-style-type: none"> - Reassure patient, and explain why the following Physical observations are necessary. - Monitor physical observations (B/P, temp, pulse, respiratory rate, hydration) - Encourage fluids as appropriate, and monitor input/output on fluid balance chart. - Record on RT observation form, every 5-10 minutes until patient is ambulatory. 	
		The following should be implemented if patient is sedated/unconscious: <ul style="list-style-type: none"> - RMO must be informed of patients physical status - Patient should be placed in recovery position using approved moving and handling techniques. - Monitor physical observations as above every 5 minutes, with close attention to respirations, airways and level of consciousness, and record on RT observation form. - Monitor pulse oximetry until awake. - Patient must be maintained on level 4 observations (qualified nurse) until fully conscious and verbally responsive. - Patient should be offered drink and light snack when conscious and ambulatory. 	

		<ul style="list-style-type: none"> - Any physical changes in the patient should be reported immediately to the RMO - No nursing/physical observations should be discontinued until the RMO has been consulted, and a review takes place with the nurse-in-charge. 	
2.	For nursing staff to feel confident and competent when implementing care for a patient following rapid tranquilisation.	<ul style="list-style-type: none"> - Nursing staff to be aware of the location of the nearest emergency trolley. - Reference should be made to QMSPR232, 'management of acute disturbed/violent behaviour', and this should be adhered to throughout the RT procedure. - Close attention to, and understanding of 'remedial measures in RT, and 'guidelines on use of flumazenil' is essential for all qualified nurses involved in the management of RT which is included in the above guidance. - Nursing staff involved in physical observations following RT, should be trained in the use of pulse oximetry. They should also be trained in BLS/IMLS. - If a patient is secluded following RT, the above physical interventions should be adhered to in conjunction with the seclusion care plan. - If a patient is refusing physical interventions, or too aroused and therefore a safety risk to nurses, the advise of the RMO must be sought, and a record of the same made by a qualified nurse. - Physical observations should continue for a period of at least 24 hours following RT. 	

Was a copy of Care Plan offered to patient? YES / NO

Nurse's Signature:

Date and Time Plan Discontinued: dd/mm/yyyy @ 00:00 hours

Nurse's Signature:

(Office use only) PDN Ref.: 1. Appleby L, Thomas S, Ferrier N et al. 'Sudden unexplained death in psychiatric patients. *British Journal of psychiatry*, 2000, 176: 405-406.

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Rapid Tranquillisation – Observation Chart

Patient's Name:

Ward:

Patient's Date of Birth:

Date																			
Time																			
Pulse																			
Temperature																			
Resps. rate/min.																			
Sedation Score																			
EPSE Score																			
Oxygen Sats.																			
Blood Pressure	200																		
	190																		
	180																		
	170																		
	160																		
	150																		
	140																		
	130																		
	120																		
	110																		
	100																		
	90																		
	80																		
	70																		
60																			
50																			

Extra Pyramidal Side Effects Scale:
 0 – No EPSE
 1 – Mild ESPE
 2 – Moderate EPSE
 3 – Severe EPSE

Sedation Scale:
 S – Sleeping
 0 – Alert
 1 – Mildly sedated, responsive to stimuli/ambulant
 2 – Moderately drowsy, responsive to stimuli
 3 – Difficult to rouse, poor response to stimuli

REPORT FOR PATIENTS REQUIRING PHYSICAL RESTRAINT (LEVELS 1, 2, AND 3)

This form must be completed during the shift in which the restraint took place, at the earliest opportunity. A copy must be sent along with a Clinical/Non-Clinical Incident Report Form to the governance & assurance department, and the Modern Matron (If incident occurred on an acute in-patient ward).

The controller involved in the incident (Number 1) should complete this form and submit it to his/her line manager. The Nurse in Charge of the ward is responsible for bringing the incident to the attention of the Responsible Medical Officer/staff grade doctor and also the Ward Manager & Modern Matron (if applicable).

Ward/Department:..... **Area Incident Occurred:**.....

Date of Incident:..... **Time Occurred (use 24hr clock):**.....

a) **Patient's Name:**..... **Date of Birth:**.....

Legal Status:..... **Time Ended (use 24hr clock):**.....

Describe the factors leading up to the Incident

.....
.....
.....
.....
.....

b) **Outline details of de-escalation used prior to consideration/implementation of physical intervention. Identify how long de-escalation used to attempt to manage the situation**

.....
.....
.....
.....

c) **Describe events during restraint incident**

.....
.....
.....
.....
.....

Level of restraint used (please circle as applicable)

Level 1 Restraint - Restrictive (one or two staff). A minimal hold which restricts the movement of patient's arms.

Level 2 Restraint - Secure/Supportive (two or three PMVA trained staff). Supportive holds with patient standing/kneeling/sitting (not on floor). Bent wrist/bent elbow/block.

Level 3 Restraint - Full Restraint involving three to five PMVA trained staff. Patient restrained prone/supine on bed or floor.

Was patient restrained in prone position? Yes or No (please circle)

If level 3 restraint utilised length of time in restraint:

i) Specify length of time –

ii) Was recovery restraint in prone position utilised – Yes or No

iii) * did the patient experience any pain? – Yes or No (if yes, please specify reason(s) why)

.....

d) Describe events/actions after the restraint incident

.....

g) If patient restrained in prone position and/or administered rapid tranquilisation, ensure baseline observations have been recorded (T, P, R, BP and oxygen saturation levels) and frequency discussed with RMO/staff grade doctor. Document observations on Rapid Tranquilisation Observation Chart and follow Rapid Tranquilisation Care Plan

If not followed, state reasons why:

.....

h) Staff involved in restraint incident (to include response staff, unit responding from and their role; also include any team changes that have occurred).

Name	C&R Trained	Role Used*	Response Staff Name	C&R Trained	Dept.	Role Used*

*Roles: 1 = Controller (head); 2 = Left Arm; 3 = Right Arm; 4 = Legs; 5 = other (specify)

It is the responsibility of the restraint co-coordinator to ensure names/roles of staff involved in restraint incidents are documented.

i) Were any injuries sustained to any person or property damaged during the restraint (please indicate) – Yes or No.

1. Patient 2. Staff 3. Other person 4. Property

If yes, please ensure a clinical/non clinical incident report form is Completed.

Reference numbers: / /

j) What is the likelihood of a restraint incident occurring again?
Almost certain / Likely / Possible / Unlikely / Rare (please circle)

Post incident analysis

When did post incident analysis take place following restraint for:

The Patient?.....The Staff?.....Other persons?.....

k) Please detail any reasons why analysis did not take place or any issues raised as a result of restrain analysis. Please ensure details of analysis with patient are documented in MDT notes.

.....
.....
.....
.....
.....

l) Do those involved consider the incident requires a formal post incident review?
Yes / No. Please state reasons below.

.....
.....
.....
.....

m) Has the patient been advised of the availability of an independent post restraint debrief?
Yes / No. Please state reasons if not advised.

.....
.....
.....

n) Has the patient risk assessment/care plan been reviewed as a result of the restraint incident? Yes / No. Please state any changes made.

.....
.....
.....
.....

Name of person completing form:..... Date:.....

Signature..... Designation.....

Nurse in Charge (if different from above):..... Signature.....

Ward Manager/Modern Matron advised of restraint incident on:

Date.....

Doctor advised of restraint incident: Name

Time..... Date Time attended

Copies of restraint documentation for the following:

- Governance & Assurance dept Modern Matron in patient's notes

Recognition, Prevention and Management of Aggression and Violence Policy

Staff participation in restraint

1. Introduction
2. Use of restraint techniques
3. Participation
4. Restraint training
5. Temporary exemption
6. Permanent exemption
7. Action to be taken to decide whether an individual is exempt
8. Role of Occupational Health in the temporary or permanent withdrawal of an employee from participation in restraint
9. Action regarding permanent exemption
10. Action regarding temporary exemption
11. Ratio of staff unable to participate in restraint
12. Line managers accountability

1. Introduction

This document outlines managers' actions in relation to maintaining available staff to carry out restraint

2. Use of restraint techniques

NELFT have indicated which staff should be trained in restraint techniques.

3. Participation

Staff can only be exempt from training and/or participation in applying restraint techniques if they have met conditions as outlined in sections 5 or 6 below

4. Restraint training

Training is available via the training department and places must be booked in advance. Staff completing the PMVA course will be assessed as 'competent' or 'not yet competent' by the lead instructor. Staff assessed as 'not yet competent' during or at the end of the course will be temporarily exempt from practicing restraint (see section 5). These staff will be offered further opportunities to achieve competence and the lead instructor will liaise directly with the employee's line manager. Staff who continues to be assessed as 'not yet competent' after completing additional inputs as suggested by the lead instructor will meet with their line manager to review whether the individual should be considered as permanently exempt (see section 6)

5. Temporary exemption

The following are a guide to reasons for temporary exemption:

- Staff waiting to attend training (must still contribute to the management of emergencies as required).
- Pregnancy
- A medically diagnosed condition which would be aggravated by using restraint techniques
- A medically diagnosed condition which prevents the individual from using restraint techniques

6. Permanent exemption

The following are a guide to reasons for permanent exemption:

- A medically diagnosed condition which would be aggravated by using restraint.
- A medically diagnosed condition which prevents the individual from using restraint.

7. Action to be taken to decide whether an individual is exempt

The individual must inform their line manager that they have a condition which s/he believes makes him/her exempt from using restraint techniques either temporarily or permanently.

The line manager must ascertain whether the condition has been medically diagnosed and if not ask the employee to provide written of this.

Except for pregnancy, which is an automatic exemption, the line manager must refer the employee to Occupational Health for confirmation that the condition is one which exempts the employee from participation. The referral should also request an estimation of how long the employee may be unable to use restraint techniques

8. Role of Occupational Health in the temporary or permanent exclusion of an employee from participation in restraint

Occupational Health doctors/staff must be made aware of the physical requirements of restraint and will use this knowledge to decide whether the particular medical condition will be aggravated by their involvement in restraint activity.

9. Action regarding temporary exemption

When the line manager has confirmed that staff are temporarily unavailable to use restraint techniques, a decision regarding whether the individual can remain on the ward/unit is taken considering the following factors:

- Anticipated length of time the individual will be unavailable
- Number of staff currently unavailable (e.g. awaiting training, pregnant)
- The contribution the individual can make to other aspects of managing emergencies

10. Action regarding permanent exemption

When the line manager has confirmation that staff are permanently unavailable to use restraint techniques a decision regarding whether the individual can remain on the ward/unit is taken considering the following factors:

- The contribution the individual can make to other aspects of managing emergencies
- The long term impact on the team of a staff member being unable to participate in a restraint
- Any plans within the team of retiring or leaving, the line manager must discuss the various alternatives with a senior manager and human resources manager. The alternatives are:
 - The individual remains on the ward/unit and the individual and staff team are made aware of any change in role.
 - Redeployment may be considered if appropriate and practicable and the individual and team members are made aware of any change of role and when this will be reviewed

11. Ratio of staff unable to participate in restraint techniques

Each ward/ unit should function at a minimum of 70% of staff available to use restraint techniques. In a team of 30 staff this means that only 9 can be unavailable to use techniques either temporarily or permanently. This number can only rise if staff are awaiting training. Some clinical areas (PICU and YPU) should function at a minimum of 80% of staff available to use restraint techniques

12. Line manager's accountability

Line manager's have a responsibility to maintain a safe environment. If line managers are concerned about the ratio of staff unavailable to carry out restraint techniques this must be raised with a senior manager as soon as possible. The training department has a responsibility for the provision of courses. Any difficulties encountered regarding access to training must be directed promptly to the training manager.

A guide to the initial response for Hostage, Siege, Barricade or Suicide Intervention Incidents

These incidents are dangerous – it is about maintaining your safety, as you cannot help anyone if you become a victim or are seriously injured.

Inform the Police – 999/PET 2 via switchboard – providing clear information regarding the location and the events occurring.

All staff involved should think about safety and preventing anyone from getting hurt.

The initial priority of all incidents is to contain the incident, isolate the area where the incident is occurring (police call it the stronghold), evacuate persons at risk then negotiate with the person. This will prevent the situation escalating or moving somewhere else where you have less control.

You cannot do this alone; it needs a team response.

When dealing with the situation you should:

- Talk to the person as ignoring communication from them until you get help will only inflame the situation.
- Always be available to the person.
- Work with a partner who can help with prompts and make notes. Keep the speaking role to one person.
- Take any threat from the person seriously. Don't make your own assessment of the risk just because you know them in their 'normal' behaviour. Always challenge the threat e.g. "please take the knife away from your throat."
- Do not deliver anything into the area unless instructed to by the Police. Deliveries are extremely dangerous situations in a siege.
- Do consider using a telephone rather than shouting through a closed door. It is safer and more conducive to building a rapport.
- Consider what you can do to prevent a breakout or if s/he surrenders – are there enough staff to deal with this?
- Use active listening – it's not what they say but how they are saying it. There may be clues in their emotions which are not in line with the content of their words.
- Use open ended questions e.g. what has happened, who is with you? This will help you to gain as much information as possible.
- Let the person know you are there and that you are listening, encourage them to talk/ keep talking.
- Always make sure you understand, but do not invite demands. Paraphrase and repeat back "are you saying...."
- Take your time.
- Be polite and remain as calm as possible.
- Personalise yourself; consider using your first name (if the person sees you as part of the problem you should not be the negotiator).
- Seek to personalise others who may be with the person.
- Always ask to speak to those being held to show you are working for them. Never refer to them as 'hostages'.
- Never miss an opportunity to press for an early release of anyone being held.
- Do be prepared for hostility, anger and confrontation from the subject

- Challenge any threat to injure or harm any persons inside e.g. “ you are responsible for any harm that you do – don’t do it”.
- Do thank the person for even the smallest concession.
- Try and be consistent with your message and seek them to confront reality.
- If it is unclear if the person is suicidal or not, ask them. Do not be afraid to use the words “ suicide” or “death”.
- Do keep a record of what is being said and the key points so that others can be briefed.
- Be prepared to tell the Police everything you have learned from the person/ about the situation so that the incident can be handed over.

In these situations, don’t:

- Negotiate if you are the person who will be making decisions. Negotiators must defer decisions to someone else.
- If demands or deadlines are given, listen closely and note them, however do not accept them or make promises. Instead reply with “the things you have asked for may be hard to get, I will see what I can do”.
- Do not get close or expose yourself to danger. Face to face is the most dangerous form of negotiation.
- Do not offer an exchange of people, we want to get people out.
- Do not bring friends or intermediaries of the person into the negotiations as this could make the situation more complex. Leave these decisions to the Police.
- Don’t lie to the person. If there is a repeat situation it will make it extremely difficult to resolve because you have lied to them just to get them to come out or surrender.
- Don’t be afraid to talk about your feelings after the incident.

Always ensure a full post incident review and de-brief for all involved.

Good Practice Guidelines for Ward Design and Organisation

A well planned physical environment is one that allows adequate space, reasonable comfort, privacy and safety. Staff must be aware of the ward's design features so that they may help patients to benefit from the good aspects and minimise the effects of the bad.

1) Calming features

- All areas look clean and tidy
- There is natural daylight and fresh air
- Crowding is avoided
- There is a perception of space
- Noise levels are controlled (e.g. television area)
- Non- smoking and smoking areas are provided
- Personal effects are safe and accessible
- There are safe activity areas inside and outside
- Private spaces and rooms are provided
- Privacy in toilet and bath and in single sex areas is ensured
- Staff privacy areas are provided
- Ambient temperature and ventilation are adequately controlled
- Opportunity for physical exercise should be provided
- Sleeping and day areas should be separate and the lounge areas should be open to those who cannot sleep

2) Ensuring a secure environment

- There is a safe room for severely disturbed people (secure fittings, reinforced glazing, sound insulation and nearby toilet and washing facilities)
- Movable objects are of a safe weight, size and construction
- Sight lines are unimpeded
- Exits and entrances are within sight of staff
- Some doors should have 'one way' locks or keypads to prevent intruders from entering but allowing those inside to leave of their own accord
- Doors are easily accessible i.e. can facilitate prompt exit
- Seating is arranged so that alarms/ panic buttons can be reached and doors are not obstructed
- Alarms are accessible and collective response to alarm calls are agreed and consistently applied

3) Features of an effective clinical environment

- Collaboration with patients in planning clinical environments, policies and practices
- Adequate handover between clinical teams for continuity
- Clear management policies and leadership
- Management/staff communications open at all levels
- Ward size and design appropriate to patient population
- Staff training and development with regular updating
- Critical reviews of incidents are carried out
- Adequate staff ratios, well supervised and experienced staff
- Gender and ethnic mix of staff appropriate to patient group
- Multi-disciplinary consensus on clinical care
- Structured timetable and activities for patients

4) Staff and Management responsibilities

- Encourage and provide privacy for visits from friends and relatives
- Ensure access to and privacy with their key worker
- Ensure complaints are taken seriously
- Ensure there is a member of staff for patients to talk to when feeling distressed
- Ensure appointments are kept
- Assure sensitivity to ethnic and cultural values
- Provide activities to alleviate boredom
- Ensure that patients dignity is maintained
- Ensure protection from intimidation and violence
- Provide full information concerning legal status, diagnosis, treatment and progress, discharge and post discharge arrangements.

(The Royal College of Psychiatrists 1998: Management of Imminent Violence).

Equality Impact Assessment Screening Tool

(Please include this as part of your policy)

Directorate/Department	Chief Operating Officer and Chief Nurse
Policy or Procedural Guidelines Title/Service	Recognition, Prevention and Therapeutic Management of Violence and aggression
New or Existing Policy/Service?	Review of existing policy
Name and role of Assessor	Andrea Fox
Date of Assessment	December 2008

Please complete the following questions

		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:	Yes	
	<ul style="list-style-type: none"> • Race, Ethnic origins (including, gypsies and travellers) and Nationality 		The policy does not reflect on meeting the needs of different cultures.
	<ul style="list-style-type: none"> • Gender 		
	<ul style="list-style-type: none"> • Age 		
	<ul style="list-style-type: none"> • Religion, Belief or Culture 		
	<ul style="list-style-type: none"> • Disability – mental and physical disability 		
	<ul style="list-style-type: none"> • Sexual orientation including lesbian, gay and bisexual people 		
2	Is there any evidence that some groups are affected differently?	No	
3	Is there a need for external or user consultation?	No	
4	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
5	Is the impact of the policy/guidance likely to be negative?	No	
6	If so, can the impact be justifiable?	Yes	
7	What alternatives are there to achieving the policy/guidelines without the impact?		When the policy is next reviewed to include an equalities section.
8	Can we reduce the impact by taking different actions?		

Recommendation	
Full Equality Impact Assessment required:	NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>
Assessor's Name: Andrea Fox	Date: December 2008
Name of Director: Stephanie Bridger	
Assessment authorised by: Name: Harjit K Bansal (member of the Equality and Diversity Group)	Date: December 2008