Coventry and Warwickshire NHS Partnership Trust

Policy for the recognition, prevention and therapeutic management of aggression and violence

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1. INTRODUCTION

Coventry and Warwickshire Partnership Trust is required to provide effective therapeutic care in safe conditions that promote recovery. The Trust recognises that occasionally some service users - because of the impact of ill-health on their social functioning - may behave in an aggressive or violent manner that requires effective management.

The Trust believes that all clinical practitioners can often prevent an individual service user who is over-aroused, agitated or aggressive from deteriorating further by the use of skilled interventions. Appropriate training and support for employees who have direct and regular contact with service users has to be provided to enable these skills to be generated. The application of this policy is intended to minimise the risk of aggression and violence and consequently the risk of injury to any service user, employee or member of the public.

1.1 Linked Documents

This policy should be read in conjunction with:-

- Policy for the admission of a child to an adult ward
- Policy for the observation and engagement of clients
- Policy for rapid tranquilisation
- Policy for incident, reporting management and investigation (CWPT, 2009)
- Policy for safeguarding children and vulnerable adults
- Data Quality Policy
- Staff support policy
- Risk assessment and management policy (Working with risk). (CWPT, 2009)
- Cultural directory
- Interpreting guidelines

1.2 Principles (Beliefs)

1.2.1 The Trust believes that employees should not be expected to accept personal injury as part of their job.

1.2.2 During any aggressive incident skilled practitioners must provide care for service users using contemporary evidenced-based approaches.

1.2.3 Service users must always be treated with dignity and respect regardless of provocation and with due regard to an individual's race, ethnicity, religion, gender, sexual orientation, mental, physical or learning disability.

1.2.4 The Trust will actively support any member of staff who is assaulted or threatened with an assault, which arises out of the course of their work.

1.2.5 All services will actively implement the positive practice standards set out in the National Institute for Clinical Excellence (NICE) and National Institute for Mental Health in England (NIMHE) guidelines on the Therapeutic Management of Violence and Aggression.

2. PURPOSE

2.1 This is a corporate policy applicable to all staff across the Trust. However, due to the diverse nature of the services within the Trust, local procedures will need to be established that are reflective of these inherent differences.

2.2 The respective operational managers will have responsibility for considering the above and will ensure that local provision and procedural arrangements conform to the framework detailed within this policy.

3. DUTIES

3.1 Individual Professional Duties and Accountabilities

All staff undertaking interventions relating to the management of violence and aggression are responsible for ensuring that they are aware of and understand the policy and have undergone training sessions appropriate to their role.

3.2 Chief Executive

The Chief Executive is responsible for monitoring the implementation of this policy.

3.3 Trust Board Responsibilities

In accordance with Secretary of State Directions on NHS security management Measures 2004, an Executive Director will be nominated as the Director with security management responsibilities or Director for Security Management and will have overall responsibility at board level for security management and tackling violence against staff.

A Non-Executive Director will be nominated to promote security management measures within the Partnership Trust.

3.4 The Local Security Management Specialist (LSMS)

The LSMS will be responsible for:

- Ensuring compliance with the Secretary of State Directions, the CFSMS Security Management Strategy and all subsequent CFSMS regulations and guidance.

- The development of a pro-security culture across CWPT, initially giving priority to tackling the problems of violence against staff, professionals, and patients, raising awareness and encouraging them to report violent incidents when they occur.

- The investigation of incidents, in a fair and professional manner, to ensure that offenders are dealt with appropriately, and to reassure staff and professionals that the NHS will take firm action against offenders.

- Taking action to ensure that that the full range of possible sanctions is considered when dealing with offenders, to ensure that these are applied consistently and appropriately, as well as to provide good quality feedback to those who have suffered from violence.

- Working with the CWPT Risk Management Team, Training providers and acting as the Liaison Officer between the Trust and CFSMS.

- The development, monitoring and review of the quality assurance processes in relation to security, training and the provision of support mechanisms for any person assaulted.

- To participate actively in the post-incident review process and attend multidisciplinary team meetings as appropriate in order to support staff in taking steps to tackle violence and security issues and promote a pro-security culture.

3.5 Directorate Responsibilities

- Ensuring members of staff work in an environment that is as safe as possible by ensuring links between policies on staff security and management of conflict at work.

- Co-operating with the LSMS in the furtherance of his / her responsibilities.

- Carrying out risk assessments and reducing the risks identified.

- Designing and implementing training plans that meet staff and service needs.

- Ensuring accurate records are kept of incidents.

- Ensuring that there is full support for staff following violent incidents or associated stress including referral to Occupational Health and support for access to counselling services if required.

- Setting all the above in the context of comprehensive procedures.

- Giving clear and accurate legal guidance to staff.

- Each Directorate will develop local procedures to support the Partnership Trust's policy.

- Where required, the CFSMS will support the development of Directorate procedures as appropriate.

- Training will be implemented in accordance with identified priorities and offered to all grades and disciplines of staff but tailored to their level of risk.

3.6 Employee Responsibilities

Individual members of staff are primarily responsible for:

- Making themselves aware of the triggers or causes of conflict in their own clinical area, and to try to minimise the impact of these.

- Identifying his/her own high-risk situations and agreeing action plans with management.

- Undertaking identified training and the maintenance of competence in these by practising conflict management and physical intervention skills.

- Reporting environmental issues that may lead to a risk of violence or conflict.

Individual employees have a responsibility to take all practicable steps not to place themselves, colleagues/volunteers, patients/service users or visitors/members of the public at risk and to communicate known problems as and when they become aware of them.

Employees have an obligation to comply with the Partnership Trust's Incident Reporting Policy and Risk Assessment procedures. This includes the reporting and completion of incident report forms, a violence & aggression monitoring form and a PARS form (if required), after each incident or near miss.

Employees are also required to identify, to their managers, situations, which they believe to be potentially hazardous including, e.g., workplace stress. Managers are required to take appropriate action based upon information received and provide feed back to the staff about these actions.

Employees who feel that they are subjected to unsafe situations and/or environments whilst discharging their duties should discuss the issues with their line manager. If they feel that the issues are still unresolved they must complete an incident report form themselves or report confidentially to the Risk Management Team following the Partnership Trust's Incident Reporting Procedure.

All employees should be aware of how their behaviour might be perceived by others and ensure that they do not behave in a way that is aggressive or violent.

Any member of staff who commits a non-physical and/or physical assault as defined in this guidance, against another member of staff, service user or member of the public must be aware that these actions will result in the Disciplinary Policy being invoked. This could result in disciplinary action and, ultimately, in some cases, dismissal.

4. DEFINITIONS

The Trust defines aggression and violence as being 'an incident in which any individual is verbally abused, threatened, or assaulted by a service user, employee or member of the public. This also involves an explicit or implicit challenge to their safety, well being or health' *(Adapted from the Health and Safety Executive (1993) 'Health and Safety at Work Regulations'*

4.1 Physical Assault – General Baseline Definition

The following baseline definition of a physical assault was applied to the NHS from April 01, 2004 and replaces any other definition previously used:

"The intentional application of force to the persons of another, without legal justification, resulting in physical injury or personal discomfort."

Physical assaults include being shoved, pushed, punched, kicked, head-butted, etc.

4.2 Non-Physical Assault – General Baseline Definition

The following baseline definition of a non-physical assault was applied to the NHS from April 01, 2004 and replaces any other definition previously used:

"The use of inappropriate words or behaviour causing distress and / or constituting harassment."

It is very difficult to provide a comprehensive description of all types of incidents that are covered under this non-physical assault policy, however, examples of the types of behaviour covered are summarised below:

- Offensive language, verbal abuse and swearing, which prevents staff from doing their job or makes them feel unsafe
- Loud and intrusive conversation.
- Unwanted or abusive remarks
- Negative, malicious or stereotypical comments
- Invasion of personal space
- Brandishing of objects or weapons
- Offensive gestures
- Threats or the potential for a situation to arise which could lead to a physical assault to a member of staff, fellow patients or visitors
- Bullying*, victimisation or intimidation

  **Staff on staff bullying does not fall into the remit of this policy. Any such issues should be dealt with via the Trust policy on bullying and harassment at work.*
- Stalking

- Alcohol or drug fuelled abuse
- Unreasonable behaviour and non-cooperation such as repeated disregard of hospital visiting hours
- Any of the above linked to destruction of or damage to property
- The aggressor has failed to respond to previous sanctions
- The aggressors behaviour is motivated by hostility towards a particular group or individual on the grounds of race, religious belief (or lack of), nationality, gender, sexual orientation, age, disability or political affiliation
- A weapon, or object capable of being used as a weapon, is brandished or used to damage property
- The incident is not the first to involve the same aggressor
- There is an indication that a particular member of staff or department/section is being targeted
- There is serious concern that any threats made will be carried out
- There is a concern that the individual's behaviour may deteriorate or that other NHS bodies should be advised or alerted
- The response to the incident has caused significant alteration to the Trust's security policies or caused significant additional expenditure

(For further guidance please refer to "Non-physical Assault, Explanatory Notes" CFSMS 2004)

4.3 Security Management Service

4.3.1 The SMS forms part of the Counter Fraud and Security Management Service (CFSMS), which was launched in April 2003 with a remit encompassing policy and operational responsibility for the management of security in the NHS (Statutory Instrument 3039/2002).

4.3.2 The remit is broad but can be defined as protecting people and property so that the highest standards of clinical care can be made available to patients.

4.3.3 An immediate priority area for security management work is tackling violence against staff. No one can guarantee that violence can be completely eradicated in any environment. Work in this area, however, is already underway - not only to ensure that robust systems are in place to minimise the risk of incidents occurring in the first place but also to enable clear action to be taken against assailants.

4.3.4 The SMS aims to put in place tangible measures that will help to minimise the risk of assault, and meet the standards expected from health bodies under the Improving Working Lives OWL) programme. This will be done through learning from the experience of staff, professionals and patients through working with:

- The DH and NHS bodies
- Other government departments, such as the Home Office and with agencies such as the HSE, the police and the Crown Prosecution Service (CPS) to ensure that it can successfully deal with violence in the workplace
- Partners in NHS professions and their representative bodies, trade unions and patient representative groups to ensure that where action is taken, it is relevant, credible and supported by all those working in, using, or delivering services to the NHS.

5. POLICY (WHAT)

5.1 Clinical, Organisational and Environmental Risk Assessment

5.1.1 Assessment and the management of risk is an essential part of the care and treatment provided for service users and is an integral part of the Effective Care Co-ordination. It is essential that on admission/referral or initial contact a clinical risk assessment is carried out and a risk management plan is put into place. This should be in collaboration with the service user and their carer wherever possible. The risk assessment process is designed to be comprehensive with the potential risk of violence being just one element that is considered as part of the assessment.

5.1.2 Risk assessments and risk management plans should be regularly reviewed with the service user and their carer whenever possible. Plans should record known triggers to aggressive/violent behaviour based on previous history and discussion with service users and their carers/families.

Changes in levels of risk should be recorded, communicated and risk management plans changed accordingly.

5.1.3 The approach to risk assessment must be multidisciplinary and reflect the care setting in which it is undertaken. Any risk factors must be communicated appropriately across care settings.

5.1.4 A well designed and appropriately maintained physical environment, coupled with an effective therapeutic atmosphere is known to have a strong mitigating effect on the levels of latent agitation, frustration and boredom that can be experienced by service users. The ward/area manager will therefore be required to carry out an environmental and organisational risk assessment at least once every twelve months or sooner if there is a significant change to the facility. This should include an assessment of the physical environment; safety and security issues; access to purposeful activity; and adequate staff to service user ratios (see Appendix B).

5.1.5 Each service will have a local procedure that describes how to summon help in an emergency and which determines the need for alarm systems. The procedure will be based on an evaluation of the risk assessment processes. The procedure must be disseminated to all staff who are required to familiarise themselves with its content.

5.1.6 Collective responses to alarm calls should be agreed before incidents occur, consistently applied and be periodically rehearsed.

5.2 Prevention

5.2.1 A wide range of appropriate occupational, social and recreational activities will be provided for the service user group taking into account an individual's abilities, level of functioning and resources available.

5.2.2 All staff will demonstrate a positive attitude when communicating with service users. Staff must never use language that could be construed as supporting negative stereotypes. This would include verbal or non-verbal responses that could be interpreted as carrying aggressive, threatening, sarcastic or disrespectful intent.

5.2.3 Tensions between staff and service users, carers and the public can arise and must be dealt with promptly in a fair, equitable and constructive manner. All clinical staff, but particularly matrons have a responsibility to ensure that any concerns are dealt with promptly and that local resolution of any difficulties is facilitated. The input of advocates and/or P.A.L.S (Patient Advisory Liaison Service) can be sought if other avenues have proven un-successful.

5.2.4 Open, clear and effective communication between staff members, service users, relatives and their advocates (especially those with visual, hearing, cognitive impairment or whose first language is not English) minimises misinformation and confusion arising. Each clinical area/service will avoid this by producing unambiguous collaborative care plans that encourage co-operation and cohesion.

5.2.5 Individual spiritual, religious and cultural needs, beliefs and behaviours must be understood and taken into consideration by staff when dealing with a potentially and aggressive person. Staff will receive appropriate equality and diversity training to help them facilitate this approach.

5.2.6 Where appropriate, staff in collaboration with service users and their carers, will develop individualised advanced statements, so that future interventions, wherever possible, meet the specific needs and wishes of service users as part of their overall package of care.

5.2.7 The Trust's violence reduction teams will provide learning packages that will enable practitioners to gain greater competence to prevent aggression and violence occurring. Training will include methods of anticipating, de-escalating or coping with violent behaviour by developing greater awareness of their own verbal and non-verbal behaviours.

5.2.8 Risk assessments and risk management plans will be regularly reviewed with the service user and their respective carers whenever possible. Plans will record known triggers to aggressive/violent behaviour based on previous history and discussion with service users and their carers/families. Changes in levels of risk should be recorded, communicated and risk management plans changed accordingly.

5.3 Lone Worker

Staff visiting a client, or client's relative in their own home, in another location not belonging to the Trust, or in a Trust building where they are the only person in the building must carry out a formal risk assessment, of the individual being seen and the location of the visit before meeting with them. The staff member must base this assessment on the Trust working with risk policy and take all practical steps to access available information, which may include information from the referring clinician, Trust staff, clinical records or other sources. The result of the risk assessment must be documented as appropriate and should be readily available to other members of staff.

The staff member must ensure that another member of the their team, or an appropriate alternative employed by the Trust, is aware of their meeting, where they are, who they are with and when the meeting is planned to be concluded. If the member of staff is not planning on having contact with other members of their team following the meeting (last visit of the day) they must ensure that a telephone check in arrangement is in place that clearly agrees the time by which the clinician will have telephoned the identified person to confirm they are safe and the meeting concluded.

If the risk assessment indicates the risk is too high for the person to be seen alone, then a colleague or other appropriate clinician must accompany the member of staff, in certain circumstances this may include the police. If this is not possible or does not sufficiently mitigate the risk then the visit must not take place irrespective of the client's condition and/or the need for treatment. The clinician should consider relocating the meeting to a more suitable location.

On arrival at the person's home or other location, the member of staff must on every occasion:

- Not enter the property if there are suspicious circumstances or other indications that an unacceptable risk or danger is present

- Assess the risks as they appear at the time, e.g. patient's condition, state of the property, escape routes, animals, etc., and take suitable precautions

5.4 Approaches for the Actual Management of Aggression & Violence

5.4.1 The choice of intervention must be guided by clinical need and the obligations owed to the service user (i.e. advanced statements, physical and cultural needs), other service users affected by the disturbed behaviour and to members of staff and any visitors.

5.4.2 The intervention selected must amount to a proportionate and reasonable response to the risk posed.

5.5 De-escalation Techniques

5.5.1 Service user anger needs to be addressed using a measured and reasonable response. Where at all possible, attempts at de-escalation need to be employed prior to other interventions being used.

5.6 Observation

5.6.1 Observation is a core healthcare worker skill and should be used to help recognise, prevent and therapeutically manage aggression or violence through timely interventions (refer to the Observation and Engagement policy).

5.7 Implementation and Monitoring of Physical Interventions

5.7.1 Those staff who are expected to therapeutically engage on a continuous and direct basis with service users who pose a potential risk must receive mandatory training in the use of physical intervention upon commencement of employment and annually thereafter. The extent of this training will be based on each service's specific risk assessment carried out by the operational managers.

5.7.2 All staff who employ physical interventions must receive mandatory Basic Life Support training (BLS).

5.7.3 When taking part in planned physical interventions staff must only use those physical intervention techniques taught by trainers approved by the Trust.

5.7.4 Physical intervention should be avoided if at all possible. It should never be used as a punishment. It should not be used for prolonged periods and should be brought to an end at the earliest opportunity.

5.7.5 At all times a doctor should be quickly able to attend an alert by staff members when physical intervention, rapid tranquillisation and/or seclusion are implemented (see Appendix D). The clinical team must review this incident as soon as practically possible.

5.7.6 There are real dangers with continuous physical interventions in any position (i.e. Positional Asphyxia). To avoid prolonged physical intervention an alternative strategy, such as rapid tranquillisation or seclusion, where available, should be considered. (refer to NICE Guideline 25 February 2005: *The short term management of disturbed/violent behaviour in psychiatric in-patient settings and accident and emergency departments).*

5.7.7 At those times when physical restraint does occur at all times one member of the team will be responsible for protecting the head and neck. The team member who is responsible for supporting the head and neck should take responsibility for leading the team through the restraint process and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.

5.7.8 Under no circumstances during physical interventions should pressure be applied to the neck, thorax, abdomen, back or pelvic area. The overall physical and psychological well being of the service user should be continuously monitored throughout the whole process.

5.7.9 During physical observations, verbal de-escalation techniques must continue to be employed. It is essential that staff attempt to communicate and reassure the service user as to what is happening to them and provide advice as to what they can do to help alleviate the situation.

5.7.10 There may be very extraordinary situations where pain or discomfort is unavoidable for both staff and service users, i.e. the need to breakaway from an attacker, or where its use is deemed the only way to resolve an emergency (such as impending death or grievous bodily harm) when alternative interventions have been considered and proven ineffective.

5.7.11 All physical interventions employed should take into consideration the age, gender, culture, medical history, disability or special need e.g. pregnancy and be reflected/recorded in the service user's management plan.

5.7.12 Where physical intervention has been used, all service users will be offered the opportunity to review the use of the specific interventions employed.

5.8 Restraint Devices

5.8.1 In highly exceptional circumstances the use of restraint devices may be considered by the Multi-disciplinary Team. Any such use must be a justifiable, reasonable and a proportionate response to the risk posed by the service user. They should only be employed once all other interventions have been exhausted and authority gained through formal service governance arrangements.

5.8.2 For each individual case independent expert legal, medical and ethical advice must be sought and documented and a local procedure and protocol written to govern its use.

5.9 Seclusion

5.9.1 Seclusion should only be used as a last resort when violence is uncontrolled by other means, such as medication and restraint and should not be used as a threat or punishment.

5.9.2 Staff employing seclusion must receive mandatory Basic Life Support training (BLS).

5.9.3 Procedures must be produced that cover all aspects of seclusion, i.e., adequate staffing levels, adequate instruction, regular audit and adverse incident analysis. Such protocols should be in accordance with relevant NICE guidelines, Mental Health Act 1983 Code of Practice and the Protocol for the Use of Seclusion contained within The Royal College of Psychiatrists (1998) Guidelines for Management of Imminent Violence.

5.10 Rapid Tranquillisation

5.10.1 Medication, skilfully given (in the context of good clinical care and milieu), can safely and effectively be used to manage disturbed / violent behaviour. Staff must utilise the Trust Policy for the use of Rapid Tranquillisation.

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5.10.2 Staff involved in the administration, prescribing or monitoring of service users receiving parental rapid tranquillisation must have received training in the provision of Immediate Life Support (ILS), or have the direct support of colleagues trained to that level.

5.11 Police Involvement: The Use of C.S Incapacitant (C.S) Spray, and links to the Criminal Justice System

5.11.1 Local protocols have been formulated around the criteria for summoning the police to a violent incident, the methods of achieving that assistance, the potential use of C.S incapacitant spray and the subsequent care of those affected by its use.

5.12 The Use of Weapons

5.12.1 Where potential weapons may be available the aggressor, if possible, should be isolated or relocated to a safer environment. Staff should vacate an area where such an immediate risk is posed and secure the area concerned if it is safe to do so. On no account should an attempt to physically disarm a service user.

5.13 Incident Reporting and Post Incident Support and Clinical Review

5.13.1 Any incidents of violence and aggression should be recorded as per the Policy for incident Reporting. Incident data is then collated and disseminated to service areas to look for patterns and enable risk management strategies to be put in place via the Violence and Personal Safety group.

5.14 Complaints

5.14.1 Service users who wish to complain about their care during physical intervention or any aspect of aggression management must have their concerns fully considered and acted upon accordingly.

5.14.2 Staff with concerns about the care a service user has received has a responsibility to make their concerns known. Such concerns should be raised through the normal line management structures. Any outstanding concerns can be raised in accordance with the procedures laid down within the Public Interest Disclosure Act 1998 and the Trust Whistle-blowing Policy.

5.15 Clinical Audit and Monitoring

5.15.1 Regular auditing of violent and aggressive incidents should take place to identify trends, and inform training and preventative strategies as agreed within the violence and personal safety group.

5.15.2 The National Institute for Mental Health in England 2004: Mental Health Policy Implementation Guide, positive practice standards will be adopted and audited to enable services to effectively benchmark current education, training and clinical practice.

5.15.3 Results of clinical audit will be disseminated to all stakeholders for recommendations to be made regarding future education, training and practice.

5.16 Staff Training

Life Support Training

5.16.1 Training will be made available for identified staff involved in the administration, prescribing or monitoring of service users receiving parenteral rapid tranquillisation to Immediate Life Support level. (ILS - Resuscitation Council UK). This should cover airway management, cardio-pulmonary resuscitation (CPR) and use of automated defibrillators.

5.16.2 A refresher course will be undertaken every 12 months.

5.16.3 Staff who employ physical intervention or utilise seclusion will receive Basic Life Support training (BLS – Resuscitation Council UK).

5.16.4 A refresher course will be undertaken every 12 months.

5.17 Non-Physical Approaches and Physical Skills Training

5.17.1 Training for staff in the recognition, prevention and therapeutic management of violence and aggression will be available for all employees. Programmes should be tailored to the specific needs of the service and its service users to ensure its appropriateness and acceptability, particularly concerning age, gender, racial and cultural diversity and disability issues.

5.17.2 Training in the recognition and prevention of violence and aggression including the use of non-physical and physical intervention techniques (e.g. de-escalation & breakaway training) will be provided through ongoing training.

5.17.3 The Trust will focus on meeting the ten aims of the NHS Security Management Service (SMS), in delivering non-physical interventions to frontline staff. Delivery of the courses will be undertaken by approved Trust trainers (i.e. Personal Safety Co-ordinators / Instructors) specialising in meeting the needs of staff and service users in each business unit. Until approved national standards are developed, the Trust will ensure that all trainers will meet the Positive Practice Standards detailed in Section 13 of the NIMHE guidelines. All approaches and interventions taught will be subject to an on-going process of audit and validation by the Violence and Personal Safety group.

5.17.4 Training will be mandatory for all staff employees who have contact with service users and the various levels of training are as follows:

Non-Restrictive Interventions:

5.17.5 Training in the use of non-physical approaches including verbal de-escalation training is currently available for all clinical staff. This activity will be developed in line with the (SMS) standards.

Restrictive Physical Interventions:

5.17.6 All employees appointed to clinical areas will have access to suitable training in the prevention of violence at a level identified by the service risk assessment and training needs analysis.

Refresher Courses:

5.17.7 The Trust trainers will liaise with each business unit to review their training strategy annually to ensure they identify those staff groups that require ongoing training in the recognition, prevention and de-escalation of disturbed behaviour and the physical intervention skills to professionally manage violence.

5.17.8 Within this review process the directorate should also establish the frequency with which staff should receive refresher training, typically every 12-15 months.

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

5.17.10 Where the Trust continues to use Bank and Agency staff then the professional lead for the violence reduction team will liaise with the Trust's Bank co-ordinator to ensure that such individuals have received training appropriate for the respective services in which they will work.

5.17.11 It is the responsibility of each staff member to ensure they attend all relevant mandatory training and keep up to date records in PDPs. In the event of non-attendance, the individual must inform the course facilitator and line manager.

5.17.12 It is the responsibility of line managers to ensure staff attend all relevant learning events and to ensure systems are in place for staff to be followed up in relation to non-attendance.

5.17.13 The MVA Service will maintain a central database of all staff trained by the service.

5.18 Rapid Tranquillisation Training

5.18.1 Multi-disciplinary teams will be trained in assessing and managing the risks of medication, working and training as a team using cardio-pulmonary resuscitation (CPR) techniques and equipment, prescribing within therapeutic limits, the use of flumazenil and the need to titrate to effect in accordance with The Royal College of Psychiatrists 1998: Management of Imminent Violence Guidelines & NICE Guidelines 2002.

5.18.2 A refresher course should be undertaken every 12 months.

6. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

In developing this policy a clinical stakeholder group was established that included representation from Learning Disabilities, Adult psychiatry, Management of Violence and Aggression Trainers and Professional Nursing Leads.

7. APPROVAL OF THIS DOCUMENT

The Nursing Forum and the Violence and Personal Safety group have approved the content of this policy. Once this approval was gained the final ratification will be via the Safety and Quality Committee, and in turn communicated to the Policy Review Group.

8. EQUALITY IMPACT ASSESSMENT

A reviewing panel consisting of Jamie Soden, Assistant Director of Nursing, Jan Gartside and Patricia Gott, Infection Control Nurses carried out an equality impact assessment and ratified the policy.

9. REVIEW AND REVISION ARRANGEMENTS INCLUDING VERSION CONTROL

9.1 Process for Review of this Document

The Management of Violence and Aggression policy will be reviewed annually by the author, who will ensure that all relevant stakeholders are included in the process. Once reviewed, the policy will be re-approved via the appropriate route as described above. The first review date will be March 2010.

9.2 Document Control including Archiving Arrangements

This should follow the organisations process identified in the Organisation-wide Policy for the Development and Management of Procedural Documents.

9.3 Version Control

The Version Control Sheet in Appendix E documents the history of the Observation and engagement policy and has been completed in line with CWPT policy.

10. COMMUNICATION AND AWARENESS

10.1 Dissemination

The policy document will be made available to staff via the Trust intranet policy site and staff will be made aware of the new policy through an all user e-mail and the internal Trust Team Brief document. Line managers, service leads and team leaders will further support the dissemination through discussion and team meetings.

10.2 Implementation

Once the policy is agreed and signed off the briefing information will be agreed and distributed to all operational managers using the dissemination process described above. Operational managers will then confirm through line management processes that each of the clinical areas has implemented the policy. An early audit will be carried out to confirm the extent to which the policy in its original and reviewed format has been adopted.

11. MONITORING COMPLIANCE WITH AND THE EFFECTIVENESS OF THIS POLICY

The policy will be monitored via a regular audit of incidents of violence and/or aggression carried out locally by operational managers and co-ordinated by the clinical governance department.

12. REFERENCE DOCUMENTS

Human Rights Act (1998) London. The Stationary Office

Health and Safety Executive (1993*) 'Health and Safety at Work Regulations'*.

NICE Guideline 25 February 2005: *The short term management of disturbed/violent behaviour in psychiatric in-patient settings and accident and emergency departments.*

Department of Health and Welsh Office (1999) *Mental Health Act 1983 Code of Practice* London, HMSO

The Royal College of Psychiatrists 1998: *Management of Imminent Violence.*

NICE Clinical Guideline 1 December 2002: *Core Interventions in the treatment and management of schizophrenia in primary and secondary care*. Pages 21-24

National Institute for Mental Health in England 2004*: Mental Health Policy Implementation Guide.*

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APPENDIX A

Risk Factors

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

1. Demographic or Personal History

- History of disturbed/violent behaviour.
- History of misuse of substances or alcohol
- Carers reporting service user'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 event or the threat of loss
- History of bed wetting, cruelty to animals, reckless driving, loss of a parent before the age of 8 years.

2. Clinical Variables

- Misuse of substance and/or alcohol
- Drug effects (disinhibition, akathisia).
- Active symptoms of schizophrenia or mania, in particular if:
- Delusions or hallucinations are focused on a particular person
- Preoccupation with violent fantasy
- Delusions of control (especially with violent theme)

- Agitation, excitement, overt hostility or suspiciousness
- Poor collaboration with suggested treatments
- Antisocial, explosive or impulsive personality traits or disorder.
- Organic dysfunction

3. 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 parameters for activities, choices etc.)
- Staff attitudes (aggressive, sarcastic, disrespectful, discourteous, demeaning language or behaviour).

(NICE Guideline 25 February 2005: *The short term management of disturbed/violent behaviour in psychiatric in-patient settings and accident and emergency settings departments).*

APPENDIX B

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 a wards design features so that they cam help patients to benefit from the good aspects and minimise the effects of the bad.

1. Calming Features

- All areas look clean and tidy
- Reception areas are well planned
- There are separate areas for patients with police escorts
- 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 day room should be open for those who cannot sleep.

2. Ensuring a Secure Environment

- There is a safe room for severely disturbed people (strong fabrics, secure fittings, reinforced glazing, sound insulation, nearby toilet and washing facilities).
- Movable objects are of safe weight, size and construction.
- Sight Lines are unimpeded.

- Exits and entrances are within sight of staff.
- Some doors should have ‘one way’ locks preventing 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 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 service users 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 any incident carried out
- Adequate staff ratios, well supervised, trained and experienced staff
- Gender and ethnic mix of staff appropriate to patient population
- Multi-disciplinary consensus on clinical care
- Structured timetable and activities

4. Staff and Management Responsibilities

- Encourage and provide privacy for visits from friends and relatives
- Ensure access to, and privacy with, keyworker.
- Ensure complaints are taken seriously
- Ensure there is a member of staff available for users to talk to when feeling distressed.

- Ensure users reporting angry feelings are not ‘threatened’ or ‘punished’ with the use of interventions such as medication or seclusion.
- Appointments should be kept.
- Assure sensitivity to ethnic and cultural values.
- Provide easy access to, and privacy and security for, personal possessions.
- Provide activities to alleviate boredom.
- Ensure optimum self –determination and dignity.
- Ensure protection from intimidation and violence.
- Provide full information concerning legal status; diagnosis; treatment and progress; discharge and post discharge arrangements; policies and procedures.

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

APPENDIX C

Verbal De-Escalation Techniques

The staff member who assumes control of the situation should explain to the service user what they intend to do. This will involve:

- suggesting to the aggressor that he/she moves to another area, creating space and making sure that the service user feels that they have options.
- Managing others in the environment, for example removing other service users from the area or if more appropriate enlisting the help of colleagues to do this.
- Giving clear, brief, assertive instructions, negotiating options and avoiding threats.
- Moving towards a safe place and avoiding being trapped in a corner.

The staff member who assumes control should ask for facts about the problem and encourage reasoning. This will involve:

- Offering realistic options
- Encouraging reasoning by use of open questions and inquiring about the reason for the service user's anger.
- Asking questions about the facts rather than the feelings to assist in de-escalation, such as 'What has caused you to feel upset / angry?'
- Showing concern and attentiveness through non-verbal and verbal responses.
- Listening carefully and showing empathy, acknowledging any grievances, concerns or frustrations. Not being patronised or minimising service user concerns.

The staff member should also ensure that their own non-verbal communication is non-threatening. This will involve:

- Considering which de-escalation techniques are appropriate for the situation.
- Paying attention to non-verbal cues, such as eye contact.
- Allowing greater body space than normal.
- Adopting a non-threatening but safe posture.
- Avoiding provocative non-verbal behaviours.
- Attempting to establish rapport and emphasising cooperation.
- Appearing calm, self controlled and confident without being dismissive or overbearing

APPENDIX D

Physical Care and Observation during Restraint

Situations requiring the use of physical restraint constitute a medical emergency and should be treated as such by mental health service providers.

On admission, or at least within 24 hours of admission, service users should have a basic physical examination and their physical condition and needs assessed, with particular attention to conditions which may impact on cardio-pulmonary function or muscle and joint impairment, e.g.

- Asthma
- Heart disease
- Obesity
- Arthritis
- Propensity for using illicit drugs and/or alcohol
- Women who are pregnant

Where an older person is assessed the Single Assessment Process should be followed and particular attention given to the older person's level of frailty.

Any physical condition which may increase the risk to the service user of collapse or injury during restraint should be clearly documented in the service user's records and an appropriate care plan formulated. This should be communicated to all multidisciplinary team members.

At all times, a doctor should be quickly available to attend an alert by staff members when physical intervention, rapid tranquillisation and/or seclusion are implemented. Any injuries must be reported through the Trusts reporting system.

Any person subject to restraint should be physically monitored continuously during restraint and at least every 2 hours post restraint for a period of 24 hours. This check should include:

- Care in the recovery position where appropriate
- Pulse
- Blood Pressure
- Respiration
- Temperature
- Fluid and food intake and output

If consent and co-operation for these observations is not forthcoming from the service user to this process, then it should be clearly documented in the case notes why these checks could not be performed and what alternative actions have been taken.

(National Institute for Mental Health in England 2004*: Mental Health Policy Implementation Guide).*

APPENDIX E

Version Control Sheet

Version	Date	Author	Status	Comment
V1	June 08	Jamie Soden	Draft	Interim policy
V2	August 08	Jamie Soden	Draft	Interim final review
V3	Sept 08	Jamie Soden	Ratified	Interim policy agreed
V4	February 09	Jamie Soden / Ted Foulger	Draft	Reviewed policy in NHSLA format Out for consultation
V5	March 09	Jamie Soden / Ted Foulger	Draft	Change some content re responsibilities of staff
V6	March 09	Jamie Soden / Ted Foulger	Draft	Change to process and training sections to reflect consultation