Somerset Partnership NHS
NHS Foundation Trust

PREVENTION AND MANAGEMENT OF VIOLENCE AND AGGRESSION POLICY

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DOCUMENT CONTROL

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Amendments: To reflect the acquisition of Somerset Community Health and changes to the Trusts governance structure. New format to ensure compliance with the revised NHSLA Risk Management Standards 2012-2013.			
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Intended recipients: All staff			
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CONTENTS

1. INTRODUCTION

1.1 Somerset Partnership NHS Foundation Trust recognises and accepts its responsibility and obligations under the Health and Safety at Work Act 1974, and under the Equality Act 2010 and the Human Rights Act 1998, to prevent violence and aggression. It is committed to providing a safe environment for staff, patients and visitors.

1.2 This Policy is intended to address violence and aggression on and off Trust premises by applying the Public Health model for the Prevention and Management of Violence and Aggression (PMVA), Appendix 1.

1.3 All staff, especially those involved in the detention of the patient, must ensure the patient's rights are explained to them, in a language that they are easily able to understand. This may involve the use of interpreters (see Trust Policy for the Use of Professional Interpreters on the Trust Intranet). Any written information must be provided for them in a language or format that they are easily able to read. This information should be provided again at appropriate intervals.

1.4 This policy must be read in conjunction with the Lone Working Policy, Fitness to Practice PMVA Policy, Risk Management Policy and Procedure, Clinical Assessment and Management of Harm to Self and Other, the RCPA Policy and the Equality and Diversity Policy (please note, all other policies are referred to within this document).

2. PURPOSE & SCOPE

2.1 The purpose of the Policy is to provide guidance for managing violence and aggression and to promote health, safety and welfare of patients, carers, visitors and members of staff. It applies, but is not confined, to:

- all staff associated with the Trust, including Bank and Volunteers;
- staff from other healthcare organisations;
- patients;
- members of the public, including carers and visitors;
- contractors and third parties on Trust property.

Background and General Principles

2.2 Staff should be aware the fear of violence can create situations in which uncertainty, apprehension and misinterpretation can increase the risk. Staff should be mindful people of different cultural backgrounds and those with sensory impairment can behave in ways which could be misinterpreted as being aggressive or violent. Risk Assessment, together with regular professional/ clinical supervision, can reduce anxieties inherent in potentially violent situations. The key to successful PMVA rests with local managers developing procedures to meet the needs of the staff and patients within their area of responsibility.

2.3 Patients in need of care and treatment for mental disorder or who lack mental capacity may as a consequence present particular risks to themselves or others. These might include hyperactivity, leaving the ward without permission, self-harming, aggressive and threatening behaviour towards others, physical violence and drug or alcohol abuse. Staff should also be aware of other risks that may not be so apparent, such as self-neglect.

2.4 NHS Protect has an agreed approach to deliver PMVA training to staff which the Trust supports.

2.5 The Trust has two appointed Security Managers to assist in this process.

2.6 Measures for the use of Physical Restraint in Mental Health services are summarised in Appendix 2.

Aims

2.7 This Policy aims to ensure systems are in place to:

- assess the risk of violence and aggression within Trust premises and community settings;
- identify the risk of violence or aggression in relation to the nature and circumstances of the Trust's work;
- manage assessed and identified risks;
- achieve compliance with all related legislation, guidance and best practice;
- enable staff to develop knowledge and competencies in order to fulfil their responsibilities to PMVA;
- promote safer therapeutic services;
- investigate incidents of violence and aggression.

2.8 The primary focus for managing patients who may present with disturbed or violent behaviour (or both) should be early recognition, prevention and de-escalation of potential aggression, using techniques that minimise the risk of its occurrence. Interventions must be used in a way that minimises any risk to the patient's health and safety and that causes the minimum interference to their privacy and dignity, while being consistent with the need to protect the patient and other people.

3. DUTIES AND RESPONSIBLITIES

3.1 The **Chief Executive** and **Trust Board** have overall responsibility for ensuring systems and processes are in place to appropriately manage PMVA to:

- ensure the working environment is as safe as reasonably practicable for PMVA.
- ensure all PMVA training is delivered by competent trainers (i.e. trainers who are trained in PMVA, Control and Restraint and Spontaneous Protection Enabling Accelerated Response known as SPEAR).
- ensure pre-incident risk assessments are undertaken to identify both clinical, environmental and operational risks and appropriate action plans are developed and implemented.

- ensure robust post incident management takes place, including completion of DATIX, post incident review post incident reviews and support for staff, patients and visitors who are victims of violence and aggression.

3.2 The **Director of Governance and Corporate Development** is the Executive Lead for this policy, who has devolved responsibility for the continuous development and review of this policy. The policy will be reviewed at least once every three years or sooner if required by changes in national or local guidance.

3.3 **Heads of Service/Service Managers and Ward/Team Managers** will:

- assess and record the level of clinical, environmental and individual risk of violence and aggression to staff, patients and visitors.
- continually develop and implement PMVA.
- report to the Police relevant incidents and notify level of mental capacity.
- ensure all their staff understand the PMVA procedures and provisions contained in this Policy
- ensure their staff thoroughly understand the PMVA emergency procedures and personal alarm systems, such as Pinpoint, for their work area and the need for continual raising awareness. Measures must be adopted so that visitors know what to do in emergency.
- Ensure equality and diversity issues are taken fully into account when managing violence and aggression;
- ensure PMVA emergency systems are serviceable and regularly tested and that inspections and faults are recorded. Trust personal alarms are not to be removed from wards.
- ensure robust post incident management takes place, including completion of DATIX, post incident reviews and support for staff, patients and visitors who are victims of violence and aggression. Any actions that come out of a post incident review or investigation must be recorded on the investigation screen in DATIX.
- ensure staff undertake appropriate scheduled and refresher training as specified by the PMVA department and the mandatory training matrix.
- ensure a copy of all lone working arrangements for each team are sent to the Security Managers
- ensure evidence checks and local induction is undertaken for staff working on Trust premises who are not employed by the Trust (in line with the Bank and Agency Workers Policy).
- ensure optimum staffing levels/skill mix relevant to the working environment
- identify and record any heath and wellbeing issues during the process of staff appraisal and management supervision (in line with the Staff Appraisal and Management Supervision Policy).
- refer staff to occupation health for assessment where there are concerns regarding there fitness to practice PMVA techniques (in line with the Fitness to Work – PMVA Policy).
- correspond, in the first instance, with the perpetrators of violence and aggression reminding them of the consequences of their actions.
- where relevant, report intentional and reckless violence and assaults to the Police.

- co-operate fully with the Head of Risk and the Security Managers in the discharge of their duties in respect of this Policy.
- ensure clear notices are posted in relevant staff areas providing information relating to positional asphyxia.

3.4 **All Staff***,* including temporary and bank staff and volunteers will:

- acknowledge their individual responsibility for PMVA under the Health and Safety Act.
- report PMVA concerns about the working environment to their line manager and/or health and safety representative.
- participate in raising PMVA risk assessment and recording.
- understand PMVA emergency procedures for their work area to summon assistance and to ensure that visitors are aware of these procedures.
- be familiar and up-to-date with associated Trust policies, procedures and guidelines and make sure that local induction includes advice about relevant equipment and local procedures (as per Corporate and Local Induction Policy).
- participate in the appropriate level of PMVA awareness, training and development and refreshers in a timely manner.
- promptly and accurately report incidents of aggression and violence using DATIX.
- follow the Public Health Model on managing PMVA (Appendix1)
- staff should be aware that for PMVA module 4 training they must refresh annually. There is an 8 week grace period to allow for sickness, annual leave or ward related difficulties. After this period staff will be required to complete a 5 day team work course again.
- advise their manager of any pre-existing disabilities, injuries or any circumstances which may compromise either their own safety, the safety of other staff on duty and the safety of patients during restraint to ensure that their manager is kept well informed and in a position to make an appropriate risk assessment and initiate appropriate fitness to work (PMVA) procedures where necessary (see Fitness to Work – PMVA Policy).
- Staff will ensure **patients, carers and visitors** are aware of the principles of this policy through posters, formal and informal briefings and leaflets where appropriate, highlighting the Trust's Zero Tolerance approach to violence and aggression.

3.5 The **Head of Risk** will:

- commission reviews, when required in line with the Serious Incidents Requiring Investigation (SIRI) Policy and the Untoward Event Reporting Policy.

3.6 The **Risk Team** will:

- maintain DATIX to enable staff to record and update incidents of aggression and violence
- ensure multiple entries are not recorded for the same incident.
- ensure managers complete relevant entries within an appropriate timescale, such as 'Action Taken' and investigation boxes. .
- provide quarterly trend reports to the Health, Safety and Security Management Group.

3.7 The **Security Managers** will:

- review violence and aggression reported incidents on DATIX and record in the Investigation window comments on each incident any action taken. 'No security intervention' is permissible, where relevant.
- support management, staff and patients who have been victims of violence and aggression.
- instigate investigations, where relevant, in accordance with NHS Protect protocols.
- liase with NHS Protect, Police, Crown Prosecution Service and other law enforcement agencies, when relevant.
- correspond, in support of managers, with the perpetrators of violence and aggression, advising them of the consequences of their actions.
- advise on all aspects of protective security in relation to PMVA.
- disseminate violence statistics to NHS Protect, when required.

3.8 The **PMVA trainers** will:

- develop and provide sufficient PMVA information, instruction and training at appropriate levels depending on the area in which staff work; these should include awareness of cultural and diversity issues and the effects these may have on perceived violence and aggression.
- incorporate the NHS Standard for Conflict Resolution approach into PMVA training for Trust employees.
- advise on policies and procedures relating to PMVA.
- raise awareness of staff to recognise violent situations.
- review all incidents of violence and aggression and the use of restraint.
- advise on environmental factors pertaining to violence and aggression.
- liase with both staff and managers following issues of competency or incidents of injury during PMVA training

3.9 The **Head of Corporate Services** will:

- ensure systems are in place so that policies and advice are available to staff, patients, carers and visitors.
- provide line management to the Security Managers

3.10 The **Head of Estates and Facilities** will: liase with the security managers to consider incorporating into new and refurbished development planning measures to enhance PMVA, such as the fitting of 'panic' buttons, personal attack systems and appropriately fitted 'safer' interview rooms.

3.11 The **Health, Safety and Security Management Group** will discuss and monitor quarterly reports of untoward event reports, restraint forms and security reports and on an annual basis will include details of the report to NHS Protect. Where deficiencies have been identified the Health, Safety and Security Management Group will develop action plans which will be monitored at each meeting.

3.12 The **Regulation Governance Group** will be responsible for overseeing and monitoring the work of the Health, Safety and Security Management Group and will escalate areas of concern to the Integrated Governance Committee.

4. EXPLANATIONS OF TERMS USED

4.1 **Zero Tolerance.** The Trust acknowledges whilst violence and aggressive behaviour may occur for a variety of reasons, it does not consider this to be acceptable. This approach is known as *Zero Tolerance*. Responses depend on several factors, including mental illness and lack of mental capacity. In addition to the legislation relating to the several degrees of assault, this definition of aggression and/or violence will apply: *Incidents where individuals are abused, threatened or assaulted in circumstances related to their work involving an explicit or implicit challenge to their safety, well being or health* (adapted from European Commission; 1997; Wynne).

4.2 **Assault** is defined by NHS Protect (formerly the Counter Fraud and Security Management Service (CFSMS)) as *intentional application of force to the person of another without lawful justification, resulting in physical injury or personal discomfort.*

4.3 **Non-physical assault** is defined as *use of inappropriate words or behaviour causing distress and/or constituting harassment.*

4.4 **Prevention and Management of Violence and Aggression (PMVA).** The measures adopted to reduce the risk of violence and aggression in the workplace.

4.5 **Verbal abuse.** It is often a matter of judgement to assess if unreasonable verbal abuse face-to-face, telephone and written, should be considered within the context of this Policy. Useful guidance for staff is if they feel threatened by the situation, the substance of this Policy would apply.

4.6 **De-escalation** is defined as the range of verbal and non-verbal skills used to assist in the calming of an individual or a situation.

4.7 **DATIX** – web-based tool used within the Trust for recording, incidents, PALS enquiries, complaints and risk.

5. PMVA

Prevention

5.1 Every effort will be made to enhance PMVA by demonstrating and encouraging respect for racial and cultural diversity and recognise the need for privacy and dignity of patients, carers and visitors and providing a pleasant, comfortable and therapeutic environment, including for example quiet rooms, recreation rooms, single-sex areas, separate visitors' rooms and access to fresh air; designed to reduce stress and anxiety.

5.2 Staff must take reasonable measures not to place themselves, their colleagues or other patients at risk of violence and aggression.

5.3 **Staff / Patient Relationships**

The relationship between staff and patients is important and staff should at all times attempt to establish a professional and therapeutic relationship with all patients and their carers. Staff attitudes and interactions should be based on honesty, empathy and respect from the staff member towards the patient. The relationship is enhanced when staff engage patients proactively and use a range of skills including; de-escalation techniques, listening and problem solving skills. There may be no need for physical restraint if staff interactions are carried out in a sensitive manner and any unnecessary actions that the patient may perceive as being provocative or threatening are avoided.

5.4 **Personalised Care Planning**

Individual care plans are fundamental to the appropriate management of disturbed behaviour.

Care plans should state clearly what the interventions are and what is expected of the nursing staff and patient. It should be appropriate to the patient's needs, realistic and have measurable outcomes. Seeking the patient's co-operation and participation in the process helps develop and maintain good working relationships with staff.

Measures which can be taken may include:

- engaging patients and keeping them fully informed, in a way they can understand, of what is happening and why;
- developing a therapeutic relationship between each patient and a key worker or nurse;
- identifying those patients most at risk and implementing appropriate risk management plans;
- involving patients in identification of their own trigger factors and early warning signs of disturbed or violent behaviour and in how to respond to them
- ensuring patients are able to make telephone calls in private, wherever possible;
- providing appropriate activities for all patients and encouraging patients to take part in activities appropriate to them;
- ensuring patients' concerns and complaints are dealt with quickly and fairly.

6. RISK ASSESSMENT

As described within the Risk Management Policy and Procedure there are three different types of risk assessment

- **IPRA** – Individual Patient Risk Assessment
- **ORA** – Operational Risk Assessment
- **PRA** – Prescriptive Risk Assessment

Clinical Risk Assessment (IPRA)

6.1 It is important to acquire an in-depth knowledge and understanding of each individual patient, including their history, particularly where the patient has been aggressive or has been involved in violent incidents. This should be identified

through the process of clinical risk assessment recorded within the patient's healthcare record and considered within the patients users care plan. This process is described in more detail within the Clinical Assessment and Management of Risk of Harm to Self and Others Policy (accessible on the intranet) and includes the Risk Management planning and review process and screen shots of the Risk Screening and Information tool used within RiO.

6.2 Through the process of risk assessment, any individual factors identified should inform the interventions used. These should take into account the patient's physical condition, disabilities, age, gender, ethnicity, physiological, sensory loss, race and language issues.

6.3 'In applying a particular risk assessment, it must be directed towards the overall best interests of the patient, be based on the principle of the minimum necessary force or action to achieve the desired outcome and be carried out in a professional, competent and safe manner'. Guidelines for Mental Health and Learning Disabilities Nursing UKCC - now Nursing and Midwifery Council (1998).

6.4 Clinical risk assessments will be recorded during initial assessment, pre and post incidents, during subsequent reviews and discharge/end of episode of care as described within the Recovery Care Plan Approach (RCPA) Policy.

Operational Risk Assessments (ORA)

6.5 **ORAs** are undertaken before any operational activity to ensure any risks to patients, staff and others are considered and actions developed to minimise the risk of harm. These are recorded using the DATIX Local Risk Assessment database (in line with the Risk Management Policy and Procedure), populated by Ward/Team Managers/Workplace Health and Safety Monitors and monitored by Senior Managers, unless unable to treat or manage locally and requested to transfer to the Corporate Risk Register when they will be monitored by the Risk Manager and the appropriate Governance Group.

Prescriptive Risk Assessment (PRA)

6.6 **PRAs** are undertaken formally to identify and minimise risks in a timely prospective or retrospective format, and are utilised in respect to a new process, equipment or as a result of an untoward event or near miss. These will be and are recorded using the DATIX Local Risk Assessment database (in line with the Risk Management Policy and Procedure).

6.7 The Trust has developed and implemented a Risk Management Strategy which outlines the responsibilities of the Executive Directors and the Governance Group arrangements for managing risk. The Risk Management Policy and Procedure provides guidance to managers who have responsibility for managing and monitoring Corporate and Local Risks.

Physical Intervention

6.8 Physical intervention should be:

- used as a last resort after all other options have been exhausted or are inappropriate.
- necessary and proportionate.
- applied with minimum reasonable force necessary to prevent harm to the patient or others.
- used only for as long as is absolutely necessary.

Anyone not involved in managing the incident should be asked to leave the area, although supporting staff should be available.

6.9 Physical intervention with mental health patients must be practised in accordance with national legislation and the guidelines contained within the Trust's guidance on Physical Restraint Techniques and the Mental Health Act (1983): Code of Practice (2008), please refer to Appendix 2).

6.10 Staff are entitled to use reasonable force to enable self-preservation and effect withdrawal. However, this action could be tested in Court.

Post-incident

6.11 Staff may experience a range of emotions, not necessarily immediately, and therefore it is important managers ensure a post incident review is carried out as soon as possible after the incident with all those involved to:

- review the incident and identify lessons learnt.
- ensure victims have access to appropriate support from a clinician and Human Resources.
- complete a DATIX form after every incident in which restraint of any level has occurred.
- review care plan and, if relevant, enter a risk alert onto the patient record. This may mean a Violent Patient Indicator (VPI) being included on a patient's notes, described in Appendix 3.

6.12 The PMVA trainers and Security Managers are available to advise staff if difficulties continue.

Lone Working

6.13 Staff working independently, either in the community or within Trust premises, must follow the Trust's Lone Working Policy and all local written procedures and lone working arrangements. Managers will send a copy of all lone working arrangements for each team to the Security Managers.

6.14 Staff working in high risk areas of the Trust must familiarise themselves with local operating systems for the use of personal alarms in Trust buildings (see Lone Working Policy).

6.15 The Health and Safety at Work Regulations confirm employees should leave places where they believe themselves to be in "serious and imminent" danger, even if this later proves to be erroneous. If this is the case, the Trust will support staff for their action.

7. REPORTING, RECORDING AND INVESTIGATION OF INCIDENTS.

7.1 Incident reporting is essential because it helps to identify trends and evaluate the effectiveness of existing measures.

7.2 Incidents of violence and aggression, including threats, must be logged on DATIX.

7.3 The Security Managers, working with Heads of Service, Service Managers, Matrons and ward/team managers, will decide the necessity for an investigation taking into consideration mental capacity, previous incidents and aggravation and mitigation. The following options are available:

- no further action.
- a verbal warning.
- a written warning.
- report to the Police.
- investigation by a Security Manager. This will be conducted, where relevant, in accordance with NHS Protect Protocols to prove 'On the balance of probability……'
- Serious Incident Review

7.4 The Trust will support staff involved in, or who wish to pursue, prosecutions.

7.5 It is the intention that when up and running the Trust will report all incidents of physical assault to NHS Protect using the Security Incident Reporting System (SIRS).

8. EXCLUSION AND WITHHOLDING OF TREATMENT

Patients

8.1 While the Trust has an obligation to consider the measures to protect staff balanced with the need to provide healthcare and treatment, some treatment can be withheld from any patient showing persistent violence and aggression. This is usually a last resort and would be made following consultation between the patient, their carer, the Responsible Clinician, the multi-disciplinary team and Trust senior management.

8.2 Treatment will not be withheld from a patient as a result of the behaviour of visitors, relatives and carers.

Relatives and carers

8.3 Abusive relatives or carers should be asked to desist and offered the opportunity to explain their actions. It may be appropriate to refer their concerns to PALS (the Patient Advice and Liaison Specialist) if the issue relates to a patient.

8.4 Where an incident including a relative or carer occurs in a patient's place of residence, the relevant manager must consider undertaking a local risk assessment and consider alternative methods or locations for appointments. If

the risk to staff remains significant, the advice of the Security Managers should be sought.

8.5 Staff will adhere to local procedures and guidelines that are in place in their work area to support PMVA.

Visitors

8.6 Depending upon the seriousness of the incident, visitors displaying violence and aggression can be excluded from Trust premises. This decision would be made following consultation between staff, the Security Manager, the individual concerned and Trust senior management

9. PHYSICAL RESTRAINT AND PERSONAL DEFENCE READINESS TRAINING

9.1 The physical restraint and personal defence readiness training provided by the PMVA Trainers is based on a model of current research, based on best practice (SPEAR System). This is grounded in a model of early recognition of potential aggressive/violent incidents, which utilises the natural startle/flinch reaction when faced with an actual violent incident.

9.2 The Older Adults Safe Holding and the Control and Restraint techniques taught in the Trust are based on the techniques originally developed by Broadmoor Prison Hospital for the prison service, which have then been adopted by a number of NHS organisations.

9.3 The techniques used maintain the safety of patients, whilst reflecting the needs of the organisation and promoting the least restrictive approach in managing actual violent and aggressive situations.

9.4 All the techniques taught have been assessed legally, ethically and medically, and are regularly reviewed by the PMVA Trainers and through peer review and updated where necessary.

9.5 All restraint training is delivered with a legal framework for its use (Common Law, Criminal Law, the Equality Act and the Human Rights Act) which promotes necessity and proportionality when utilising any physical intervention.

10. TRAINING REQUIREMENTS

10.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs analysis). Further training details are accessible to staff within the Learning Development and Mandatory Training Policy and the Training Prospectus in the Learning and Development Section of the Trust Intranet.

10.2 The PMVA model adopted by the Somerset Partnership NHS Foundation Trust is the PMVA Partnership Validated Training model. It is compatible with professional conduct standards and enhances the professionalism of staff. The PMVA Mandatory Training Requirements are outlined in a guidance document in Appendix 5 (see also Mentorship for New PMVA Trainers Appendix 4).

10.3 Staff who are out of date with their PMVA training should not get involved in any planned restraints.

10.4 All staff using modules 3 and 4 should be up to date with Basic Life Support training or Immediate Life Support training as per the mandatory training matrix.

11. EQUALITY IMPACT ASSESSMENT

11.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry'

12. MONITORING COMPLIANCE AND EFFECTIVENESS

12.1 The Chair of the Health, Safety and Security Management Group will provide the Regulation Governance Group with a quarterly report (using the Governance Group reporting Template accessible in the Risk Management Strategy). The report will include quarterly reporting of untoward event reports, restraint forms and security reports and on an annual basis will include details of the report to NHS Protect. Where deficiencies have been identified the Health, Safety and Security Management Group will develop action plans which will be monitored at each meeting.

12.2 The Regulation Governance Group will escalate areas of concern and risk issues to the Integrated Governance Committee (held each quarter). Lessons learned will be shared with the Clinical Governance Group, if relevant to clinical teams and forwarded to the Clinical Effectiveness Team to raise awareness within the Somerset Partnership Improving Clinical and Social Care Effectiveness (SPICE) newsletter to ensure lessons are shared throughout the Trust.

13. COUNTER FRAUD

13.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

14. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

14.1 The standards and outcomes which inform this procedural document, are as follows:

Section	Outcome	
Information and involvement	1	Respecting and involving people who use services

Safeguarding and safety		
	10	Safety and suitability of premises
	11	Safety, availability and suitability of equipment
Suitability of staffing	12	Requirements relating to workers
	13	Staffing
	14	Supporting workers
	20	Notification of other incidents

Relevant National Requirements

NICE Guidelines 25

NHS Protect Memorandum of Understanding and promoting safer and therapeutic services

NHS Protect - Secretary of State's Directions

Withholding treatment from violent and abusive patients in NHS Trusts – NHS Guidelines

NHSLA Risk Management Standards 2012-2013 for NHS Trusts providing Acute, Community, or Mental Health and Learning Disability Services and Non-NHS Providers of NHS Care

15. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

15.1 References

David (Rocky) Bennett Independent Inquiry (2004) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

CF Public Health Model for PMVA

NHS Protect – PSTS Syllabus

15.2 Legislation

Health and Safety at Work Act 1974

Equality Act 2010

Human Rights Act 1998

European Commission 1997; Wynne

Security Management Measures 2004 issued by the Counter Fraud and Security Management Service (CFSMS)

Mental Health Act (1983): Code of Practice (2008).

Mental Capacity Act

15.3 Cross reference to other procedural documents

Bank and Agency Workers Policy

Clinical Assessment and Management of Risk of Harm to Self and Others Policy

Corporate and Local Induction Policy

De-escalation and Seclusion Policy

Equality and Diversity Policy

Fitness to Work – PMVA Policy

Guidance for the Use of Physical Restraint Techniques

Learning Development and Mandatory Training Policy

Lone Working Policy

Professional Interpreting and Translation Service Policy

Records Keeping and Records Management Policy

Recovery Care Programme Approach (RCPA) Policy

Risk Management Policy and Procedure

Observation whilst maintaining Safety and Patient Engagement Policy

Safeguarding Vulnerable Adults Policy

Security Policy

Serious Incidents Requiring Investigations Policy

Staff Appraisal and Management Supervision Policy

Staff Mandatory Training Matrix (Training Needs Analysis)

Training Prospectus

Untoward Event Reporting Policy

All current policies and procedures are accessible on the Trust Intranet under Home Page/Policies and Procedures. Trust Guidance is accessible to staff on the Trust Intranet on Home Page/Local Guidance).

16. APPENDICES

16.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix 1 Public Health Model for PMVA

Appendix 2 Measures for the Use of Physical Restraint – Mental Health

Appendix 3 Procedure for Placing a Risk of Violence Marker on Electronic and Paper Records

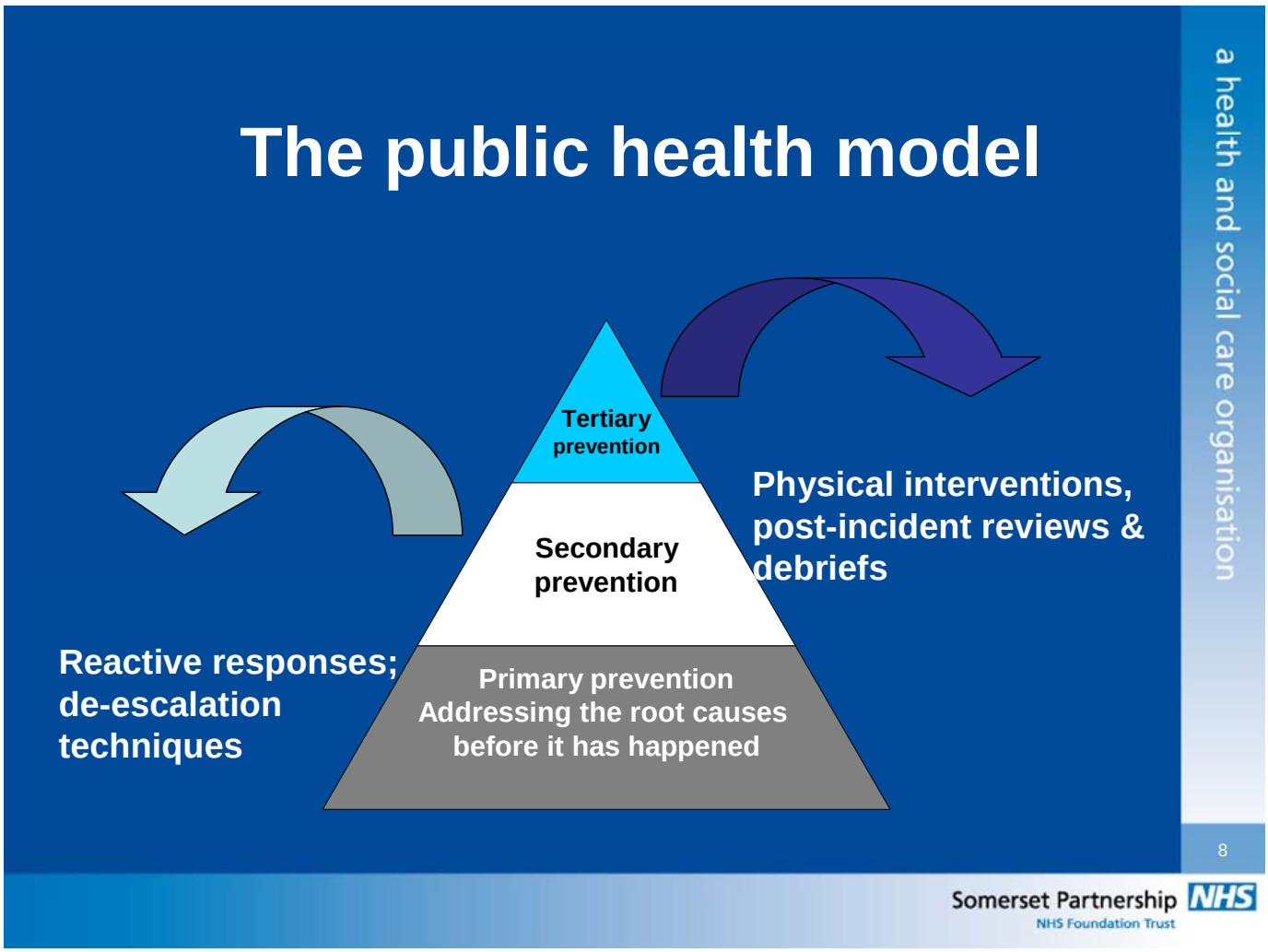
Appendix 4 Mentorship for New PMVA Trainers

Appendix 5 Prevention and Management of Violence and Aggression Mandatory Training Guidance

APPENDIX 1

Somerset Partnership NHS Foundation Trust

PUBLIC HEALTH MODEL FOR THE PREVENTION AND MANAGEMENT OF VIOLENCE AND AGGRESSION



APPENDIX 2

Somerset Partnership NHS Foundation Trust

MEASURES FOR THE USE OF PHYSICAL RESTRAINT TECHNIQUES – MENTAL HEALTH

INTRODUCTION

The Trust has a statutory obligation under the Health and Safety Act to ensure safe systems of work are provided for the safety for patients, staff and the general public.

This guidance outlines the procedure for employees in relation to the nature, circumstances and use of approved physical restraint techniques currently adopted by the Trust.

Services and their staff should demonstrate and encourage respect for racial and cultural diversity and recognise the need for privacy and dignity.

RELEVANCE

This document is relevant to all staff deployed in areas designated to require either Personal Defence Readiness or Control and Restraint techniques. These work areas have been identified following a risk assessment carried out by the Trust. Personal Safety Training and /or Control and Restraint Training in these areas is therefore mandatory, in line with the Mandatory Training Matrix accessible to staff on the Trust Intranet.

PRINCIPLES

The Trust acknowledges that within its role as a provider of care to people with mental health problems there will be occasions when behaviour will necessitate the use of physical restraint. Decency, honesty, humanity and respect for the rights of the individuals concerned should be evident at all stages of restraint procedures.

The primary focus for managing patients who may present with disturbed or violent behaviour (or both) should a focus on early recognition, prevention and de-escalation of potential aggression, using techniques that minimise the risk of its occurrence.

Tranquillisation, seclusion and observation should be used only where de-escalation alone proves insufficient, and should always be used in conjunction with further efforts at de-escalation; they must never be used as punishment or in a punitive manner.

Any such intervention must be used in a way that minimises any risk to the patient's health and safety and that causes the minimum interference to their privacy and dignity, while being consistent with the need to protect the patient and other people.

Staff must try to gain the confidence of patients so they can learn to recognise potential danger signs. Staff should understand when to intervene to prevent harm from occurring.

Care Planning

Where a patient has a known history of, or exhibits, violent, aggressive or challenging behaviour, this must be highlighted on RiO using the “Alert triangle’ or appropriate notes system.

Care planning should:

- anticipate circumstances in which violence and aggression may occur.
- contain contingency plans listing appropriate responses to these behaviours, where possible and appropriate, negotiated with the patient.
- be used in conjunction with a current risk assessment that includes a clear statement about how to deal with non-compliance and episodes of challenging behaviour.

Physical restraint should only be used as a last resort after reasonable attempts at other therapeutic interventions have been made, be a late solution in a risk reduction Plan (care Plan),or in an emergency.

The application of physical restraint techniques can be implemented as follows:

- *Section Chapter 15.20 of the Mental Health Act (1983) Code of Practice (2008):*
    - to take immediate control of a dangerous situation.
    - to contain or limit the patient’s freedom for no longer than is necessary.
    - to end or reduce significantly the danger to the patient or others.

- *Planned response.* For instance, compulsory treatment under the provisions of the Mental Health Act 1983 is required when:
    - the patient may be non-compliant but does not pose an immediate threat to others.
    - if intervention is withheld, the patient’s physical and/or mental health is likely to deteriorate.

- *Emergency response*. When behaviour necessitates immediate physical restraint in order to prevent harm occurring to the individual or others.

STANDARDS

The Team Approach

All episodes of physical restraint using PMVA and C&R MUST involve a minimum of three people. The Team Approach focuses on the importance of staff working together using effective communication skills so that the autonomy of the patient can be re-established as soon as possible. One member of staff MUST be sited at the patient’s head for the duration and has the following responsibilities:

- ensure that at all times during the restraint the patient is able to see, hear, breathe and communicate.

- constantly monitor the physical and psychological condition of the patient.
- ensure that at no time is any weight placed on the patient's chest, neck, back or abdomen by the staff holding limbs.

Physical restraint requires that the duty of care afforded patients, employees or members of the public should not be compromised. Emphasis will be placed upon maintaining dignity and respect during physical intervention.

Safety is a key element of intervention. Employees trained and updated in the Somerset Partnership approved restraint techniques (see Mandatory Training Matrix) will be able to deal with violent behaviour in a safer and more effective manner. It is the responsibility of each individual staff member to ensure they are aware of, and are up-to-date, with the risks associated with restraint, in particular restraint asphyxia.

Factors Increasing the risk of death during restraint:

- mania/excited delirium states.
- prolonged struggle.
- restraint in the prone (face down) position.
- any cardiovascular disorders.
- any respiratory conditions.
- obesity.
- drug and alcohol intoxication including prescribed medication.
- any disorders which inhibit the oxygen carrying capacity of the blood such as anaemia.
- exposure to CS spray.
- other conditions that may increase the risk of complications such as diabetes, anorexia or pregnancy.
- absence of head person during restraint.

These factors can apply in acute mental health settings. If any are present, a risk assessment will be carried out which may include a medical opinion.

If any of the following warning signs are present, intervention should be terminated immediately and normal First Aid procedures followed, which may include summoning medical assistance or an ambulance:

- complaints of difficulty breathing.
- quickening or slowing of respiration.
- changes in levels of consciousness (verbal and non-verbal).
- changes in colour (cyanosis).
- confusion or increase in confusion.

- ceasing to struggle. However, it is important to remember that if someone is struggling, it does not mean that they are conscious.

DURING ALL RESTRAINT IT IS ESSENTIAL THAT A C&R TRAINED MEMBER OF STAFF BE ALLOCATED TO STAY AT THE PATIENTS HEAD TO MONITOR ALL VITAL SIGNS. THROUGHOUT THE RESTRAINT PROCEDURE IT IS VITAL THAT AT ALL TIMES THE PATIENT CAN SEE, HEAR, BREATHE AND COMMUNICATE. THEY SHOULD ALSO ENSURE THAT THE STAFF RESTRAINING STAY CLEAR OF AND PUT NO WEIGHT OR PRESSURE ON THE CHEST, ABDOMEN, BACK OR NECK.

De-escalation

Following a period of physical restraint, the patient should, in the first instance, be observed on Level 3 as listed in the Trust's *Observation Whilst Maintaining Safety and Patient Engagement Policy*.

All wards utilising physical restraint must identify an appropriate area within their ward for de-escalation that meets the minimum requirements stipulated in PMVA and Control and Restraint. Advice on this is available from the PMVA training team.

After physical restraint has been used, staff should reassess the patient's care plan and help them reintegrate into the ward environment. They should also give the patient an opportunity to write their account of the episode, which will be filed in their notes.

For further detail please refer to the De-escalation and Seclusion Policy accessible on the Trust intranet.

MANAGERIAL RESPONSIBILITY IN RELATION TO USE OF RESTRAINT

The Ward Manager or Nominated Deputy must:

- be informed of any patient who is being subjected to any form of restraint as soon as possible.
- arrange for the debriefing of staff and other patients to take place as soon as possible.
- visit the patient and ascertain if he or she has any concerns or complaints and if so, assist them in the process (Mental Health Act (1983) Code of Practice (2008). PALS may need to be informed.
- ensure staff complete a DATIX report and list any Risk issues that need to be recorded on the Risk Register, in line with the Trust Risk Management Policy and Procedure.
- ensure staff complete a "Restraint Report Form" within the patient's RiO notes and update the patient's care plan.

APPENDIX 3

Somerset Partnership NHS Foundation Trust

PROCEDURE FOR PLACING A RISK OF VIOLENCE MARKER ON ELECTRONIC AND PAPER RECORDS

INTRODUCTION

This procedure for placing a 'Risk of Violence' Marker on electronic and paper records has been adopted from the National Procedure produced by NHS Protect.

PURPOSE

This procedure gives guidance to NHS staff on the management of the risk to themselves, other NHS staff and the public from individuals who either pose or could pose a risk of violence and aggression.

APPLICATION

Irrespective of whether the act was intentional, reckless, accidental, the result of a medical condition or in response to treatment, such as a negative response to medication, the placing of a marker on medical records is part of the proactive national strategy to reduce violence and aggression to staff. The process of placing a marker on electronic and paper records does not replace the functionality of warnings on clinical information systems.

It may be applied to:

- the patient's associate, for example, a friend, relative or guardian.
- a patient or associate with responsibility for a dangerous animal.

The marker does not apportion blame. It is a mechanism for alerting staff of the possibility of violence and aggression from an individual. All incidents involving assault must be reviewed with a view to placing a marker

Rationale

The placing of a marker helps to ensure that:

- the threat of violence and aggression is noted by all staff working with the patient and their role in risk reduction understood.
- information can be shared with other NHS organisations at risk.
- specific management plans direct the arrangements used to reduce the risk and should.
- appropriate staffing levels required are considered.
- involvement with the Police and other agencies considered.
- the venue to meet the patient and its design of venue is appropriate.

- specialised risk assessments are considered as an aid to developing risk management plans.
- the use of MAPPA and MARAC Multi Agency Risk Panels is considered and information from such agencies forms part of the decision making process, where applicable.
- communications with the patient regarding their violence and aggression and their effect on staff is undertaken, enabling them to change their behaviour.

PROCESS AND STAGES

Reporting

It is the responsibility of all staff to report all incidents of physical violence and aggression using DATIX. If there is an immediate threat, staff should follow local protocols and/or contact the internal security service and/or the police.

As a rule, the Security Managers will collect information on violence and aggression from DATIX will then determine the level of investigation required. It is likely the victim and witnesses may be interviewed.

Decision Making

The following risk factors will be considered when determining whether records should be marked:

- nature of incident in terms of violence and aggression.
- degree of violence and aggression and categorised as physical or non-physical.
- injuries sustained by the victim.
- impact on staff and/or victims and/or witnesses.
- impact on the provision of services.
- the individual has an appointment scheduled with another NHS provider.
- the individual is an in-patient.
- the medical condition, mental capacity and medication of the individual at the time of the incident.
- the incident, while not serious, is part of an escalating pattern of behaviour.
- the context of continued care from the Trust
- staff are due to visit a location where the individual may be present.
- the individual is a frequent or daily attendee to a clinic or out-patients.
- level of continued risk of violence that the individual poses.
- level of urgency required to alert staff
- likelihood of a repeat incident.
- time since the incident occurred.

If an animal is involved in an incident and the patient or associate is responsible for that animal, this will be reflected on the marker.

Decisions should be based on specific and objective information and not personal opinion or hearsay. The victim should be asked by a Security Manager if a marker would be justified, but this alone will not warrant a marker.

Security Management

The role of the Security Managers is to:

- determine the viability of placing a marker on the individual's records, as soon as practical.
- recommend strategies to assist staff in managing the risk based on information from:
    - the victim.
    - their line manager.
    - the patient's clinical team.
- liase with and assist the police investigating officer. Waiting for relevant information from the police should not delay the decision-making process for a marker.

No action required

If the Security Manager concludes that it is inappropriate to mark the record, the decision will be recorded.

The Violence Risk Review Panel

The Violent Risk Review Panel (VRRP) is a forum convened within 48 hours of an incident.

It will be chaired by the Director of Governance and Corporate Development or his appointed representative and will have a membership of three to five people, to include a Risk Manager and Union Representative. Its Terms of Reference must include reviewing markers and organising a planned schedule of meetings. Decisions should be based on the risks to staff, rather than on any relationship between the individuals concerned.

Those involved in the VRRP Review are to be familiar with:

- the Data Protection Act.
- guidance issued by the Information Commissioner's Office.
- information governance requirements.

The VRR Panel

The department requesting the marker will need to review the patient's past and current risks and provide a management plan detailing the management of the risks.

The investigating Security Manager will prepare and present the file and detail the rationale for a marker.

Implementing the marker

Based on the information presented, the VRRP will decide on the need for a marker.

In exceptional circumstances, further deliberation may be required in order to decide if the marker should be applied to:

- other members of the household also in receipt of care from Somerset Partnership Foundation Trust.
- an associate, irrespective of whether the marker relates to a carer, relative or friend or animal.
- a particular address.

If circumstances change, the changes will be brought to the attention of the provider.

The decision to add a marker does not preclude other existing lines of communication being used to inform relevant Trust staff that there is an imminent risk to them.

Notification of the marker

Whenever possible, the Security Manager will write to the individual giving the reasons and rationale for implementing the marker. The letter will explain:

- the nature of the incident.
- the reasons why the marker is being placed on their records
- the circumstances for sharing information about the marker and why one has been implemented.
- duration and date of removal.
- the process for complaints.
- relevant contact details.

If a decision is reached that a marker is not appropriate, the Security Manager must explain the reasons to the victim and offer them any further assistance necessary.

If the incident is committed by an associate of a patient, the letter will be sent to the patient and the associate informing them that the decision has/has been made.

The letter to the associate will include the relevant information listed above. Care must be taken not to disclose any confidential medical information when notifying associates.

There may be exceptional cases when it is decided that notification to the individual may increase the risk to staff and that notification is not appropriate. Examples of such situations include:

- informing the individual may provoke a violent reaction and put staff at further risk.

- notification of a marker may adversely affect an individual's mental or physical health. In this instance, the senior clinician responsible for the individual's care must review the case and make the decision that notification is not appropriate for clinical reasons.

A detailed record must be kept in the patient record of any decision not to notify an individual and the reasons for this course of action.

Informing the victim

The Security Manager will inform the victim of the Panel's decision, giving reasons and offering support. In exceptional circumstances, this may be delegated to another person, for instance, a manager.

Record Keeping

A consolidated list of individuals issued with a marker will be retained by the Security Manager under secure conditions and with access restricted to those who need to know.

Expired markers will be removed from the patient's records and records revised accordingly.

Complaints

Individuals notified that a marker is to be placed on their records will be advised on the complaints procedure and contact details. All complaints will be handled under the Patient Advice and Liaison Service (PALS) and Complaints Policy and Process.

Reviewing a marker/removing a marker

Markers will be reviewed every six months by the VRRP to ensure they are up-to-date and remain relevant. Review dates can be extended by the Panel if the marker is current and has been in place for more than 18 months. The maximum period between reviews is 12 months.

If the Panel concludes that a marker is to be removed, it is the responsibility of the Panel to:

- ensure that the outcome of the review is communicated to the Care Co-ordinator/Lead Professional.
- notify the Information Governance Manager to ensure it is removed.
- ensure the decision is recorded.

APPENDIX 4

Somerset Partnership NHS Foundation Trust

MENTORSHIP FOR NEW PMVA TRAINERS

PMVA trainers are considered specialists, as they are required to have an in-depth knowledge of issues relating to PMVA as well as demonstrate a high level of physical skill and knowledge of the techniques taught in order to effectively meet the needs of the organisation and the learners attending.

On completion of their course new trainers will undergo a period of compulsory mentorship, in order to help them progress their skills and ensure their competency. All trainers will be supervised in their first year and develop a portfolio, which will enable them to record, monitor and evaluate their progress.

Trainers will develop their teaching strategies and approaches to ensure that they are:

- Approachable and supportive
- Respectful, fostering equality and promoting inclusivity
- Promoting the principles and values of the organisation.
- Supporting the learner in achieving the objectives set.

Trainers will develop their knowledge and skills base through:

- Greater understanding of relevant guidance governing bodies, such as HSE, NHS Protect, NICE etc.
- Sharing new learning and knowledge with colleagues.
- Having an understanding of local organisational policies and procedures.
- Having an understanding of national policies and guidance such as MHA code of practice.
- Greater understanding of the strategic needs of the organisation and the local needs of service and individual learners.

New PMVA trainers will be given individual and group supervision to explore their personal growth, as well as evaluate and develop the training packages offered.

Trainers will be encouraged to access further training where required, to support their skills and knowledge.

APPENDIX 5

PREVENTION AND MANAGEMENT OF VIOLENCE AND AGGRESSION MANDATORY TRAINING GUIDANCE

1. INTRODUCTION

1.1 The Trust recognises and accepts its responsibility under the Health and Safety at Work Act 1974 and is committed to provide, as far as is reasonably practicable, a safe environment for all staff, patients and visitors and seeks to actively reduce and safely manage acts of violence and aggression. The Trust is mindful of its duties and obligations under the Equality Act 2010 and the Human Rights Act 1998 when preventing and managing violence and aggression.

2. MODULE 1: PROMOTING SAFER AND THERAPEUTIC SERVICES/ CONFLICT RESOLUTION TRAINING

2.1 This is a half day course of theory based around the NHS Protect syllabus and is mandatory for front line staff across the Trust. Administrative and Clerical Staff who are not frontline will find this course desirable but not mandatory. Administration and Clerical Staff whose role requires them to have contact with patients and the public should attend this training as Mandatory.

Staff are required to refresh every three years.

3. MODULE 2: PERSONAL DEFENCE READINESS TRAINING, UTILISING THE SPEAR SYSTEM

3.1 This is a half-day course of instruction and practice in Personal Defence Readiness Training, incorporating the SPEAR system (Spontaneous Protection Enabling Accelerated Response) and is mandatory for all staff who have face-to-face contact with patients, visitors and/or members of the public within the Mental Health and Social Care Directorate. Community Health Services Directorate staff and Administrative and Clerical Staff who are not frontline will find this course desirable but not mandatory. Admin and Clerical Staff whose role requires them to have contact with the patients and the public should attend this training as Mandatory. Administration, Clerical and community-based Mental Health and Social Care Directorate staff are required to refresh every 2 years, although they may wish to refresh yearly depending on personal need.

Mental Health and Social Care Directorate in-patient ward staff will need to attend annually. Note this training is included in the annual Modules 3 and 4 training.

4. MODULE 3: CONTROL AND RESTRAINT FOR OLDER ADULT SERVICES

4.1 This module is a one day course of instruction and practice in Removal and Restraint Techniques and is mandatory for all Mental Health and Social Care Directorate staff who work in Older People's Inpatient wards. This module includes the content of Module 2.

Community Health Services Directorate staff working with Older People, especially those who present with aggressive behaviours, might find this course desirable but not mandatory.

Staff are required to refresh every year.

5. MODULE 4: CONTROL AND RESTRAINT TEAMWORK COURSE.

5.1 This module is a five day Control and Restraint Teamwork Course which is mandatory for some key mental health inpatient staff who work in inpatient ward settings where Control & Restraint is the adopted method for dealing with violence and aggression i.e. all adult inpatient wards and Broadway Park Young People's Unit. Staff who work within a mixed patient ward setting (older adult and adult) would also be required to attend this module as mandatory. This module includes the content of Module 2 and Personal Search Training.
Some staff in older peoples' wards would find this training desirable, as this will lead to greater support between wards and greater ability to manage challenging behavior.

Staff are required to refresh yearly on a two day programme. Please note staff must access this programme promptly or there may be a requirement for them to repeat the five day course.

6. MODULE 5: SEARCH TRAINING

6.1 This is a half day training course in environmental searching techniques and is aimed at all staff working in Mental Health and Social Care Directorate in-patient services excluding Older Adults.

Staff are required to refresh every three years.

Spencer Ball
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October 2012