Policy on Prevention and Management of Violence and Aggression (PMVA)

Document Summary

This policy provides guidance to minimise the exposure of Trust employees and patients to violence and aggression both in their total number and individual severity as far as reasonably practicable; and to ensure that violence and aggression towards staff and patients will not be accepted. “Anyone working in the NHS, receiving NHS treatment or visiting NHS premises has the right to feel safe and secure from violence and abuse, both physical and verbal.” (NHS Protect).

NOTE: THIS POLICY IS CURRENTLY UNDER REVIEW – SEPTEMBER 2017

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<th>POLICY NUMBER</th>
<th>POL/001/008</th>
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<td>ACCOUNTABLE DIRECTOR</td>
<td>Director of Quality &amp; Nursing</td>
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<tr>
<td>POLICY AUTHOR</td>
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Important Note:
The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as “uncontrolled” and, as such, may not necessarily contain the latest updates and amendments.
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1. Scope

This policy applies to all work activities and environments where staff may be exposed to risks of violence and aggression. It applies to Trust-employed staff, staff working in integrated teams, full-time and part-time clinical and non-clinical staff with the exception of Prison Health Staff. Further detailed guidance on arrangements for the management of personal safety for lone workers can be found in Trust Policy for Lone Working.

The use of this policy will apply to all violent/abusive patients whether care is delivered in the home or within CPFT premises, excluding those patients under the age of 16 and in HMP Haverigg.

**Children & Young People Aged Between 16 to 18 years**

Young people between the ages of 16 and 18 years are still regarded as children and subject to the Children Act (1989). Advice must be taken from the Named Nurse for Safeguarding before applying this policy to a patient within this age group, under which circumstances the involvement of Social Services may be appropriate.

It is acknowledged that there may be occasions when staff in children’s services or Mental Health services eg CAMHS, having taken all relevant steps have no alternative but to use restrictive physical interventions or therapeutic holds when immunising or changing dressings or preventing absconson, harm to self or others. The Royal College of Nursing has guidance on restrictive physical interventions and therapeutic holds (2010).

2. Introduction
NHS staff, particularly those who work in mental health and learning disability services, or who work alone in the community to provide health care, are exposed to risks of violence and aggression. This is underlined by annual statistics published by the NHS Protect which show the number of reported physical assaults against NHS staff.


This policy follows Health and Safety Executive (HSE) HSG65, the key elements of successful health and safety management, in relation to managing the risk of violence and aggression.

All healthcare providers have the duty to manage security issues with a view to preventing violence towards NHS staff, and taking action against those who commit violent crimes.

3. Statement of Intent

The Trust recognises and accepts that the prevention and management of violence and aggression towards its staff and patients in its care is an integral part of its statutory duties under the above stated legislation and standards. The Trust will therefore implement procedures to minimise the likelihood of employees and patients being exposed to violence and aggression whilst at work or in receipt of care provided by the Trust. It will also implement a programme of training for the prevention and management of violence and aggression (PMVA).
The Trust emphasises that Violence and Aggression will not be tolerated or accepted. The Trust will use all appropriate opportunities to inform the public and patients about its policy regarding violence and aggression to staff. This will include placing posters in public areas, inserting notices in publications and using the media.

4. Definitions

4.1 Violence & Aggression at Work

“Any incident, in which a person is abused, threatened or assaulted in circumstances relating to their work. This can include verbal abuse or threats as well as physical attacks” (HSE)

4.2 Physical Assault

“The intentional application of force to the person of another without lawful justification resulting in physical injury or discomfort”. (NHS Protect) Please note - this applies to all incidents involving physical contact with staff by patients, including incidents deemed as being clinically-related.

“Any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health”. (HSE)

4.3 Non-Physical Assault

The NHS has defined non-physical assaults as “The use of inappropriate words or behaviour causing distress and/or constituting harassment”.

4.4 Violent and aggressive actions

May include the following (NB - this list is not exhaustive):

• Physical contact in the form of hitting, kicking, punching, scratching, biting, slapping, pinching, spitting, head-butting and strangulation.
• Incidents where reckless behaviour results in physical harm to others.
• Incidents where attempts are made to cause physical harm to others and fail.
• Sexual assault.
• Use of weapons.
• Throwing of furniture and objects.
• Slamming and punching of doors.
• Damage to property – smashing windows, objects.
• Threatening comments and verbal abuse including racist or sexist language.
• Non-verbal aggression – waving fingers, fists, invasion of body space, stalking.
• Hostage taking.
• Stalking.
• Alcohol or drug fuelled abuse.

4.5 Effects of assault

The effects of non-physical and physical assault are wide ranging. As well as the more evident impacts of a physical assault, such as visible bruise or injury, there may often be non-evident, longer-lasting impacts such as emotional and psychological trauma.

4.6 Self Defence

In the event of a violent / aggressive incident, all staff have the common law right of self-defence (the minimum action and/or force necessary to remove themselves from a situation presenting imminent or present harm to their personal safety).
4.7 Physical Intervention / Restraint

Physical intervention/restraint refers to the use of force to restrict movement or mobility, or the use of force to disengage from dangerous or harmful physical contact initiated by a patient/client. Physical intervention/restraint differs from manual guidance or physical prompting in so far as it implies the use of force against resistance.

5. Duties

5.1 The Chief Executive

The Chief Executive has overall responsibility for the prevention and management of violence and aggression toward staff and patients. The duty to implement this policy is delegated through Executive Directors to local managers.

5.2 The Director of Quality & Nursing

The Director of Quality & Nursing acts as the Trust’s Security Management Director (SMD) and is accountable to the Trust Board for the effective implementation of the Trust Security Policy (POL/002/015). Duties of the SMD are to ensure adequate security management provision is made within the Trust. The SMD will also have regular liaison with the LSMS to ensure security management work is being undertaken to the highest standard.

5.3 Clinical Risk & Safety Manager/Local Security Management Specialist (LSMS)

The Clinical Risk & Safety Manager, together with the Local Security Management Specialists, is responsible for assisting the SMD in ensuring implementation of the Security Policy (POL/002/015). The LSMS works to national standards in key generic and priority action areas on issues ranging from prevention & detection to
investigation & prosecution. Refer to the Trust Security Policy (POL/002/015) for further information regarding duties of the LSMS.

5.4 Deputy Director of Quality & Nursing

The Deputy Director of Quality & Nursing is responsible for ensuring maintenance of records of incidents involving violence and aggression in accordance with the Trust’s Policy for Incident and Serious Untoward Incident and Near Miss Reporting (POL/002/006/001) and for ensuring employees who have been involved in a violent or aggressive incident while carrying out their authorised duties, are supported and assisted in any resulting civil claim or prosecution.

5.5 Workforce Services Manager

The Workforce Services Manager is responsible for ensuring adequate provision of PMVA training to all staff and the coordination of the PMVA training programme, supported by the Training Department who will record all training activity included Did Not Attends which will be dealt with in line with the Learning & Development Policy.

5.6 Resourcing & Training Lead

The Resourcing & Training Lead will plan sufficient PMVA training opportunities to meet the Trust’s requirements.

The Resourcing & Training Lead is responsible for providing monitoring reports to the Trust Clinical Governance Committees, and other Committees as appropriate, on the status of PMVA training performance. Any staff who are unable to demonstrate competence in the level of training relevant to their role, whether this is due to inability to achieve desired level of ability or due to health reasons, will be marked as non-compliant, their manager made aware and a risk assessment completed as
soon as the manager is aware of this non-compliance. A copy of the risk assessment is to be kept on the staff’s personal file.

5.7 Managers

Managers are responsible for ensuring that for within their area:

- Risk assessments for exposure to violence and aggression are undertaken and documented, and appropriate control measures as identified in the risk assessments are implemented accordingly.

- Violence risks presented by patients are assessed in accordance with the Trust’s Integrated Clinical Risk Policy (POL/001/017), and that appropriate risk management strategies are developed and implemented.

- Staff are released to attend PMVA training. If due to health or ability reasons staff are unable to complete the relevant training then a risk assessment should be completed as soon as the manager is made aware and consideration given as to whether these staff are included in rotas. Relevant control measures should be put into place.

- Incidents of violence and aggression are reported and investigated in accordance with Trust’s Policy for Incident and Serious Untoward Incident and Near Miss Reporting (POL/002/006/001) and that incidents of assault or other serious security incident are notified to the LSMS as soon as practicable.

- Staff are supported following a violent incident and directed to the appropriate agencies if required e.g. counselling.

- Staffing complements are sufficient and appropriate to prevent (where possible), manage and respond to incidents of violence and aggression.

- Alarm/communication equipment and safe systems of work, i.e. lone worker systems, are in place and effectively implemented.

- Promote a pro-security culture within their service areas by encouraging reporting of incidents of violence.
- Arranging for the assessment of patients as soon as possible following incidents of violence to assist the police and LSMS in seeking sanctions (where it is appropriate to do so) against those who commit offences against Trust staff and/or property. Refer to the Trust’s Security Policy (POL/002/015) for further information.

5.8 All Staff

All staff will take responsibility for their own safety and that of others and assisting as necessary and will:

- Follow this policy and any associated procedures and guidelines, such as lone worker systems

- Familiarise themselves with and use their local communication systems (including alarm systems, telephone and IT systems, paper-based systems as well as verbal hand-overs) as a matter of priority.

- Make themselves familiar with risk assessments applicable to their work and the control measures identified therein.

- Bring to the attention of their line manager, colleagues and all other appropriate people, if they are aware of potential violence risks that others may be exposed to.

- Report all incidents of violence or aggression in accordance with Trust’s Policy for Incident and Serious Untoward Incident and Near Miss Reporting.

- Bring any training needs in relation to the prevention and management of violence and aggression to the attention of their manager.
• Where they are responsible for clinical care of patients, ensure violence risks are assessed and identified as part of clinical risk assessments, and make a clear record in the patient's clinical notes of the risk management strategy for any identified risks.

5.9 **Expectation of Service Users wherever possible:**

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

5.10 **Expectation of Carers:**

• To communicate any concerns to the Key-worker/Care co-ordinator and/or Multi-Disciplinary Team. Contribute to reviews such as CPA meetings.

5.11 **Expectation of User / Advocacy Groups:**

• To work with service users on the basis of informed consent. Develop knowledge of the services on behalf of which the group is advocating.

5.12 **Expectations of other organisations**

Other organisations and professionals such as GPs and Adult Social Care are expected to share information where there is a potential for staff to be exposed to violent or aggressive behaviour. If an incident occurs where the personal safety or security of a staff member was, or potentially could have been put at risk and it transpires information about the individual was known but not made available, it is expected the relevant Trust Team/Service Manager will contact the partner agency to raise this as an issue and follow Trust incident reporting procedures.
5.13 Monitoring of Prevention and Management of Violence and Aggression (PMVA)

The monitoring of issues relating to the prevention and management of violence and aggression toward staff and patients, including the provision of PMVA training and incidents of violent assaults against staff will be via the Trust’s Clinical Governance structures.

6.0 Arrangements for the prevention and management of violence and aggression

6.1 Preventing & Minimising the Likelihood of Violence & Aggression

Assessment of Violence / Aggression Risks

In order to prevent (wherever possible), or minimise risks of violence or aggression toward staff and patients, violence risks presented by patients will be assessed and documented in accordance with the Trust’s Integrated Clinical Risk Policy. Please refer to the Integrated Clinical Risk Policy (POL/001/017) for details as to how violence risks are assessed and recorded. Risk management strategies appropriate to the needs and risks presented by the individual patient will be developed and implemented.

Work activities and environments will also be assessed in relation potential exposure to risks of violence and aggression in accordance with the Trust’s Service Delivery Health and Safety Risk Assessment Policy (POL/002/023).

Detection of Violence / Aggression Risks

All reasonable efforts will be made by Trust staff to obtain information from other agencies known to be involved with individual patients to ensure as far as possible all appropriate background information is available prior to an initial assessment/visit with a new patient.

Previous reported incidents of violence or aggression should also be considered as part of the risk identification process.
Risk Management Care Plans / Safe Systems of Work

Risk management care plans for patients will be recorded in accordance with the Integrated Clinical Risk Policy (POL/001/017). They will include information relating to known triggers of violence/aggression, and strategies for enabling staff and patients to cope with that aggression. Where appropriate detailed care plans should state interventions to be used in line with patient needs. All staff working with patients who present risks of violence / aggression must be familiar with the content of their risk management care plans in order that appropriate care can be provided to that patient and appropriate action taken in the event of a violent/aggressive episode.

Safe systems of work for management of violence risks will be recorded in accordance with the Service Delivery Health and Safety Risk Assessment Policy.

Behaviour Agreements / Advanced Directives

Patients’ risk management care plans may incorporate a ‘behaviour agreement’ developed in conjunction with the patient, which is an acknowledgement by the patient that their violent/aggressive behaviour will have consequences.

Verbal & Written Warnings for Unacceptable Behaviour

Violent / aggressive behaviour is acknowledged as unacceptable. The individual concerned will be contacted about it accordingly, either verbally or in writing, as soon as is reasonably practicable after the event. Appendix 1 of this policy provides a template for a ‘warning letter’ that is appropriate to send to individuals, including those in receipt of mental health or learning disabilities services and to relatives whose behaviour is unacceptable. In all cases your LSMS should be contacted and informed that a letter is being sent. A copy must be sent to the LSMS. If the situation requires an adaptation of this letter your LSMS who will provide support in drafting a more personalised / appropriate version.
Incident Management

All mental health inpatient areas, and other areas where control and restraint of patients may be required, will have a safe system of work which incorporates the means of calling for assistance, where assistance will come from, and how that response will be managed.

All other areas will have in place procedures to monitor the safety and welfare of staff whilst at work and for follow up action should there be concerns about their safety or welfare. Please refer to the Trust’s Security Policy and Policy for Lone Working for further information.

Physical Restraint

Restraining patients should be avoided wherever possible and only used as a final and last resort, however where it is not possible, this should be for the shortest period of time and for the central reason of gaining control of the situation. In exceptional situations where the patient needs to be placed in the prone position (face down) this should be for the shortest possible period of time to bring the situation under control. Please refer to Appendix 3 for detailed guidance on the use of physical restraint. Any force applied must be justifiable, appropriate, reasonable and proportionate to the specific situation. It must be applied for the minimum amount of time commensurate with managing the risk.

6.2 Reporting of Incidents and Incident Investigation

All incidents of violence and aggression, including those where there was no physical contact or where there was no physical injury, will be reported and investigated in accordance with the Trust’s Policy for Incident and Serious Untoward Incident and Near Miss Reporting, and also the Trust’s Security Policy.
Abuse received by telephone, electronically or in person should be recorded using victim / witness statement forms in order to preserve as many details of the incident as possible. Under no circumstances should individuals working for the Trust engage in covert recording. Consent should be sought in all instances where it is intended to record. If consent is not forthcoming then the recording should not take place.

If the abuse was received by letter or other written means, the original communication should be preserved, handled as little as possible, placed in a plastic sleeve and maintained for further instruction from your LSMS.

Please see Appendix 2 flowchart showing how incidents of violence or other security incident should be reported and followed up by managers and the LSMS.

6.3 Reporting of Violent Incidents to the Police

All incidents falling within the NHS definition of the ‘intentional application of force to the person of another without lawful justification resulting in physical injury or discomfort’ should be considered for reporting to the police (if the police have not already been involved in the incident). The only occasions where this would not be recommended is if the assault was as a result of the patient’s clinical condition and to do so would be detrimental to the care of the patient.
6.4 Assaults against Patients

Any incident where a patient has been assaulted should be considered for reporting to the police (see section 6.3 above). The victim should be asked for their consent prior to doing this. In situations where the victim is unable to provide consent (for clinical or other reasons), the decision whether or not to report the incident should be made by the clinical team involved with the patient’s care. The incident may also trigger safeguarding reporting. Further guidance on this should be obtained from the LSMS and/or the Trust’s Safeguarding Team.

6.5 Supporting Staff following traumatic or stressful incidents

Post Incident Support

The staff member will be supported by their line manager and the LSMS through the incident reporting and witness statement process. Should criminal sanctions be sought against the offender, the staff member will be supported through the prosecution process by the LSMS, Quality, Safety and Safeguarding Department, the Trust’s solicitors, and any other agency acting on the Trust’s behalf. Refer to the Trust’s Untoward Incidents/Formal Complaints/Claims Investigation Policy for details of support offered to staff following incidents and during investigations.

PMVA trainers are available for support for the individual.

6.6 Trust’s PMVA Training Model

Training will take account of the values and principles which underpin the care of all people using Trust services including people with mental health needs and people with learning disabilities. Training for employees within the Trust will take various forms and will include:

- Minimum level of PMVA training on appointment through Corporate Induction
• Additional training for those who are at higher risk of exposure to violence / aggression as a result of their occupation or work location.

• Training to provide staff with the skills and knowledge to be able to respond appropriately to violence and aggression.

• Theoretical instruction in the causes of anger and aggression, the prevention of and how to de-escalate/diffuse a situation.

All PMVA trainers are trained to and deliver The General Services Association (GSA) recognised model, all techniques demonstrated / instructed during the training are approved in accordance with the GSA syllabus. Any variations to the core syllabus will be approved by the Trust.

Where a staff member chooses to apply techniques or approaches other than those taught on the PMVA training, that staff member is solely responsible for his/her actions and must be prepared to defend that those actions were reasonable and in the patient’s best interest.

The training of each member of staff must be to a level appropriate for each person’s expected clinical responsibilities. According to NICE Clinical Guideline 25 (2005) and NPSA Rapid Response Report (2008/RRR010), staff caring for patients in any mental health inpatient settings must have competencies in monitoring, measurement and interpretation of vital signs that equip them with the knowledge to recognise acutely ill patients’ deteriorating health and respond effectively that are appropriate to the level of care they provide. The Trust’s Resuscitation Policy (POL-001-002) states that the Resuscitation Council (UK) Immediate and/or Basic Life Support course (role dependent) is recommended as a minimum standard for staff that deliver or are involved in rapid tranquilisation, physical restraint and seclusion.
6.7 Levels of Training

Level One plus breakaway and de-escalation - Recognition, prevention and management of aggression and violence. This provides a minimum mandatory level of Prevention and Management of Violence and Aggression (PMVA) training. Level 1 is equivalent to the NHS Protect PSTS (Promoting Safer Therapeutic Services) & Control & Restraint training. Level 1 training plus competency in breakaway and de-escalation techniques enables staff to be safe in their working environment thereby provides conflict resolution training for staff.

Level 2 - Recognition, prevention and breakaway training, including de-escalation techniques and legislation and policy relating to PMVA (including equality and diversity). Level Two training can be tailored to the demands of different service settings.

Level 3 - Recognition, prevention and management of aggression and violence including use of physical interventions. Level 3 is the required level of training for all mental health/learning disabilities staff in inpatient settings who will be expected to participate in PMVA teams in inpatient settings; and for other staff e.g. prison healthcare staff who may be required to use control & restraint techniques safely and effectively.

6.8 Delivery of Training

The Trust will use its in-house trainers to deliver the training, although there may be occasions when external trainers may be utilised. All in-house trainers will maintain their clinical practice skills and training skills through a combination of dedicated training time, and time in clinical practice.

The PMVA training programme will be reviewed annually by the PMVA Team supported by the Business Manager of Quality & Nursing who manages the PMVA Services to ensure it remains suitable to meet the Trust's needs.
7. Training

Mandatory training associated with prevention and management of violence and aggression is outlined in the Trust’s Corporate Mandatory Training Needs Analysis. Attendance at training is managed in accordance with the Trust’s Learning and Development Policy.

8. Monitoring compliance with this policy

The table below outlines the Trusts’ monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

<table>
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<th>Aspect of compliance or effectiveness being monitored</th>
<th>Monitoring method</th>
<th>Individual responsible for the monitoring</th>
<th>Frequency of the monitoring activity</th>
<th>Group / committee which will receive the findings / monitoring report</th>
<th>Group / committee / individual responsible for ensuring that the actions are completed</th>
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<td>Resource Pack</td>
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<td>Adherence to standards in appendices 1, 2 and 3</td>
<td>Audit of records</td>
<td></td>
<td>Annual</td>
<td>Care group</td>
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</table>
9. References/ Bibliography


Department of Health. 2002, Guidance for Restrictive Physical Interventions

Department of Health, 2003, ‘Directions to NHS Bodies on Measures to Deal with Violence Against NHS Staff’, www.cfsms.nhs.uk


Department of Health, 2006, ‘Directions to NHS Bodies on Measures to Deal with Violence Against NHS Staff (Amendment) Directions 2006’, www.cfsms.nhs.uk

Disability Services’, www.cfsms.nhs.uk


National Institute for Mental Health in England (NIMHE), 2004, Policy Implementation Guide - Developing Positive Practice to Support the Safe and
Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings


Smith, M, 2007, ‘Royal College of Nursing Lone Working Survey’, Sheffield Hallam University,


10. Related Trust Policy/Procedures

References have been made within this policy and appendices to the following:

Clinical Risk Policy

CCTV Policy
Confidentiality Policy

Consent Policy

Corporate and Local Induction Policy and Procedures

Corporate Mandatory Training Needs Analysis

Integrated Clinical Risk policy

Learning and Development Policy

Photography and Video Recording Policy & Procedures

Lone Working Policy

Incident and Serious Untoward Incident and Near Miss Reporting Policy

Service Delivery Health & Safety Risk Assessment Policy

Searching of Service Users Person, Rooms and Personal Belongings Policy on Management of Harmful Drugs Substances, Weapons or Articles

Preparing for a Serious Security Occurrence (Lockdown) Policy

Rapid Tranquilisation Policy

Resuscitation Policy

Security Policy

Seclusion Policy

Supportive Observation on Inpatient Units Policy

Untoward Incidents/Formal Complaints/Claims Investigation Policy
Appendix 1

APPENDIX 1 - TEMPLATE FOR WARNING LETTERS (CONTACT YOUR LSMS BEFORE SENDING THIS LETTER)

Direct Line: (01228) 60 XXXX
Email: firstname.surname@cumbria.nhs.uk

Our ref:
Date
Name
Address

Dear

REF: INCIDENT ON <INSERT DATE AND LOCATION>

As the Consultant/Manager/Care Professional (delete as applicable) in charge of your care, I am writing to you concerning an incident that occurred on <insert date> at <insert location>.

It is alleged that you, <insert name>, used/threatened unlawful violence/acted in an antisocial manner towards a member of NHS staff/whilst on NHS premises (delete as applicable).

Behaviour such as this is unacceptable and will not be tolerated. This trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse.

If you continue to act in an unacceptable or antisocial manner, consideration will be given to one or more of the following actions (to be adjusted as appropriate):

• The matter may be reported to the police with a view to this health body supporting a criminal prosecution by the Crown Prosecution Service.
• The matter may be reported to the NHS Security Management Service’s Legal Protection Unit with a view to this health body supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from you.
• Consideration may be given to obtaining a civil injunction or an Anti-Social Behaviour Order. Any legal costs incurred will be sought from you.
• Alternative arrangements may be made for you to receive your treatment elsewhere and any hospital transport service currently provided to you may be withdrawn.
If you consider that your alleged behaviour has been misrepresented in any way or that this warning letter is unwarranted, please write to <insert details of person in charge of local complaints procedure>, who will review this decision in the light of your account of the incident(s).
A copy of this letter will be placed on your medical file and a copy has been sent to your General Practitioner.

Yours sincerely,

<Name- Title>,

<Name- Title>,

<Name- Title>,

<Name- Title>,
APPENDIX 2 - VIOLENCE/AGGRESSION/SECURITY INCIDENT REPORTING & INVESTIGATION FLOWCHART

Security Incident
Manager deals with violent/abusive incident and takes immediate action

Manager notifies the Safety, Risk and Security Team asap

Incident managed internally / Police not notified.

Police assistance required / Police notified

LSMS opens case file & contacts Manager for details of incident & to review investigation progress

Manager carries out initial investigation / post incident review, completes incident report form online

LSMS verifies if police notification is needed / has been made

LSMS to consult victim / lead clinician to verify if they want incident progressed using sanctions available to NHS

If notification has not been made but is recommended by LSMS, LSMS to contact police & report incident

If notification has been made

If police/CPS decide not to charge / prosecute

If no follow up requested, LSMS to close case file noting reasons and update IRS

LSMS to update case file according to outcome of actions & keep victim/manager updated on progress

If police/CPS decide to prosecute, LSMS will obtain regular updates & feedback outcome to victim

Police/CPS conduct investigations and feedback decision whether to charge / prosecute

LSMS to notify SMD of readiness to take case to Legal Protection Unit or Trust’s Solicitors & seek final approval before incurring 50% costs of prosecution

Provide feedback on incident through internal governance procedures
APPENDIX 3 - GUIDANCE ON PHYSICAL RESTRAINT AND PHYSICAL INTERVENTION

Purpose and Use of Physical Restraint

Physical intervention/restraint involves the application of the minimum degree of force needed to prevent injury or physical damage to property. The Department of Health (July 2002) refer to differing forms of physical intervention and divides them into ‘Restrictive and Non-Restrictive Interventions’ as shown in the table below. The Trust will not support the use of mechanical restraint unless its use is specifically care planned and no alternative is available. Prior to the use of mechanical restraint, the Director of Operations & Exec Nurse must be consulted first.

<table>
<thead>
<tr>
<th>Bodily contact</th>
<th>Mechanical</th>
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<tr>
<td>Environment change</td>
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<tr>
<td>Non restrictive</td>
<td>Manual guidance of the cause of example walking temperature, background noise</td>
</tr>
<tr>
<td>Restrictive</td>
<td>Holding a person’s doors or hands to prevent seclusion. them hitting someone</td>
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(DOH Guidance for Restrictive Physical Interventions 2002)

Wherever possible, restraining service users on the floor should be avoided. If, however, the floor is used then this should be for the shortest period of time and for the central reason of gaining control of the situation. In exceptional situations where the service user needs to be placed in the prone position (face down) this should be for the shortest possible period of time to bring the situation under control. This is in accordance with statement 14.2.12 of NIMHE Mental Health Policy Implementation Guide – Developing Positive Practice to Support the Safe & Therapeutic Management of Aggression & Violence in Mental Health In-patient Settings.
The use of any form of physical restraint methods will be considered to be the last resort. It should not be used until all other approaches have failed and/or violence is imminent. Any restraint must be reasonable in the circumstances and the force used must be the minimum required to deal with the harm that needs to be prevented.

The purpose of physical restraint is firstly to take control of a dangerous situation and secondly to limit the service user’s freedom for no longer than is necessary to end or reduce significantly the threat to self or others.

It is generally considered to be unsafe for anybody to try to restrain another person on their own. If you are alone in a difficult situation you should try to escape from the situation and summon assistance verbally or by using the alarm system (if available).

**Methods of Physical Restraint**

Any form of physical restraint requires that the duty of care afforded to our service users is never compromised and that it takes into account the safety and well-being of everyone involved.

Physical restraint requires the safe immobilisation of a person in an effort to avoid potential harm. It is not possible or desirable to outline specific restraint skills in this document.

Staff not trained in physical intervention techniques still have a duty of care for their service users and should act in a manner reasonable to the situation and in good faith, bearing in mind guidelines on physical restraint.

**Persons Conducting Restraint**

Gender issues should be considered when undertaking restraint. Restraint of an individual should be undertaken at all times by 2 / 3 staff. It should not be undertaken singularly.

**Reporting Incidents Involving Physical Restraint**

All incidents of physical restraint will be reported in accordance with the Policy for Incident and Serious Untoward Incident and Near Miss Reporting (POL/002/006/001)

**PHYSICAL INTERVENTION TECHNIQUES**

**Guidelines**
When using physical restraint methods, the following guidelines must be borne in mind:

- One person should co-ordinate the whole situation and utilise resources to meet all of the needs of the incident, e.g. looking after the needs of other service users, staff, etc.

- Make a visual check for weapons (see Trust Policy on Management of Harmful Drugs Substances, Weapons or Articles on Mental Health / Learning Disabilities In-Patient Wards within Cumbria -POL/001/003)

- Nominate staff members to assist and allocate each a specific task.

- Fewer well briefed staff are likely to be more effective than large numbers of staff grabbing in an unorganised fashion.

- The service user should not automatically be taken to the floor, however if this is deemed necessary arms and legs should be immobilised swiftly and safely.

- Protect the head from harm and maintain airway.

- Do not use neck holds or place any weight on any areas, especially chest and stomach.

- Continually explain the reason for the action to the service user and encourage co-operation and voluntary control as soon as possible.

- Where possible staff should remove items of jewellery, name badges and ties prior to restraint. This will help to reduce the risk of damage and injury occurring.

- Any form of restraint should not be punitive.

**Implementation - Physical Restraint**

One person should co-ordinate the whole situation and utilise resources to meet all of the needs of the incident, e.g. looking after the needs of other service users, staff, etc.

Where there is an identifiable team of people involved in the physical restraint of a person, one member of staff should assume the role of team co-ordinator. All other persons in the team should take instructions from the team co-ordinator who,
wherever possible, should be the staff who has the best rapport with the service user.

Co-operation should be sought and encouraged at all times from the person who is being restrained.

Keep the service user informed about what is happening and the consequences of any actions.

Communication between the team co-ordinator and the service user should be continuous in an effort to establish when it is appropriate to end the restraint procedure or reduce the degree of physical restraint required.

Ask all other people who are not involved in the situation to leave the immediate vicinity in order to maintain the privacy and dignity of the service user.

A full detailed account of the incident will be recorded in the service user’s notes and incident forms.

**Physical Care and Observation During Restraint**

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 communicated to all multidisciplinary team members.

Where there is a foreseeable risk a care plan should clearly identify the physical condition and the strategies to minimise the risk to the service user. This care plan should be communicated to all multidisciplinary team members and regularly reviewed and evaluated with the service user and, where appropriate, their carer/advocate.

All staff who may be involved in the restraint process will be trained in:

- Basic life support skills and attend annual updates.
- The physical risks associated with restraint, i.e. positional asphyxia/ sudden collapse.
- Recognising conditions of physical and respiratory distress, signs of physical collapse, side effects of medication and how to take appropriate action.
- Use of emergency equipment.
• Know how to summon appropriate assistance.

In all wards/units where the use of restraint is foreseeable there should be immediate access to basic life support equipment which is regularly checked (i.e. weekly) and maintained in working condition.

In all wards/units where the use of restraint is foreseeable and where urgent medical assistance may be required, there should be systems in place to ensure immediate access to medical assistance via on-call duty doctor.

Any person subject to physical restraint should be medically assessed at the earliest opportunity but no longer than 2 hours after the commencement of the physical restraint. Any injuries will be reported through established reporting systems.

Any person subject to restraint should be physically monitored continuously during restraint and at least every 2 hours post restraint for a period of up to 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 person subject to this process, then it should be clearly documented in their records why certain checks could not be performed and what alternative actions have been taken.

Physical monitoring is especially important:

• Following a prolonged or violent struggle.

• If the service user has been subject to enforced medication or rapid tranquillisation (see the Trust's Rapid Tranquilisation Policy- POL/001/020)
• If the service user is suspected to be under the influence of alcohol or illicit substances.

• If the service user has a known physical condition which may inhibit cardio-pulmonary function e.g. asthma, obesity (when lying face down).

Wherever possible, restraining service users on the floor should be avoided. If, however, the floor is used then this should be for the shortest period of time and for the central reason of gaining control of the situation. In exceptional situations where the service user needs to be placed in the prone position (face down) this should be for the shortest possible period of time to bring the situation under control. This is in accordance with statement 14.2.12 of NIMHE Mental Health Policy Implementation Guide – Developing Positive Practice to Support the Safe & Therapeutic Management of Aggression & Violence in Mental Health In-patient Settings.

If extra care or seclusion is considered as an alternative strategy to physical restraint, when managing actual violence, the Trust’s Supportive Observation on Inpatient Units Policy (POL/001/007) and Seclusion Policy (POL/001/004) must be followed.

Where physical restraint methods have been employed, the care team should review their intervention strategy and discuss the treatment regime as soon as it is practicable with the rest of the multi-professional team.