



Policy Title: Prevention and Management of Violence & Aggression

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Policy On A Page

SUMMARY & AIM

This policy provides guidance to minimise both the use of restrictive practice and the exposure of Trust employees and patients to violence and aggression both in the total number of episodes and individual severity; and to ensure that violence and aggression towards staff and patients will not be accepted.

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.

TARGET AUDIENCE:

All staff, patients and visitors in all work activities and environments where staff may be exposed to risks of violence and aggression with the exception of Prison Health Staff.

TRAINING:

There are 3 levels of PMVA training: –

- Level 1 for Community Care Group Clinicians.
- Level 2 is a face session for Mental Health and Specialist Care Group clinicians who work in a lone working capacity.
- Level 3 is for staff working on mental health or learning disability inpatient wards and is a blend of theory and practical over 4 days.

All sessions are assessed by PMVA Tutors and staff only accredited if they meet the requirements of the assessment.

KEY REQUIREMENTS

1. This policy will outline our approach to the aspiration to minimise the use of restrictive practices and acknowledgement of the potential harm these practices can cause.
2. Restraint may only be used where it is necessary to protect individuals from harm and is proportionate to the risk of harm. “If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need.”
3. All staff are responsible for reporting incidents when instances of violence and aggression have occurred – this can be in many forms including verbal or physical.
4. Staff should only use the physical restraint techniques if they have received the necessary training which includes the principles of least restriction and utilisation of safe holds and the aspiration to be prone free where appropriate.
5. All staff are responsible for reporting incidents relative to all approaches from de-escalation, safe holds and restrictive practice. The Trust will have processes in place to review and learn from these incidents
6. Where possible, decisions concerning the use of restraint must be discussed and agreed with patients, relatives and carers. If a patient lacks capacity to make a decision about the use of restraint then the decision as to whether to use restraint must be made in the patient’s best interests and needs to be recorded.
7. This policy covers anticipating and reducing the risks of violence and aggression as well as the use of restrictive intervention in the management of violence and aggression.

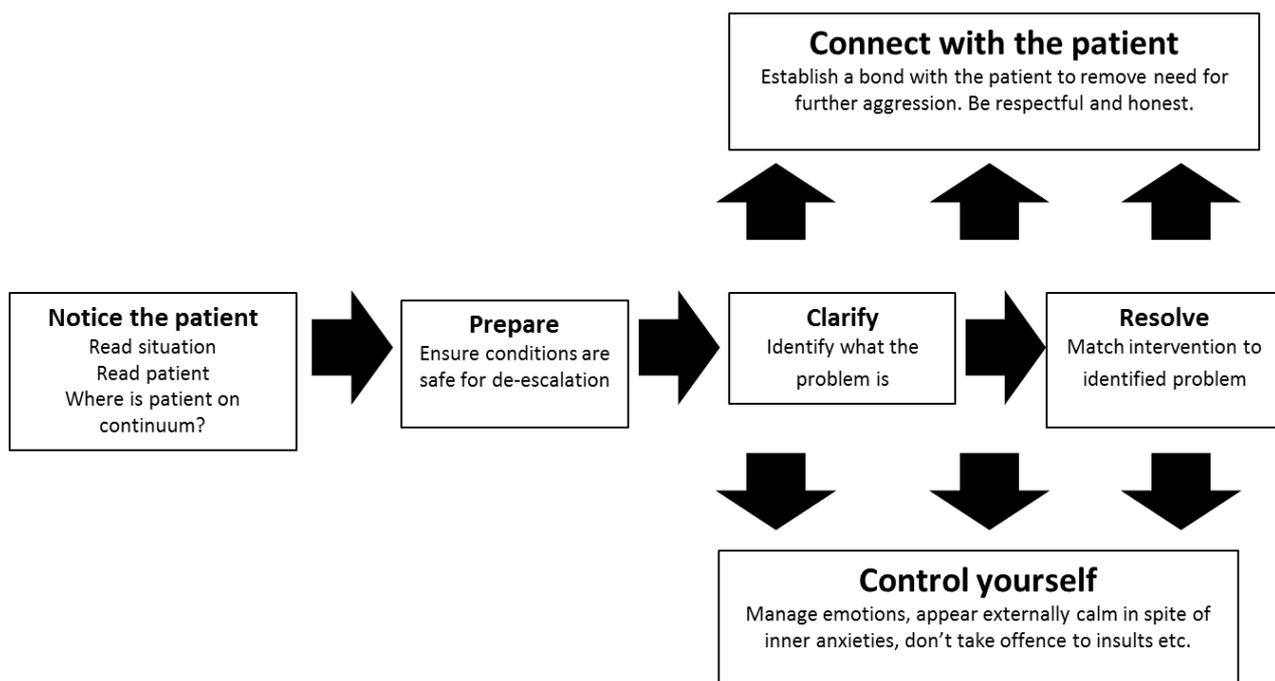
TABLE OF CONTENTS

1.	INTRODUCTION	6
	The definition of violence & aggression at work according to the HSE is:	6
2.	PURPOSE	8
3.0	POLICY - ARRANGEMENTS FOR THE PREVENTION AND MANAGEMENT OF VIOLENCE AND AGGRESSION	9
3.1	Preventing & minimising the likelihood of harm to others	9
3.2	Assessment of Violence / Aggression Risks.....	9
3.3	Detection of Violence / Aggression Risks	9
3.4	Risk Management Care Plans.....	9
3.5	Behaviour management plans.....	10
3.6	Advanced Directives.....	10
3.7	Incident Management.....	10
3.8	Physical Restraint.....	11
3.9	Physical health monitoring.....	12
3.10	Reporting of incidents and incident investigation.....	12
4.	TRAINING AND SUPPORT	12
5.	PROCESS FOR MONITORING COMPLIANCE	14
6.	REFERENCES:	14
7.	ASSOCIATED DOCUMENTATION:.....	15
8.	DUTIES (ROLES & RESPONSIBILITIES)	15
8.1	Chief Executive / Trust Board Responsibilities:	15
8.2	Executive Director Responsibilities:	15
8.3	Manager's Responsibilities	15
8.4	Staff Responsibilities:	16
8.5	Expectation of patients wherever possible:	16
8.6	Expectations of Carers:	16
8.7	Expectation of User / Advocacy Groups:.....	17
8.8	Expectations of other organisations:	17
9.	ABBREVIATIONS / DEFINITION OF TERMS USED	17
	APPENDIX 1 - GUIDANCE ON PHYSICAL RESTRAINT AND PHYSICAL INTERVENTION	19
	DOCUMENT CONTROL	27

Preface: De-escalation

This policy outlines the role of restrictive practice in the management of behaviours which challenge services. These are practices that can be employed in the context of the de-escalation and management of behaviours that challenge services and place individuals at risk. The core strategy prior to implementation of restrictive practice should be de-escalation. As such, a model and guidance around de-escalation is provided below as a preface to the policy. This model is taken from the 'safe wards' guidance.

A model of de-escalation



This looks at the whole process of de-escalation so that many different factors can be explored in an attempt to understand what is happening for the patient and how this is manifested in their presentation.

Notice the patient

This allows us to think about where a patient may be on the arousal cycle. Having knowledge of their early warning indicators and trigger factors is an essential tool to support this process as we can identify the correct individualised intervention for that patient. There are different methods of collecting this information dependent upon the patient group, these include:

- My safety plan
- Well-being diary
- Positive behavioural plans

Completing the previously identified tools can bring about empowerment for the patient when co-produced as this can aid understanding for the patient and can be transferable post discharge.

Prepare

This encourages us to consider the safety of the situation and environment that the episode is taking place. It enables us to ascertain if we can contain the situation or if additional support is required from other wards or on some occasions the police.

Clarity

It is essential during the de-escalation process that we think about what might be happening for the patient to cause them to present in a challenging way. The need to think about the problem from a physical, psychological or environmental perspective assists us to further understand the underlying problem.

Connecting with the patient

This supports us to think about the barriers which may occur in the process of de-escalation and consider how we can make a meaningful connection with the patient in order to support them to deescalate. It allows us to explore the fragile interaction between us and the patient and the skills required by the member of staff to successfully manage the situation.

Control yourself

This gives us the opportunity to explore what it feels like for the member of staff dealing with a challenging patient. An exploration of your own emotional response can help us to understand how to potentially manage our own response as well as consider the patient's perception of us which may be hampering the process of de-escalation.

Resolve

This enables us to consider what we might need to do to bring about a successful outcome, to explore the meaning of de-escalation in bringing about a "safe resolution" and that this may require us to facilitate a range of options.

1. INTRODUCTION

NHS staff are exposed to risks of violence and aggression which is always unacceptable. Equally staff have a significant role to play in supporting a healthy patient safety culture which promotes least restriction and reduces the likelihood of such episodes. Our patients tell us that the experience of using services can be scary and traumatic; therefore we have a joint duty of care to both our patients and staff.

The main legislation governing the management of violence and aggression towards staff in NHS establishments are contained in, but not limited to The Health and Safety at Work Act 1974 (HASWA), Management of Health & Safety at Work Regulations (1999 (MHSW)), and Secretary of State 'Directions to NHS Bodies on measures to deal with violence against NHS staff ('Directions'). NHS Protect guidance "A Professional Approach to Managing Security in the NHS" is considered best practice in relation to security management and is enforceable by the Health and Safety Executive. National Institute for Health and Clinical Excellence clinical guidance, NG10 – "Violence and aggression: short term management in mental health, health and community settings." (NICE 2015), Department of Health (2008) "Code of Practice – Mental Health Act 1983"

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 patients, staff and visitors, taking action against those who commit violent crimes in any related healthcare setting.

The definition of violence & aggression at work according to the HSE is:

"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".

The HSE definition of physical assault is:

"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".

NICE definition of restrictive practice:

Restrictive intervention is defined in the NICE guidance on violence and aggression (NG10) as *'Interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation.'*

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. Physical intervention/restraint differs from manual guidance or physical prompting in so far as it implies the use of force against resistance.

This policy should be considered in conjunction with those that deal with particular forms of restrictive practice such as seclusion (POL/001/004) and Rapid tranquilisation (POL/001/020/001, POL/001/020/002, POL/001/020/003, POL/001/020), Search (POL/001/003) and taking into consideration any previous local blanket restrictions which will be discussed at PMVA Training.

Non-Physical Assault

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

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.

The above list is not exhaustive, and further does not imply that staff would always intervene in these circumstances. For example staff would not generally be expected to intervene where a weapon is in use due to the need to safeguard staff themselves, similarly there are situations where staff may not act to intervene for clinical reasons, such as in specific management plans around the destruction of property.

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.

Self Defence

In the event of a violent / aggressive incident, all individuals have the common law right of self-defence using the minimum action and/or force necessary to remove themselves from a situation presenting imminent or present harm to their personal safety or towards others.

2. PURPOSE

- 2.1 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).
- 2.2 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.
- 2.3 This document provides information and guidance on the use of restrictive practice with patients within a healthcare environment for staff employed by Cumbria Partnership NHS Foundation Trust.
- 2.4 The policy outlines the general principles that must be applied to practice across the Trust, including the legal position where appropriate.
- 2.5 Decisions about restraint and other restrictive practices are not easy or straightforward. It is acknowledged that decisions on the use of restraint in urgent and emergency situations may have to be made quickly and without consultation with colleagues. Sometimes such restraint may lead to complaints by patients or their relatives. Unlawful restraint may give rise to criminal or civil liability. It is self-evident that staff may be required to account for their actions in such circumstances. However, the Trust will always support employees who act in a way that is deemed reasonable and measured at the time of the incident and in accordance with professional standards and training.
- 2.6 The Care Quality Commission has a specific remit to ensure that restraint, if used to deliver necessary care or treatment, is in the best interests of someone lacking mental capacity, and is proportionate, and complies with the Mental Capacity Act.
- 2.7 The policy is in line with the Trust's values whilst remaining patient focussed. It also upholds the principles of restraint reduction and acknowledges that any form of restraint has the potential to cause harm whether that be physical, emotional or psychological.
- 2.8 The Policy provides:
- Guidance for the prevention and management of behaviours which challenge services, including violence and aggression. There may be circumstances where this will apply to other clinical areas for example where clinical holds need to be used in best interests.

- Information specific to the use of restrictive practice in the prevention and management of violence and aggression with regard to behaviours that challenge services, which might include physical intervention in order that safety for all and therapeutic care is maintained.
- Guidance about restrictive physical intervention and therapeutic holding of children and adults to deliver essential care.

3.0 POLICY - ARRANGEMENTS FOR THE PREVENTION AND MANAGEMENT OF VIOLENCE AND AGGRESSION

3.1 Preventing & minimising the likelihood of harm to others

Any episodes of violent or aggressive behaviour can be distressing for patients as well as staff involved and any third parties (e.g. other patients, visitors etc.). At worst if full physical intervention is used the episode can cause significant physical and psychological harm to all who are involved or witness the event. It is necessary, therefore, to ensure that every opportunity has been identified and an appropriate intervention utilised to minimise the risk.

3.2 Assessment of Violence / Aggression Risks

In order to prevent and minimise the risk of violence or aggression toward staff and patients, violence risks presented by patients will be assessed and documented in accordance with the Trust's Clinical Risk Policy. Please refer to the 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, implemented and recorded in the patient's record.

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 and Process (POL/002/012). This will include assessing the suitability of the environment to maximise the sense of safety and security for the patient.

3.3 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.

As soon as possible in the assessment process Trust staff should involve family, carers and significant others in jointly developing an assessment and plan of care. This should be done with due regard to the wishes and consent of the patient as well as the risks posed by not sharing information.

3.4 Risk Management Care Plans

Risk management care plans for patients will be recorded in accordance with the 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. Care plans should detail 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.

While care planning to manage risks posed by the patient is a key strategy, it is also important that other factors are taken into account including the impact of individual staff, or the impact of the environment, which may involve a wider care plan held by the service manager.

3.5 Behaviour management plans

Patients' risk management care plans may incorporate a positive behaviour management plan developed in conjunction with the patient and where appropriate shared with carers. This should be a collaboratively developed plan, which documents the triggers and consequences of a specific behaviour, and identifies how the patient, staff or identified others intend to act to prevent, manage and/or respond to the identified behaviour.

3.6 Advanced Directives

The use of advanced directives allow patients to make their wishes regarding their treatment clear in advance, and this may include their wishes around the use of restrictive interventions. In line with NICE guidance (NG10), staff should endeavour to identify whether an individual making use of services has an existing advanced directive.

Where individuals do have advanced directives, these are given due regard in decisions about the treatments and interventions used. For individuals being treated under the mental health act, these decisions are not always legally binding, but should be considered in line with the Advanced Care Planning Policy (POL/001/036).

Where individuals do not have advanced directives, they should be offered the opportunity to develop these as soon as possible (for example during an admission) as described in NICE guidance (NG10). Where individuals lack capacity relating to a decision and restrictive interventions are being considered in the 'best interests' of a patient, carers should be involved wherever this is possible and appropriate. Advanced statements in this context should be considered in line with the Multi-Agency Mental Health Act policy (POL/001/005/001).

3.7 Incident Management

Where there is a risk that patients may exhibit behaviours that challenge services each area will have a protocol 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 (POL/002/015) and Policy for Lone Working (POL/002/057 for further information).

Following an incident of violence or aggression, in particular where restrictive practices are used efforts must be made to ensure staff and patient wellbeing. This may be effected by means of a post incident review or 'debrief' with the staff involved, which should focus on

establishing that staff are safe, that the patient is safe, and reviewing what happened such that immediate lessons can be learned and support given.

Patients involved in the incident (either as bystanders, or directly) may also benefit from time with staff when appropriate to establish wellbeing and to review what happened and establish management plans to reduce the risk of future violence and aggression. Consideration should be given to when and how this would be appropriate based on the wellbeing of the patient.

At times where incidents are particularly complex or distressing a further reflective practice or learning lessons meeting, facilitated by an independent member of staff, may be offered. This should be voluntary, and take place in the weeks after the incident. This should not be in immediate response to an incident and psychological debriefing techniques should not be used. This is in line with NICE guidance about the prevention of post-traumatic stress (NG116), which recommends against any immediate psychological debriefing.

Debriefing serves a dual purpose, focussing both on immediate safety in the aftermath of an incident, but also in supporting a learning culture, where the evidence gathered from each individual incident can be used effectively to reduce the likelihood of future episodes of aggression and support the improvement of practice to reduce the overall number of episodes in an environment.

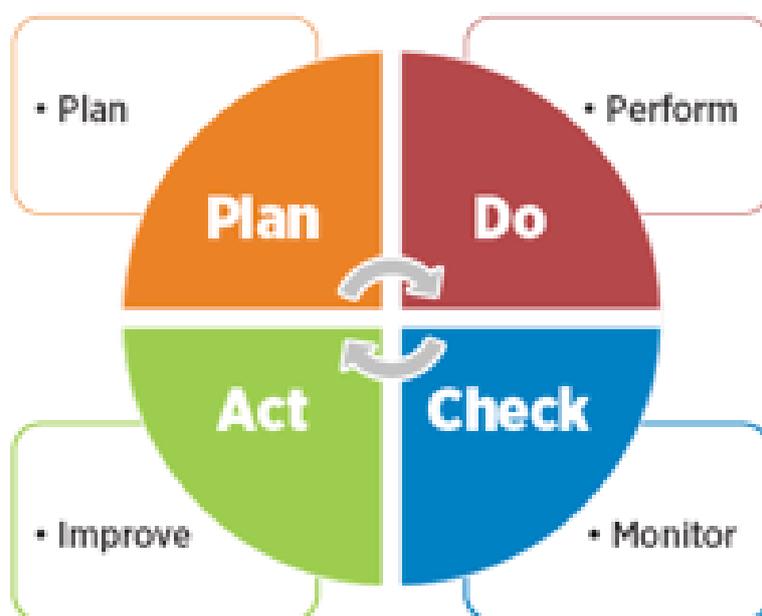


Figure 1 - Plan, Do, Study, Act cycle (Deming – 1993)

The PDSA cycle (above) reflects one strategy that can be used to do this, offering an opportunity to identify a plan, implement a strategy, monitor for change and act on the results. This could result in meaningful changes to ward practice such as staff becoming aware of, environmental triggers (for example banging doors or high traffic areas) and making changes to ward practice that results in a reduction in future episodes.

3.8 Physical Restraint

One form of restrictive practice that the Trust may employ is physical restraint. The Trust is committed to understanding the impact of these types of restrictive intervention for both our patients and staff and recognise the challenges for both parties when restraint is used. We also recognise from our patients that restraint can be therapeutic as part of a

planned and co-ordinated approach and that the shared development of plans to manage necessary restraint can improve the effectiveness of this.

Prone restraint (where a patient is held in a face down position) is increasingly recognised to have unacceptable physical and mental health consequences for our patients. In addition to the minimisation of restrictive practice more broadly, our aspiration is to end the use of this type of restraint and become 'prone-free.' Therefore the use of prone restraint as an initial front line approach is to be avoided.

In exceptional situations where the patient needs to be placed in the prone position. Attempts should be made to turn the patient into a supine (face up) position, or other alternative at the earliest possible opportunity as the situation is brought under control.

Restraining patients should be avoided wherever possible. However, where restraint techniques do have to be used, this should be for the shortest period of time and for the central reason of gaining control of the situation. Please refer to Appendix 1 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. This should be read with Appendix 2 - the physical health monitoring and restrictive practices: overview of requirements.

3.9 Physical health monitoring

Any patient who is restrained must have their physical observations taken during full restraint using a continuous approach of monitoring through non-contact observations eg what can be seen, heard, what the patient is telling us. After the restraint patients should be monitored in-line with NEWS2 and repeated based upon the initial assessment score and escalated accordingly. There are instances where patients might refuse to have their physical observations taken and in these situations staff can follow Appendix 3 non-contact approach.

3.10 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 Incidents that require investigation (POL/002/006/001, and also the Trust's Security Policy (POL/002/015).

Debriefs will need to be uploaded to Ulysses and learning lessons sessions will be held as appropriate.

Reporting of violent incidents to the police - all incidents where there is an intentional application of force to the person without lawful justification which resulting in physical injury or discomfort should be considered for reporting to the police. Guidance can be sought from the Safeguarding Team.

4. TRAINING AND SUPPORT

Mandatory training associated with prevention and management of violence and aggression is outlined in the Trust's Corporate Mandatory Training Needs Analysis.

Training will take account of the values and principles which underpin the care of all people using Trust services. Training for employees within the Trust will take various forms and will include:

- Minimum level of PMVA training as identified according to their job role.
- Training will provide staff with the skills and knowledge to be able to respond appropriately to violence and aggression taking consideration a trauma informed approach.
- All teaching will be delivered in accordance with the 6 Core Strategies of Restraint Reduction to ensure that any physical intervention is used as a final and last resort having exhausted all other approaches.

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 via the TMVA Committee.

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 10 (2015) and NPSA Rapid Response Report (NPSA/2008/RRR010: Resuscitation in mental health and learning disability settings), 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.

Levels of Training

Level 1: provides a minimum mandatory level of Prevention and Management of Violence and Aggression (PMVA) training. Level 1 is equivalent to the NHS Core Skills Framework Conflict Resolution training. Level 1 training plus competency in breakaway and de-escalation techniques enables staff to be safe in their working environment as it provides awareness of lone working. Any staff who complete this level of training are marked as being compliant with the CSF Conflict Resolution module by CPFT Training Team.

Level 2: Recognition, prevention and breakaway training, including de-escalation techniques, 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.

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.

The PMVA training programme will be reviewed annually by the TMVA Committee support to ensure it remains suitable to meet the Trust's needs.

5. PROCESS FOR MONITORING COMPLIANCE

The process for monitoring compliance with the effectiveness of this policy is as follows:

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
Compliance with Appendix 1	Review of Ulysses reports	Quality & Safety Leads	TMVA Committee	Quarterly
Review of Suitability of PMVA training programme	Report produced by the TMVA Committee support		TMVA Committee	Annually

Wherever the above monitoring has identified areas for improvement, the following must be in place:

- Action plan
- Progress of action plan monitored by the TMVA Committee minutes
- Risks will be considered for inclusion in the appropriate risk registers

6. REFERENCES:

Health and Safety at Work Act 1974 (HASWA)

Management of Health & Safety at Work Regulations (1999 (MHSW)

Secretary of State 'Directions to NHS Bodies on measures to deal with violence against NHS staff ('Directions')

Code of Practice – Mental Health Act (1983)

Health and Safety Executive (HSE) HSG65, the key elements of successful health and safety management

NHS Protect guidance "A Professional Approach to Managing Security in the NHS" is considered best practice in relation to security management and is enforceable by the Health and Safety Executive.

NG10 – "Violence and aggression: short term management in mental health, health and community settings. (NICE 2015), Department of Health (2008)

NG116 - post-traumatic stress disorder

NPSA/2008/RRR010: Resuscitation in mental health and learning disability settings

A Positive and Proactive Workforce (2014) DoH, Skills for Health & Skills for Care

NIMHE Mental Health Policy Implementation Guide – Developing Positive Practice to Support the Safe & Therapeutic Management of Aggression & Violence in Mental Health In-patient Settings.

NG11 – Challenging behavior and learning disabilities: prevention and interventions for people with learning disabilities whose behavior challenges (NICE May 2015)

7. ASSOCIATED DOCUMENTATION:

Seclusion (POL/001/004)
Rapid tranquilisation (POL/001/020/001, POL/001/020/002, POL/001/020/003, POL/001/020)
Search (POL/001/003)
Clinical Risk Policy (POL/001/017)
Risk Assessment Policy and Process (POL/002/012)
Advanced care planning policy (POL/001/036)
Multi-Agency Mental Health Act policy (POL/001/005/001)
Security Policy (POL/002/015)
Policy for Lone Working (POL/002/057)
Incident and Serious Incidents that require investigation (POL/002/006/001)
Security Policy (POL/002/015)
Resuscitation Policy (POL/001/002)
Pressure Ulcer Policy (POL/001/069)
Supportive Observation on Inpatient Units Policy (POL/001/007)

8. DUTIES (ROLES & RESPONSIBILITIES)

8.1 Chief Executive / Trust Board Responsibilities:

The Chief Executive and Trust Board jointly have overall responsibility for the strategic and operational management of the Trust, including ensuring that Trust policies comply with all legal, statutory and good practice requirements

8.2 Executive Director Responsibilities:

Executive Director of Nursing and the Executive Director of Mental Health ensure that Trust policies meet statutory legislation and guidance where appropriate. They must ensure that this policy is kept up to date by the relevant author and approved at the TMVA Committee.

8.3 Manager's Responsibilities

Managers are responsible for ensuring that for within their area:-

- Managers and staff jointly review monthly learning letters to identify compliance with mandatory training requirements in line with Trust TNA.
 - 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.
 - Staff are supported following a violent incident and directed to the appropriate agencies if required e.g. their own GP, accessing Trust Occupational Health Services, counselling, First Step, and Employee Assist Programme. Full debrief should take place.
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- 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 culture within their service areas which seeks to improve the safety of patients and staff by reducing the incidents of violence and aggression.

8.4 Staff Responsibilities:

All staff will take responsibility for their own safety and that of others and for working in a manner consistent with the minimisation of restrictive practice 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 alarms, telephone and IT systems, paper-based systems as well as verbal hand-overs) as a matter of priority.
- Be clear about the content of risk assessments applicable to their work area (patient and environmental) 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.

8.5 Expectation of patients wherever possible:

- To work in partnership to reduce the incidents of verbal and physical aggression.
- To work with staff to identify situations which may cause them to become upset or trigger aggression and work with staff to minimise these.
- Whilst every opportunity is taken to manage episodes of violence and aggression therapeutically there may be occasions where this will result in contact with the criminal justice system.

8.6 Expectations of Carers:

The Trust values the role of carers and staff should ensure that carers feel able to communicate any concerns to the Key-worker/Care coordinator and/or Multi-Disciplinary Team and positively contribute to the care of the patient.

8.7 Expectation of User / Advocacy Groups:

To work with patients on the basis of informed consent. Develop knowledge of the services on behalf of which the group is advocating e.g. Independent Mental Capacity Advocate (IMCA).

8.8 Expectations of other organisations:

Other organisations and professionals are expected to share information in line with Caldicott principles to ensure the safety of patients, staff and others.

8.9 TMVA Committee Responsibilities:

The Chair of the TMVA Committee will ensure the policy approval is documented in the final section of the Checklist for Policy Changes. The committee will agree the approval of the final draft of the policy.

The Committee will review Ulysses incident reports and training reports as specified in section 4

9. ABBREVIATIONS / DEFINITION OF TERMS USED

ABBREVIATION	DEFINITION
CPFT	Cumbria Partnership NHS Foundation Trust
DoH	Department of Health
DOL	Deprivation of Liberty
GSA	General Services Association
IMCA	Independent Mental Capacity Advocate
MCA	Mental Capacity Act
NHS	National Health Service
NICE	National Institute of Clinical Excellence
PMVA	Prevention & management of violence and aggression
TNA	Training Needs Analysis

TERM USED	DEFINITION
De-escalation techniques	These are techniques to reduce the level and intensity of a difficult situation. De-escalation means making a risk assessment of the situation and using both verbal and non-verbal communication skills in combination to reduce problems.
Restrictive interventions	<p>'Restrictive interventions' are defined in this guidance as: 'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:</p> <ul style="list-style-type: none"> • take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and • end or reduce significantly the danger to the person or others; and • contain or limit the person's freedom for no longer than is necessary'.

TERM USED	DEFINITION
Physical restraint	Physical restraint such as staff holding or moving the person, blocking their movement to stop them leaving.
Seclusion	The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving. Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others.
Segregation	<p>Segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis.</p> <p>“This refers to the situation where a person is prevented from mixing freely with other people who use a service. This form of intervention should be rarely used and only ever for hospital patients who present an almost continuous risk of serious harm to others and for whom it is agreed that they benefit from a period of intensive care and support in a discreet area that minimises their contact with other users of the service.” (Positive and Proactive Care 2014).</p>
Therapeutic Holding	<p>This means immobilisation, or by using limited force. It may be a method of helping children, with their permission, to manage a painful procedure quickly or effectively.</p> <p>Therapeutic holding is distinguished from restrictive Physical intervention by the purpose of the required intention. For example following the best interests process it may be necessary to consider restraint in order to maintain or assess physical health aspects for the patient e.g. taking of bloods.</p>

APPENDIX 1 - GUIDANCE ON PHYSICAL RESTRAINT AND PHYSICAL INTERVENTION

Purpose and Use of Physical Restraint

Methods of Physical Restraint

Any form of physical restraint requires that the duty of care afforded to our patients 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 to self and/or others. 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 patients and should act in a manner reasonable to the situation, bearing in mind guidelines on physical restraint and providing that they act in line with Common Law..

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 patients, 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. It should be borne in mind that a large group of staff responding to events can inflame a situation further.

-
- A range of interventions is taught in training so that staff can identify the most appropriate individualised intervention for that patient, at that time. This might include taking someone to the floor in holds. Effort must be made to disengage from the hold as soon as it is safe to do so.
 - Protect the head from harm and maintain airway.
 - Do not use neck holds or place any weight on any areas, especially chest and stomach.
 - Continuous verbal de-escalation during the restraint is essential. This encourages co-operation and seeks to provide reassurance to the patient throughout. If staff are removing items from the patient, such as spectacles, full explanation should be provided even if the patient is not engaging with staff.
 - 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 patients, 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 patient.

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

Keep the patient informed about what is happening.

Communication between the team co-ordinator and the patient 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 patient.

A full detailed account of the incident will be recorded in the patient's notes and incident forms.

Physical care and observation during restraint

Any physical condition which may increase the risk to the patient of collapse or injury during restraint should be clearly documented in the patient'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 patient. This care plan should be communicated to all multidisciplinary team members and regularly reviewed and evaluated with the patient 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, respiratory distress.
- Skin integrity and infection prevention and control precautions.
- 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.
- Body map/skin integrity (Pressure Ulcer Policy)

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:

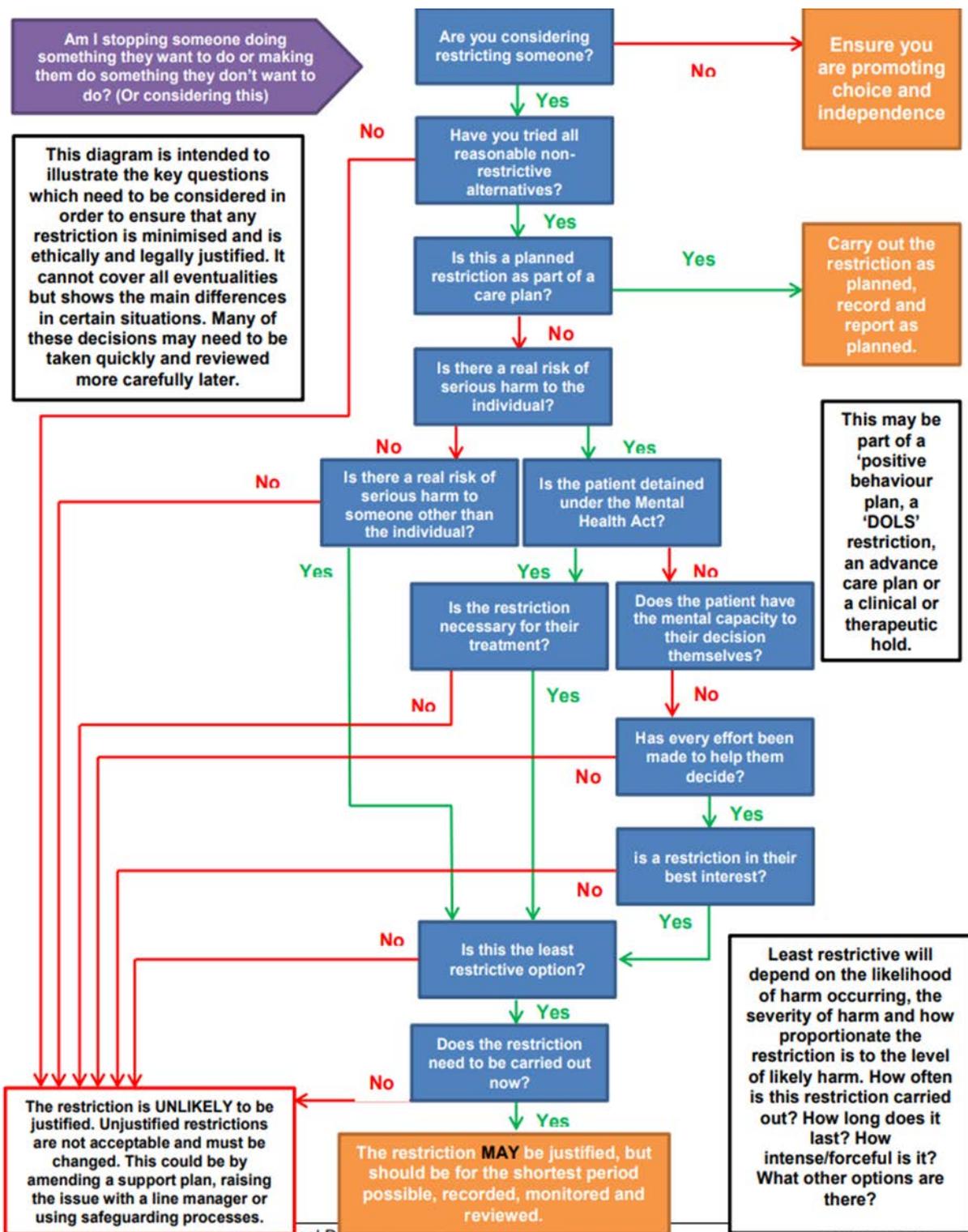
- Following a prolonged or violent struggle.
- If the patient has been subject to enforced medication or rapid tranquillisation (see the Trust's Rapid Tranquillisation Policy)
- If the patient is suspected to be under the influence of alcohol or illicit substances.
- If the patient has a known physical condition which may inhibit cardio-pulmonary function e.g. asthma, obesity (when lying face down).

Wherever possible, restraining patients 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 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.** 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.

APPENDIX 1 - GUIDE FOR STAFF WHEN CONSIDERING INTERVENTIONS



Positive and proactive care: reducing the need for restrictive interventions (DH 2014)

Appendix 2 - Physical Health Monitoring and Restrictive Practices: Overview of Requirements

	Rapid Tranquilisation	Prone Restraint	Restraint	Seclusion
Minimum Requirement	Every 15 mins for the first hour	Every 15 mins for the first hour	60 mins after restraint commenced. Once only	Every formal seclusion review (2 hourly intervals)
Caution	All patients treated as high risk of physical complications when administered RT 16-18yrs – 1:1 continuous observation + NEWS	Prone and RT is very high risk. NEWS MUST be undertaken every 15 minutes	If concerned, contact medic for advice and agree ongoing monitoring plan. Restraint + RT = 15 min NEWS for first hour	Additional observations may be required in line with personal health assessment e.g. Diabetes.
Review	Must be seen by a medic within the hour, agree ongoing NEWS and observations	Must be seen by a medic within the hour, agree ongoing NEWS and observations	Must be reviewed by a medic within 24 hours	As per formal review schedule
Refusal	All refusals to allow NEWS to be carried out MUST be recorded on the NEWS chart and in the clinical record at the required time interval. Attempts should continue in line with required monitoring and ongoing refusals recorded. Alternative clinical indicators MUST be recorded in lieu of NEWS: Observed Respirations; Consciousness Level (AVPU); facial pallor; activity levels and behaviour.			

Appendix 3 - Consideration of non-contact observations as per the table below:**Assessment of patient using a NON-CONTACT APPROACH following a period of restrictive intervention**

If a patient has refused to have any physical observations to be taken, it is important that we are still able to **report and record** any observations we can make via a non-contact approach.

If you have any concerns about your observations seek staff support and undertake full ABCDE assessment – depending on outcome contact the medical team or consider (9)999.

Expected	A B C D E	Areas of concern
<ul style="list-style-type: none"> Airway clear, they can speak? Normal complexion If awake can they speak? If asleep or resting back/side/front? 	AIRWAY	<ul style="list-style-type: none"> Airway obstructed? Silence? Coughing? Gurgling? Wheezing? Snoring? Is airway unsafe? Risk of vomiting? No moans or groans (Consider observation level and moving onto their side if there is felt to be a risk of vomiting)
<ul style="list-style-type: none"> Is breathing quiet and clear 12-20 respiration per minute? Breathing causes no extra difficulty or effort? No abnormal sounds Regular pattern 	BREATHING	<ul style="list-style-type: none"> Noisy? Irregular? Shallow? Rapid? Malodourous (pear drops) More than 20 bpm or less than 12bpm
<ul style="list-style-type: none"> Warm comfortable presentation Able to stand unaided? 	CIRCULATION	<ul style="list-style-type: none"> Flushed? Pale? Pallor? Clammy? Sweating? Mottled (purplish discolouration) Cyanosed (blue tinge or discolouration of lips, nail bed, tip of nose or even ear lobe) Ashen? Grey? Pallor – White/light coloured skin: skin takes on a white hue. Brown skin: appears yellow red. Black skin: appears ashen grey.
<ul style="list-style-type: none"> Responsive to voice No other health concerns 	DISABILITY	<ul style="list-style-type: none"> Do they look hot or flushed? Do they look cold? If possible to determine does the skin feel hot or cold to touch? Are they orientated? Consider AVPU? New or unexplained confusion or disorientation?

<ul style="list-style-type: none">• Level of activity: Active? Walking? Steady?• Resting/Sleeping?• Eating/Drinking?• Patient/Carer/Professional unconcerned	EXPOSURE	<ul style="list-style-type: none">• Signs of dehydration (cracked lips, not passing urine)• Signs of physical injury/bleeding/rash/self-harm• Infection
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DOCUMENT CONTROL

Equality Impact Assessment Date	14/2/19
Sub-Committee & Approval Date	TMVA 14/1/19

History of previous published versions of this document:

Version	Ratified Date	Review Date	Date Published	Disposal Date
1.0	November 2016	November 2019	November 2016	

Statement of changes made from version

Version	Date	Section & Description
1.1	February 2019	<ul style="list-style-type: none"> All policy has been reviewed and changes made in line with national drive for restraint reduction. All policy references have been refreshed. Guidance documentation added.
1.2	28/02/2019	<ul style="list-style-type: none"> Formatting amendments Table of contents to be refreshed to remove bullet points under section 8.1 Transfer of the first five paragraphs under section 3 to section 1 as the content is more relevant in this section Section 8 to be updated to include the approving committee and its responsibilities to review training and reports and the policy Section 6, add reference to NICE NG11 Section 5, monitoring section, update with review of training as specified in section 4

List of Stakeholders who have reviewed the document

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