Prevention and Management of Violence Policy

POLICY NUMBER & CATEGORY	**R&S 10**	**Risk and Safety**
VERSION NO & DATE	**6**	**February 2017**
RATIFYING COMMITTEE	**Clinical Governance Committee**	
DATE RATIFIED	**March 2017**	
ANTICIPATED REVIEW DATE:	**March 2020**	
EXECUTIVE DIRECTOR	**Director of Nursing**	
POLICY LEAD	**Associate Director of Nursing and Quality**	
POLICY AUTHOR (if different from above)	**Advanced Practitioner (AVERTS)**	
FORMULATED VIA	**Positive and Proactive Care Group/ Integrated Clinical Risk Group**	

POLICY CONTEXT

- This policy provides an overview of the Trust philosophy and overall strategy for managing and reducing violence in its services
- Provide primary, secondary and tertiary guidance to staff in keeping with current national violence reduction initiatives and evidence based guidance.

POLICY REQUIREMENT (see Section 2)

- As driven by the Department of Health Positive and Safe Agenda (DH, 2014), the Mental Health Act Code of Practice (DH, 2015) and NG: 10 (NICE, 2015) this policy promotes and supports the implementation of primary, secondary and tertiary preventative strategy-based approach to violence reduction Trustwide.
- The Policy will support the Trust five year violence reduction plan and annual quality account goals relating to a reduction in restrictive practices and assaults on service users and staff.

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1 INTRODUCTION

1.1 Rationale (Why)

The Trust recognises that occasionally some service users - because of the impact of ill-health on their social functioning - may behave in an aggressive or violent manner that requires effective management.

The Mental Health Act Code of Practice (DH, 2015) states:

'Providers who treat people who are liable to present with behavioural disturbances should focus primarily on providing a positive and therapeutic culture. The culture should be aimed at preventing behavioural disturbances, early recognition, and de-escalation' (Ch. 26, p. 281)

The Positive and Safe Agenda (Department of Health, 2014) provides a national framework to reduce the use of restrictive practices in health and social care settings. This agenda is now intrinsic to the management of violence in such settings in England.

This policy will be used to support the Trust Positive and Proactive Care: Violence Reduction Strategy.

The safety and wellbeing of the people in our care and those who provide this care are a priority for the organisation.

The concept of Positive Behavioural Support (PBS) and its use in violence reduction is well established in Learning Disability settings. There is less evidence of its suitability and effectiveness in mental health acute admission settings.

1.2 Scope (Where, When, Who)

This policy applies to BSMHFT staff and service users including those contracted to work on trust premises on a transient or part time basis. External staff providing security oversight to buildings and site (for example Amey, and Engie) are not contracted to be involved in clinical incidents and are therefore expected to provide a presence but not to physically intervene with service users unless there is a legally cogent reason for doing so.

This policy refers to inpatient service areas. Community based staff will follow the guidance to maintain their safety and wellbeing as laid out in the **Policy for Lone Working**.

The definition of violence and personal safety used by BSMHFT is based on the HSE definition of workplace violence namely:

"Any incident where staff, service users and visitors are abused, threatened, or assaulted in circumstances related to Trust activity or on Trust premises, involving an explicit or implicit challenge to their safety, well-being or health."

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

HMP staff will be trained in line with prison training requirements as identified in the Risk Management Training Policy.

This policy acknowledges and pays due regard to the personal protected characteristics as defined in the Equality Act 2010. Staff are expected to take these

elements into consideration when planning, implementing, undertaking and reviewing observations.

The Mental Health Units (Use of Force) Act 2018 received Royal Assent on 1 November 2018. The Act requires that Mental Health Units must have a policy on the use of force. This Policy forms part of such a policy for BSMHFT. Once regulations set out the commencement date and the Code of Practice is published, this Act will be in force.

On the date of commencement of the 2018 Act all provisions of his Policy should be read in conjunction and in compliance with provisions of the 2018 Act and published Code of Practice

1.3 **Principles (Beliefs)**

1.4 The Trust does not endorse, through its policies, procedures or training programmes, the concept of a forced restraint (this is where a person standing up is forced to the floor – usually in a prone position – by staff).

1.5 The use of tertiary restrictive interventions (for example: physical restraint) is always considered a measure of last resort, must be proven to be reasonable under the presenting circumstances, for the shortest of period of time possible, in order to minimise the risks to both the service user and staff.

1.6 Wherever possible the use of the prone position is to be avoided.

1.7 Unless there are cogent reasons for doing so the use of planned interventions that involve placing the person in the prone/face down/chest down position on any surface, not only the floor, must be avoided (DH, 2015, p. 295).

1.8 'Cogent reasons' may be informed by risk to the person or others, or form part of a service users preference in their advanced statement. Such issues should be discussed as an MDT and rationales clearly documented in the service user's aggression management care plan.

1.9 The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.

1.10 The Policy will support the Trust five year violence reduction plan and annual quality account goals relating to a reduction in restrictive practices and assaults to service users and staff.

1.11 Evidence-based violence reduction models (for example Safe Wards) will be used to promote a culture of positive and proactive care with the aim of keeping service users and staff safe. This will be a phased process beginning with a Trust pilot the findings of which will be presented to Trust Board and published via CONNECT.

2 POLICY (What)

2.1 When planning strategies to prevent and manage violence staff should apply the following process:

'Staff should ensure that patients who are assessed as being liable to present with behavioural disturbance have a care or treatment plan which includes primary preventative strategies, secondary preventative strategies and tertiary strategies. In some services such care and treatment is referred to as a positive behavioural support plan (PBSP). These individualised care plans should be available and kept up to date' (DH, 2015, p. 284)

2.2 PBSP's (or equivalent) should take account of:

Cognitive functioning

Age in terms of psychological and emotional maturity

Ethnicity

Culture

Religion or belief

Gender

Gender identity

Sexual identity

In acute services the principles of PBS (ie primary, secondary and tertiary) will be applied to risk management plans relating to management of violence and aggression with service users who display such high risk behaviours.

3 PROCEDURE

3.1 Primary Preventative Strategies

Primary strategies seek to promote the following:

'Behavioural disturbance can be minimised by promoting a supportive and therapeutic culture within the care environment' (DH, 2015, p. 285)

This includes elements of:

Care Environment

Engagement with the service user and their family

Offering care and support

3.2 Care Environment

3.3 The Trust has invested in providing the environments that are conducive to care. However, when working with service users with a propensity for behavioural disturbance staff should take into account how these environments are managed on an operational basis. Unless specific justifiable reasons exist (e.g. for security or reasons of safety) staff should ensure that service users have:

1. Predictable access to preferred items and activities.
2. A unit where excessive environmental stimulation/noise is managed
3. An appropriate number and mix of staff to meet the needs of the inpatient population
4. An avoidance of areas where there is a reliance on compliance and the adherence of 'blanket rules'

If these elements have not been applied due to specific justifiable reasons then such reasons should be clearly documented in the Electronic Care Record. Decisions not to employ any of the above strategies should be made via the MDT and reviewed weekly based on presenting risks.

3.4 Engaging with individuals and their Families

3.5 The Trust has established policies and procedures that foster an environment conducive with working with service user families and carers. Unless justifiable reasons exist this includes dedicated areas for private meetings and the means for service users to have private communication via telephone, email and letter.

3.6 Staff should actively engage service users in the identification of their own trigger factors and early warning signs of behavioural disturbance and how staff should respond to them. These should be clearly documented in the service user's care plan on **RIO**.

3.7 The PBSP (or equivalent) should be reviewed weekly at the MDT.

3.8 Unless justifiable reasons exists (e.g. consent or capacity to refuse consent) staff are to actively engage the service user's nearest relative, family, carers and advocates when compiling PBSP (or equivalent) care and treatment planning.

3.9 If a service user refuses to contribute to their PBSP (or equivalent) this should be clearly documented in their care records.

3.10 In such instances staff should continue to periodically engage the person and encourage involvement.

3.11 Offering Care and Support

3.12 Any PBSP (or equivalent) should be individually focussed and compiled using information from the service user, their nearest relative, family, carer or advocate, the MDT based on previous knowledge and risk history.

3.13 The service user is to be included in the decision making process concerning their activity and therapy programme, based on identified needs.

3.14 Service users identified at being at risk of presenting with behavioural disturbance should be given the opportunity to have their wishes and feelings documented in an advanced statement. Details of how to do this can be found in the **Advanced Statement & Decisions Policy.**

3.15 Unless justifiable reasons exist, it is expected that service users avoid spending extended periods of time in their bedrooms at the detriment of planned therapeutic activities during the daytime.

3.16 Secondary Preventative Strategies

3.17 De-escalation

'De-escalation is a secondary preventative strategy. It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance' (DH, 2015, p. 288)

3.18 Staff should use the information gathered from the PBSP (or equivalent) as a basis for de-escalation. This will include triggers and early warning signs provided by the service user, their nearest relative, carers or advocates, risk and medical history.

3.19 Wherever possible members of staff should involve the person who has the best rapport with the service user

3.20 De-escalation should always be employed when managing potential behavioural disturbance.

3.21 Unless justifiable reasons exist, staff must avoid dismissing genuine concerns or failing to act as agreed in response to reasonable requests from service users. This may contribute to exacerbating instances of behavioural disturbance.

3.22 Staff should explain any delays as to why service user's needs have not been met and involve them in any plans to redress such issues.

3.23 Staff should refer to the DEESCALATION MODEL that can be found in **APPENDIX 1**. This model is reinforced through the AVERTS training programme.

3.24 Enhanced Observations

3.25 Observations that are implemented based on an assessment of risks of violence and aggression should have a minimum of two staff. Details on the use of enhanced observation can be found in the **Therapeutic Observations and Positive Engagement Policy**

3.26 Tertiary Preventative Strategies

'Tertiary preventative strategies guide the responses of staff and carers when there is a behavioural disturbance' (DH, 2015, p. 285)

3.27 Staff will be expected to employ the process of de-escalation prior to any implementation of restrictive interventions and continue their use throughout the event.

3.28 On some occasions use of restrictive interventions may be needed to manage behavioural disturbances that pose significant risks or in an emergency situation. Restrictive interventions are defined as:

'Deliberate acts on the part of another person(s) that restrict a patient's movement, liberty and/freedom to act independently in order to:

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

End or reduce significantly the danger to the patient or others' (DH, 2015, p. 290)

3.29 Methods of restrictive interventions are:

1. Physical Intervention
2. Mechanical Restraint
3. Seclusion
4. Rapid Tranquilisation

3.30 Restrictive interventions need to be reasonable and proportionate, used only as a last resort, for the shortest period of time possible to minimise risk to service users and staff.

3.31 Such interventions must never be used as a means to punish or intimidate. Such actions constitute abuse and will not be tolerated by the organisation.

3.32 Physical Intervention

3.33 The MHA COP defines physical intervention as:

'any restrictive intervention involving direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person' (DH, 2015, p. 295)

3.34 Procedural arrangements for the effective management of violence and aggression will be established at local level that will include details on how to summon help and support should a crisis occur. This should form part of the local induction and orientation process. Whilst localised guidance will determine the operational nature and maintenance of alarm systems prevalent to a specific service, the following procedural standards should be in place in all settings where staff are expected to respond to personal alarms:

3.35 The nurse in charge on each shift must allocate a suitable staff member to respond to the personal alarm. Ideally this member of staff will be AVERTS trained.

3.36 If no AVERTS trained staff are available, the nurse in charge must use their clinical judgement to allocate the most appropriate individual and report it appropriately through the trust established incident reporting system.

3.37 Bank staff with limited clinical experience or new to the organisation should not be nominated without a localised induction and the roles and responsibilities explained.

3.38 Staff responding to alarms in another area should take their lead from the member of staff co-ordinating the incident unless clinical judgement or presenting risks to self or others otherwise dictate.

3.39 The staff member in each area responding to the alarms must be available at all times to respond immediately. If they are unable to respond due to rest breaks, undertaking observations or vital clinical activity, the nurse in charge must allocate another member of staff to be available to respond immediately.

3.40 Once the incident has been resolved, the decision to de-activate the personal alarm should be taken by the nurse in charge of the area that has activated it. Staff from responding areas can then be released by the nurse in charge to return to their own areas.

3.41 If a second alarm is raised from a second incident, each Suite will allocate a second member of staff to respond to the incident. Staff at the first incident will return to their host Suite as quickly as possible to ensure staffing levels are maintained.

3.42 Care must be taken by staff responding to the personal alarm. Staff must respond as quickly, but also as safely, as possible. Special care must be taken when running down corridors.

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

3.44 Those staff who are expected to therapeutically engage on a continuous and direct basis with service users who pose a potential risk must receive mandatory training in the use of physical intervention upon commencement of employment and annually thereafter. All ward based nursing staff would routinely fall into this category.

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

3.46 All staff must consider the respect and dignity of the person being held. Consideration as to the implications for human rights should be assessed on an on-going basis.

3.47 Staff must only use those physical intervention techniques as taught on AVERTS training courses delivered by Trust Violence and Personal Safety Advisors. Should staff witness practices that are unreasonable to the circumstances or increase the potential risks to either the service user or colleagues then they are obligated to report such instances without fear of recrimination or reprisal.

3.48 Physical intervention should never be used as a punishment. It is considered a measure of last resort to minimise risks to the person, the staff and those in immediate danger, for the shortest period of time possible. AVERTS training recognises that the employment of skills will be based on a proportionate response and least restrictive practice.

3.49 There are dangers inherent with continuous physical interventions in any position (i.e. Positional Asphyxia). To avoid prolonged physical intervention alternative strategies, such as Emergency Response Belt (ERB), rapid tranquillisation or seclusion, where available, should be considered.

3.50 Prone Restraint

3.51 The department of health defines prone restraint as:

‘the use of restraint in a face down or chest down position. Incidents of restraint that involve a service user being placed face down or chest down for any period (even if briefly prior to being turned over), should be defined as prone restraint. Similarly if a service user falls or places themselves in a face down or chest

down position during a restrictive intervention, this should be defined as prone restraint' (DH, 2014).

3.52 Wherever possible prone/face down/chest down restraint should be avoided.

3.53 Unless there are cogent reasons for doing so (e.g. security and safety – entering a seclusion room) there should be no planned or intentional restraint of a person in the prone position (whereby they are forcibly laid on their front) on any surface, not just the floor.

3.54 'Cogent reasons for doing so' should be discussed and agreed by the MDT and clearly documented in the service user's care records. As noted in **section 1.8** of this policy, cogent reasons may include: risk and safety for the service user and staff or when it is the expressed view of the service user as part of their advanced statement or PBSP (or equivalent).

3.55 Restraint should never be used to threaten or intimidate. This constitutes abuse.

3.56 Mechanical Restraint

3.57 The Trust has the facility to use mechanical restraint in Secure and Complex Care Services and Psychiatric Intensive Care Units. The Emergency Response Belt (ERB) is used to convey people to avoid prolonged restraint, and in extreme instances of sustained self-harm. This is usually from a clinical area to a seclusion area. Use of the ERB is determined by the ERB Policy and is decided as an appropriate measure by direct referral to the Director of Nursing and the Medical Director. Detailed guidance on the use of handcuffs for conveying service users can be found in the **Policy for the Use of Handcuffs**.

3.58 Seclusion and Longer Term Segregation

3.59 Comprehensive and detailed guidance on the use of seclusion and longer-term segregation can be found in the **Seclusion (and Long Term Segregation) Policy**.

3.60 Rapid Tranquilisation

3.61 Comprehensive and detailed guidance on the appropriate use and post administration monitoring of rapid tranquilisation in the management of violence and aggression can be found in the **Rapid Tranquilisation Policy**.

3.62 Training

3.63 The safety of staff working in the Trust is paramount and is as important as the safety of service users. Members of staff require appropriate training to identify unsafe situations and how to manage those that may become unsafe. The Trust refer to such training as Approaches to Violence through Effective Recognition and Training for Staff (AVERTS). The AVERTS annual capacity plan determines, via a training needs analysis, the capacity required for the organisation. This plan is designed and submitted to the clinical governance committee on an annual basis.

3.64 The AVERTS syllabus incorporates a variety of evidence based strategies informed by national guidance and statute and positive practice standards.

3.65 The Trust employs a number of Violence and Personal Safety Advisors whose role includes the delivery of training to staff to prepare them to deal with potential and actual violence including intervention skills. Their advisory capacity is an important resource for the clinical environment and each care programme has its own dedicated advisor to offer operational support.

3.66 Training in the recognition, prevention and therapeutic management of violence and aggression including the use of non-physical and physical intervention techniques (e.g. de-escalation skills) will be made available for all employees. Programmes have been developed to the specific needs of the Trust and its service users to ensure its appropriateness and acceptability, particularly concerning age, gender, racial and cultural diversity and disability issues.

3.67 It is a standard that all new staff working in PICU's and Forensic settings will access AVERTS holding courses prior to commencement on their respective unit.

3.68 Where there are concerns regarding an individual's ability to undertake training owing to pregnancy or health reasons there should be a consultation with Occupational Health and the Violence and Personal Safety Advisors who deliver the training. Competency is assessed during training. If an individual is unable to demonstrate a skill element their line manager is notified via letter. It is the line manager's responsibility to discuss and manage such information with the individual upon their return to work.

3.69 Staff are to book onto their annual update for the following year within **two weeks** of completing their course. Course capacity will be made available on Insight to accommodate this.

3.70 Staff are to update annually but in extenuating circumstances this can be extended to 15 months. Extenuating circumstances involves sickness and unexpected events beyond an individual's control. It does not cover a failure to follow the process as described in SECTION 3.69. Such matters will be addressed through the Regular Management Supervision (RMS).

3.71 Further advice and guidance for transient members of staff, including bank and agency staff, can be found in the **Approaches to Physical Intervention and Restraint in Appendix 5**.

3.72 <u>Supervised Practice and Violence Reduction</u>

3.73 Safe Wards intervention champions will support and guide staff in the application of the violence reduction strategies associated with the Safe wards model. This will be supported by the Advanced Practitioner (AVERTS) and dedicated AVERTS advisors for each service with oversight by the positive and proactive care group.

3.74 <u>Guidance for Families and Carers</u>

3.75 Service users, families and carers will have access to information related to positive and proactive care via the information leaflet in **Appendix 2**.

3.76 <u>Use of Weapons</u>

3.77 Where a weapon is used during an aggressive or violent incident the staff who assumes control of the situation should ask for the weapon to be placed in a neutral location rather than handed over. On no account should an attempt to physically

disarm any person be attempted. Staff should vacate an area where such an immediate risk is posed and attempt to secure the service user concerned if it is safe to do so. Police should be contacted in such instances under the auspices of the **Police Interventions Policy**.

3.78 Personal Protective Equipment (PPE)

There may be occasion when management of violence and aggression requires staff to utilize personal protective equipment to minimise infection control risks during the event.

Such equipment currently consists of: cut resistant gloves, protective eye-wear and full face visors.

Full face visors should be worn at the earliest opportunity in incidents involving those service users where an infection control risk exists and where there is a likelihood of spitting during a restraint.

Procedure, access and maintenance of such equipment is detailed in Appendix 7.

These items will be kept in a dedicated box which is clearly labeled 'Personal Protective Equipment' and sealed until use.

It is important that all unit staff are made aware of the location of the PPE box. This includes bank and agency staff when they are inducted onto the unit.

It is the responsibility of the ward manager to ensure that equipment is well maintained and procured using the processes as defined in this policy.

3.79 Reporting and Recording

3.80 All instances of physical intervention are reportable via the Eclipse electronic reporting system. Staff should follow the processes as described in the **Reporting, Management and Learning from incidents Policy**

3.81 The on call executive is to be contacted when a restraint lasts longer than 10 minutes and fully briefed on the management plan to end prone restraint.

3.82 Service User Support

3.83 Service users and carers should be kept fully informed of any incident reviews being undertaken by the organisation and any lesson learned disseminated accordingly as determined by the **Reporting, Management and Learning from incidents Policy**

3.84 Staff should ensure that service users involved in the incident and those who witnessed the event are offered the means to express or document their feelings.

3.85 Safeguarding

Incidents that meet the criteria for raising a Safeguarding concern will be escalated and managed via the **Adult Safeguarding Policy** or **Safeguarding Children and Young People Policy**.

4 RESPONSIBILITIES

Post(s)	Responsibilities	Ref
All Staff	All staff are to be aware and adhere to the principles of the policy Report all incidents of restrictive practice via Eclipse Attend AVERTS training as stipulated in their training statement on OLM Report policy breeches via their line management streams	
Service, Clinical and Corporate Directors	Ensure that the policy is consistently applied within their services and spheres of responsibility Ensure that violence reduction initiatives laid out in this policy are consistently applied Respond to data provided by information governance related to incidents of prone restraint and utilise AVERTS advisors for their respective areas.	
Policy Lead	Ensure that the policy is disseminated, reviewed and monitored accordingly.	
Nominated Positive and Safe Executive Director	Report to Trust board via CGC on the progress of the overall violence reduction strategy described in this policy Oversee the Trust Violence Reduction Strategy	
LSMS	Support staff who have been victim of assault in a timely manner & give feedback to the affected member of staff Liaise with the police in terms of the co-working arrangements with the Trust	
Ward Manager	Ensure that all elements of this policy are maintained, and support staff who manage behavioural disturbance. Ensure that staff are fully compliant and have booked onto their AVERTS training course update. Ensure that incidents are accurately reported and recorded.	

5 DEVELOPMENT AND CONSULTATION PROCESS

Consultation summary	
Date policy issued for consultation	14/07/2016
Number of versions produced for consultation	01

Committees or meetings where this policy was formally discussed	
Integrated Clinical Risk Group	Date 18/08/2016
Positive and Proactive Care Group	February 2016
Policy Review Group	September, 2015 November, 2015

6 REFERENCE DOCUMENTS

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8 GLOSSARY

Restrictive Practice: Any practice that limits or inhibits a person's freedom of movement or will for the sole purpose of minimising risk to self or others. This includes: physical and mechanical restraint, seclusion and observation.

Positive Behavioural Support (Or equivalent): A plan of care developed with the service user that documents how they deal with their frustrations, what strategies are effective at managing it and how staff should support them at points of crisis.

Prone Restraint: Holding a person face down/on their front/ on any surface, including the floor.

9 AUDIT AND ASSURANCE

9.1 The Positive and Proactive care group will be responsible for reviewing effectiveness and will report to the Trust Integrated Clinical Risk Group will be responsible for reviewing effectiveness and will review and report to Trust CGC/Trust Board annually.

Element to be monitored	Lead	Tool	Freq	Reporting Arrangements	Acting on Recommendations and Lead(S)	Change in Practice and Lessons to be shared
Number of incidents of violence and aggression	Medical Director	Incident Reporting	Monthly	Trust Board and Commissioners	Policy Lead	Positive and Proactive care Group/Integrated Clinical Risk Group
Number of restraints and causation	Medical Director	Incident Reporting	Quarterly	Positive and Proactive Care Group (via Integrated Clinical Risk Group) Clinical Governance Committee (via integrated quality report)	Policy Lead	Positive and Proactive care Group/Integrated Clinical Risk Group
Implementation of Safe Wards to 50% of inpatient services 2016/2017	Medical Director	Positive and Safe Expert Reference Panel	Quarterly	Positive and Proactive Care Group (via Integrated Clinical Risk Group) Clinical Governance Committee (via integrated quality report)	Policy Lead/	Positive and Proactive care Group/Integrated Clinical Risk Group

10 APPENDICES

Appendix 1 De-escalation Model (Bowers, 2014)

Appendix 2 Positive and Proactive Care Leaflet

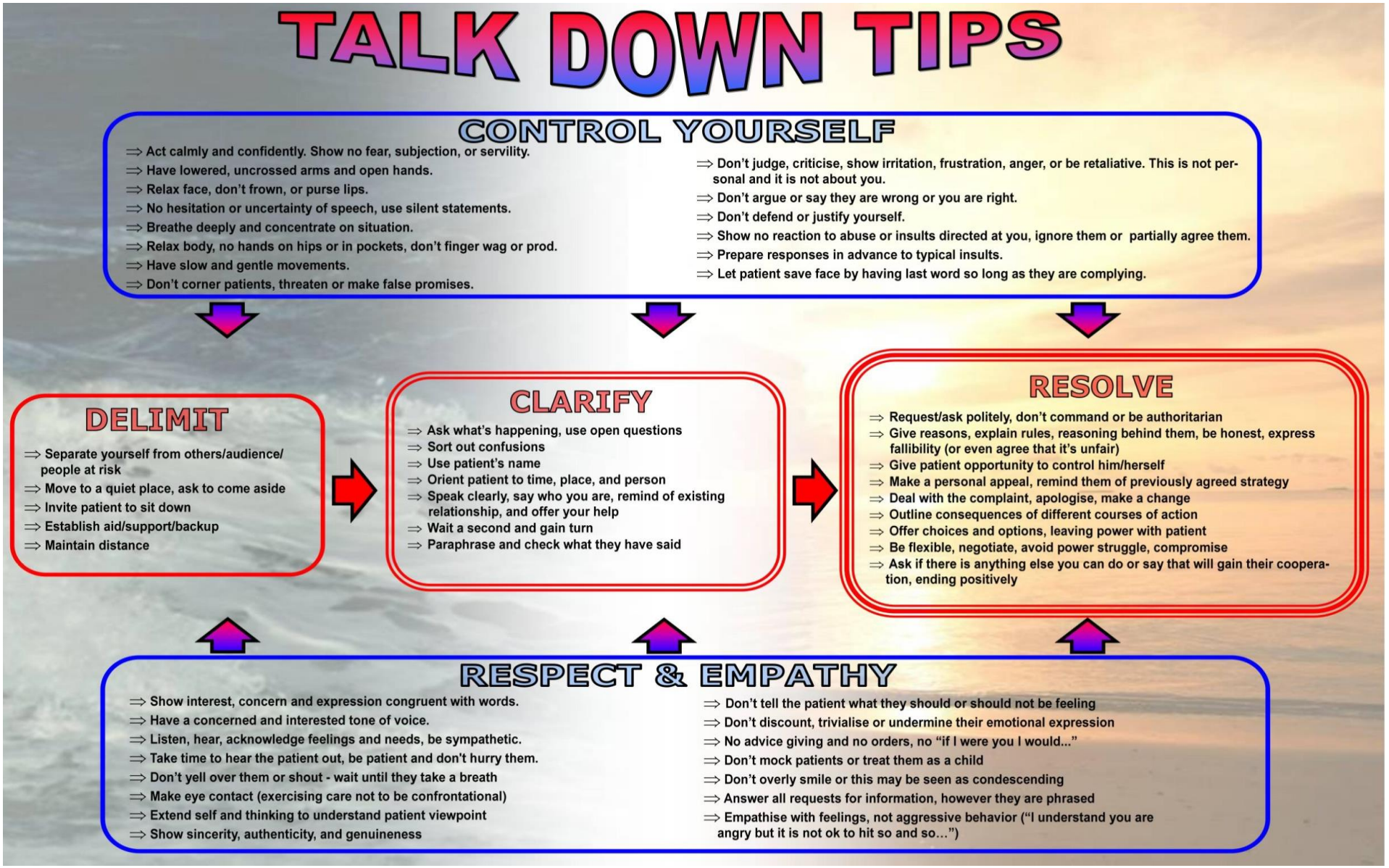
Appendix 3 Restraint Information Leaflet

Appendix 4 Approaches to Physical Restraint Guidance

Appendix 5 PPE Procurement and Maintenance Sheet

Appendix 6 Safewards

Appendix 7 Withdrawing Services From Violent or Abusive Service Users


TALK DOWN TIPS
CONTROL YOURSELF
⇒ Act calmly and confidently. Show no fear, subjection, or servility.
⇒ Have lowered, uncrossed arms and open hands.
⇒ Relax face, don't frown, or purse lips.
⇒ No hesitation or uncertainty of speech, use silent statements.
⇒ Breathe deeply and concentrate on situation.
⇒ Relax body, no hands on hips or in pockets, don't finger wag or prod.
⇒ Have slow and gentle movements.
⇒ Don't corner patients, threaten or make false promises.
⇒ Don't judge, criticise, show irritation, frustration, anger, or be retaliative. This is not personal and it is not about you.
⇒ Don't argue or say they are wrong or you are right.
⇒ Don't defend or justify yourself.
⇒ Show no reaction to abuse or insults directed at you, ignore them or partially agree them.
⇒ Prepare responses in advance to typical insults.
⇒ Let patient save face by having last word so long as they are complying.
DELIMIT
⇒ Separate yourself from others/audience/ people at risk
⇒ Move to a quiet place, ask to come aside
⇒ Invite patient to sit down
⇒ Establish aid/support/backup
⇒ Maintain distance
CLARIFY
⇒ Ask what's happening, use open questions
⇒ Sort out confusions
⇒ Use patient's name
⇒ Orient patient to time, place, and person
⇒ Speak clearly, say who you are, remind of existing relationship, and offer your help
⇒ Wait a second and gain turn
⇒ Paraphrase and check what they have said
RESOLVE
⇒ Request/ask politely, don't command or be authoritarian
⇒ Give reasons, explain rules, reasoning behind them, be honest, express fallibility (or even agree that it's unfair)
⇒ Give patient opportunity to control him/herself
⇒ Make a personal appeal, remind them of previously agreed strategy
⇒ Deal with the complaint, apologise, make a change
⇒ Outline consequences of different courses of action
⇒ Offer choices and options, leaving power with patient
⇒ Be flexible, negotiate, avoid power struggle, compromise
⇒ Ask if there is anything else you can do or say that will gain their cooperation, ending positively
RESPECT & EMPATHY
⇒ Show interest, concern and expression congruent with words.
⇒ Have a concerned and interested tone of voice.
⇒ Listen, hear, acknowledge feelings and needs, be sympathetic.
⇒ Take time to hear the patient out, be patient and don't hurry them.
⇒ Don't yell over them or shout - wait until they take a breath
⇒ Make eye contact (exercising care not to be confrontational)
⇒ Extend self and thinking to understand patient viewpoint
⇒ Show sincerity, authenticity, and genuineness
⇒ Don't tell the patient what they should or should not be feeling
⇒ Don't discount, trivialise or undermine their emotional expression
⇒ No advice giving and no orders, no "if I were you I would..."
⇒ Don't mock patients or treat them as a child
⇒ Don't overly smile or this may be seen as condescending
⇒ Answer all requests for information, however they are phrased
⇒ Empathise with feelings, not aggressive behavior ("I understand you are angry but it is not ok to hit so and so...")

Positive and Proactive Care: Service User and Carer Information Sheet

The Department of Health is in charge of health and social care in England. They want to make sure abuse **never** happens and that services must support people whose **behaviour is very difficult** and who might want to do things like:

• Hurt themselves.
• Hurt other people.
• Put themselves in harm's way.
• Smoke in hospital.
• Do something that can't be done safely without assistance.
• Run away.

What do we mean by restrictive interventions?

Staff might try and:

• Stop you doing something harmful or dangerous.

• Do something to make you better while you are not well enough to be able to make the choice.

This is called **Restrictive Intervention** (in this paper we use **RI** for short). Staff must only do this if there is no other way to keep people safe and they must:

• Understand other ways of supporting people when their behaviour is very difficult, and
• Only use RI when other things have not worked.

The advice will help staff care for people whose behaviour can be very difficult because of their:

• Mental health.
• Autism.
• Learning disability.
• Injury or brain disease.

Mental Health Act and Mental Capacity Act

Mental Health Act

The Mental health Act is a law that allows doctors and nurses to keep you in hospital in order to assess your mental health and, if needed, to treat it. If you are in hospital under the Mental Health Act you will legally be referred to as a 'detained' or 'formal' patient. If this is the case staff may have to use RI if:

- You try to leave hospital without agreement with the doctors and nurses
- Behave in a way that might hurt yourself or people around you

As a detained patient you should have access to full information about what this means for you and how to appeal against the decision to keep you in hospital. You should also have access to an independent advocate to discuss your experiences of being in hospital.

Any RI used by staff must be reasonable and justified. Yours thoughts and feeling about the use of RI should be given to staff and/or your advocate so lessons can be learned to see to prevent its use being needed again.

Mental Capacity Act

Mental capacity means being able to make your own decisions and this law is to help you do that. Staff must tell you about your care in ways you can understand and ask you if you agree with it.

You may be able to make some decisions but not others and the Act tells people what to do if you can't make some decisions for yourself.

Staff must support you to make your own decisions but if they have to decide for you, staff must think if this is what you would want. They must make sure you keep as many of your rights and freedom as possible. Staff need to understand why someone might hurt other people or themselves, and this might be because:

• Some people can't say what they need – this can make them upset or angry.

• Some people do not understand that what they are doing is harmful or dangerous.

• Some people are frightened and defensive in hospital.

What are Restrictive Interventions?

There are 4 main types of RI:

1. **Physical:** When you stop the person moving part of their body by holding them so they cannot hurt themselves or other people. Staff must keep talking to the person to calm them and check that they are safe.

   Or staff encourage someone to stop doing something they want to do e.g. getting up without assistance.

2. **Mechanical:** When you use something to stop the person using part of their body, for example: handcuff, soft cuffs or the Emergency Response Belt which is used to move people to a safer place. Staff should only do this when nothing else can stop the person hurting themselves or other people. It is very rare that these items are used unless behaviour is likely to seriously hurt you or those around you.

3. **Chemical:** When you make someone take medicine to calm down. Staff should only do this in a real emergency or when the doctor/nurse thinks it may help you get better and they must use as little medicine as they can and review it regularly.

4. Seclusion: When you keep someone away from other people, this could be in a locked room. It is usually so they cannot hurt themselves. Staff can only do this if the law allows it.

The most important things to do and to know

Making sure **RI** happens less. **RI** should happen less because:

- It can hurt people.
- Sometimes it does not need to happen.
- It stops people from doing what they want.

Staff should:

- Only use **RI** when nothing else will work.
- Think about **human rights** and the things every person has the right to expect.
- Understand laws about treating people equally and fairly.
- Support people to be safe without taking away all of their choices.
- Understand the way people behave and help keep them safe and help them do things that are important to them.
- Involve people and their family or carers whenever they can

Make care better – your behaviour support plan (or similar)

People who might need **RI** must have a **Behaviour Support Plan (or similar).** It should be about how to help them:

- Not get angry and upset so often.
- Calm down if they get angry or upset.
- See if anything could have been done better.
- Stop it happening again.

This information will be in your Behaviour Support Plan. It will help staff use **RI** less often.

Your plan must also:

- Make sure you understand what the Mental Health Act & Mental Capacity Act says.
- Say what makes you angry or upset.
- Tell others how to help you not to get angry or upset so often and how to help you calm down.
- Be shared with your relatives and carers so they know how to help.
- Write down your conversations with staff after an incident so that you and staff can learn why it happened and how to stop it happening again.

If there is anything in this information sheet that you do not understand, you must ask a member of staff who will explain it to you or your relative/carer in detail.

Adapted from:

Rotherham & Doncaster & South Humber NHS Foundation Trust (2015) *Positive and Proactive Care (Easy Read): Reducing the need for Restrictive Interventions and what it means for you. RDaSH: 2015.*

A member of the care team should take responsibility in caring for other service users who may be present or witness to the event. Individuals should be guided away from the area and support should be provided for anybody that needs it. Any staff not involved in the employment of restrictive physical interventions should also leave the area quietly.

If physical interventions are used;

- Staff should take active steps to maintain your dignity
- Staff should make sure that you don't feel humiliated during the process
- Staff should explain to you what is happening and why
- Where possible there should be at least one member of the care team who is the same gender as yourself
- One member of the team will be responsible for monitoring your physical and mental health and well being during the process.
- A member of staff should continue to talk to you in an attempt to calm the situation down
- Staff should record what is happening as soon as the situation allows

- situation which must be filed in your care records

What should happen after an event where physical intervention skills have been used?

You must be given the opportunity to talk to staff about what has happened. This may help in repairing relationships that may have been damaged. The opportunity to talk and discuss and issues should also be extended to family members, carers or other service users.

If restrictive physical interventions have been used your care plan should be checked and changed as necessary. You should be involved in this process.

If you are concerned with anything that you have read in this leaflet you should discuss this with a member of your care team or your local user voice/ see me representative.

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Restrictive Physical Interventions

Managing Disturbed/Violent Behaviour, A Guide for Service Users, Carers and Families

Birmingham and Solihull Mental Health NHS Foundation Trust understand that the term 'Restrictive physical intervention' may cause anxiety and fear for people who access mental health services. This leaflet will provide key information surrounding restrictive physical interventions and the management of disturbed behaviour. It will inform you about what you can reasonably expect to happen if staff engage in restrictive physical interventions on either yourself or if you have witnessed an incident where restrictive physical interventions have been used. The information and terminology contained within this leaflet is concurrent with the terminology used by NICE within their clinical guidelines.

What are Restrictive Physical Interventions?

A restrictive physical Intervention is a way of holding someone so that they are unable to move easily. The techniques are designed to be used as a last resort and restrictive physical intervention techniques should not be used unless it is absolutely necessary.

Restrictive Physical interventions will involve staff holding onto you for a short period of time so that you cannot hurt yourself or others around you. Before using restrictive physical interventions, staff should have tried alternative ways of managing the situation. If staff do use restrictive physical interventions they should also continue to try to calm the situation by talking to you. Staffs aim is to keep you safe.

When might Restrictive Physical Interventions be used?

There are a number of situations when staff may need to use restrictive physical interventions. It is important to remember that staff should only use restrictive physical interventions when all other ways of managing the situation have failed. Some examples of when restrictive physical interventions may be used include;

- If you become violent or aggressive towards other people. (This may include staff, other service users or visitors to the unit).
- If you attempt to hurt yourself or are at risk of accidentally injuring yourself.
- If you try to leave the unit but do not have the necessary leave.
- If you show dangerous or harmful behaviour towards property.

Staff training

The training that staff receive within BSMHFT is AVERTS. AVERTS stands for Approaches to Violence through Effective Recognition and Training for Staff. The name AVERTS was chosen by service users following consultation. The training is owned and developed by BSMHFT which allows for training to adapt to meet the current needs of the service and it's service users.

All staff that employ restrictive physical interventions have received training from the trust and none of the techniques taught are designed to deliberately cause pain. The trust provides a yearly update that staff must attend to make sure that their knowledge stays up to date.

As well as training staff in the safe application of restrictive physical interventions, the training focuses on alternative ways of managing situations which include Safe Wards philosophies. BSMHFT have identified that all units are to adopt Safe Wards. Please talk to staff and see the Safe Wards leaflet for more information.

What should happen if restrictive-physical interventions are used?

If staff are required to use restrictive physical interventions, they should think about your needs as well as managing safety.

If you have an advanced statement that covers how you would prefer to be managed this should be taken into consideration wherever possible. If following the statement would place yourself or others at even greater risk then staff may need to take a different approach. If staff take a different approach then they should record what they are doing and why they are doing it.

When deciding what should be done, staff will also need to take into consideration the effect of the situation upon other service users, staff and visitors and how to manage their safety as well as your own.

Approaches to Physical Intervention and Restraint Guidance

Introduction

This guidance is intended to provide members of Trust staff (whether permanent or transient) with supplementary information in the Prevention and Management of Violence Policy.

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) adopts the policy that all members of staff regardless of band or discipline are responsible for the safety of service users and each other. Duty of care in the context of this guidance extends beyond that of service users to include; all colleagues, students, voluntary sector workers and any other member of the public.

On this basis it is the duty of every member of staff to offer some assistance where necessary.

It is generally considered to be unsafe for anybody to try to restrain another person on his or her own. If individual staff members are faced with a difficult situation they should seek an escape route and summon assistance verbally or by an alarm system.

Should communication or language barriers prevail, every effort should be made to address these issues in the first instance. Staff should make every effort to de-escalate the situation and use non-physical strategies. Physical intervention techniques should be used as a last resort.

Implementing Physical Intervention

It is not possible or desirable to outline specific physical intervention skills within this guidance. This information will be provided to all staff who attend the required level of training as determined by the trusts fundamental training matrix.

Wherever possible it is expected that staff members who have received AVERTS training should assume a lead role in the management of situations that require physical intervention.

Where staff who are considered ‘untrained’ in AVERTS are managing an incident in a safe and professional manner, it may not be desirable or prudent for staff considered ‘trained’ to take over unless requested to do so.

Wherever possible the planned use of physical interventions should only be undertaken by appropriately trained staff however, in extreme or emergency

situations there is an expectation that all staff will assist and take their lead from the person co-ordinating the event.

When using physical intervention skills, consideration should be given to the following best practice points;

- Wherever possible the prone (face down) position should be avoided. It should not be considered as a planned event. Cogent reasons for doing so should be clearly documented.
- Staff should only employ physical intervention skills that have been endorsed by BSMHFT through the AVERTS training programme.
- Under no account should members of staff engage in any activity that is likely to force the intervention to the floor.
- Any physical intervention must be reasonable, proportionate and justifiable in the circumstances and constitute the least restrictive option available. The minimum amount of force should be used for the minimum amount of time that is necessary.
- There is no such thing as a 'safe' position with regard to physical intervention.
- Fewer well briefed staff are likely to be more effective than large numbers of staff working in an unorganised fashion. Nominated staff should be allocated roles and responsibilities. A minimum of three staff are required to initiate physical interventions.
- Ensure that one member of staff (the third person) is responsible for supporting the service users head and neck where required ensuring that the airway and breathing are not compromised and that vital signs are monitored using NEWS.
- The third person must be present throughout the intervention and must be included in any documentation relating to the incident.
- Staff should attempt to manage the service user's arms and have a third person present in a safe and swift manner. If legs are to be managed (only if the person is on the floor), they are to be held together at all times by a fourth member of staff. Only one member of staff should be present on the legs with additional staff adopting a supportive role if required.
- Intervening staff should avoid any form of neck hold, or application of weight on the chest, abdomen, back or pelvic area.
- The deliberate application of pain has no therapeutic value and could ***only*** be justified for the immediate rescue of staff, service users and/or others if deemed appropriate under the legal tenet of *reasonable force*.
- When staff are attempting to leave a situation that has required physical intervention this should be done in a co-ordinated and timely manner in accordance with the advice provided to staff during AVERTS training programmes.

Broader Considerations

Restrictive interventions should only be used if de-escalation and other preventative strategies have failed and there is the potential for harm to occur if no action is taken. Staff should continue to attempt de-escalation throughout any restrictive intervention (NICE 2015).

NHS England (2015) identify the importance of physical observations during and after restrictive interventions and physical intervention. This is supported by NICE guideline 10 (2015)

Staff should be alert to the risk of any respiratory or cardiac distress. **All staff** (including transient staff), should be aware of where the emergency resuscitation equipment, the personal protective equipment and the ligature cutters are kept on the units in which they work. This should happen as part of the local induction procedure. This equipment should be **readily accessible** by all staff members.

When physical interventions are used staff should;

- Document in RiO a clear rational and justification for their implementation, recording the decision and reasons for physical intervention along with a detailed account of the incident.
- An Eclipse entry **must** be made to include; the names of the staff members involved, the positions they adopted, any staff that 'took-over' and the duration and position of the restraint.
- As a minimum, staff members who are holding the arms and the third person **must** be documented (even if the third person isn't holding on).
- Post-incident, service users should be given the opportunity to document their version of events which can then inform future interventions (NICE 2015).
- Care plans should reflect both the needs and wishes of the service user in respect of theanticipation, prevention and management of violence and aggression. Every effort should be made to ensure service users should receive and sign a copy of the agreed plan of care.
- The service users care plan should be reviewed and risk assessment updated following any incident of violence or aggression. Wherever possible this should be done in full consultation with the service user.
- Any member of staff who has been injured/ harmed either physically or emotionally during the process of intervention should not be involved in any immediate decisions concerning to on-going care of the person being held.

PPE - Item Description, Procurement and Maintenance

PPE – Item Description, Procurement and Maintanance

Disposable Vinyl Gloves:
These will offer the wearer's hands some protection to the risks of cross-infection from escaped body fluids. All staff should ensure that these are worn at the earliest opportunity when dealing with body fluids. These gloves do not offer adequate protection to the hands from grazes, lacerations, and needle stick or stab wounds. Hands must be cleaned with soap and water or alcohol gel immediately after the removal of gloves.
FINITY PF30 stretch Vinyl Gloves can be ordered from the NHS logistics catalogue.

Protective Eyewear:
Where there is a risk of cross-infection from body fluid splashing or from spitting, these will offer the wearer some additional eye protection. Where a person already wears glasses, the protective eyewear will not necessarily offer any additional degree of protection from infection, but may offer limited impact resistance. Each member of staff must make a personal judgment in these situations whether or not to replace their glasses with the protective eyewear provided.
These can be re-ordered from NHS Supply Chain Catalogue order code- SM11.
Replacement lenses order code – SM100

Full Face Visors:
Full face visors are to be used to protect the membranes of the, eyes, nose, and mouth from exposure to body fluids. The visors may be utilised to manage instances of spitting behaviour. Pro-active use should be limited to occasions where there is a known risk of infection from a contagious disease, the individual in question has a history of spitting whilst in restraint or is actively threatening to spit at staff prior to a physical intervention. In a reactive type situation where spitting occurs prior to the use of visors, visors should be made available to staff as soon as possible. It is not envisaged that the wearing of visors will be utilised prior to all physical interventions but **only** where the above circumstances are apparent. The visors will be used once only and then should be discarded. Once the incident has ended then all used visors should be disposed of via a clinical waste bag as per policy.
These visors can be ordered from the NHS Supply chain catalogue order code- FS100

Coverall Suits:
It may at times be appropriate, where fecal smearing or “dirty protests” have occurred, for staff to utilise protective cover-all suits to offer protection to their everyday clothes whilst managing/cleaning during such circumstances. The wearing of such equipment should be based on a risk assessment with regard to the perceived degree of possible contamination or cross infection. This item is for single use only and should be disposed of in the clinical waste bags. They can be

purchased by individual wards/units and stored in an area which is known by all members of staff in the team.

These items can be obtained from the NHS Logistics catalogue order codes as listed below on page (1104)

- **Small – BQD000**
- **Medium- BQD001**
- **Large – BQD002**
- **Extra Large – BQD003**

Cut Resistant Gloves:
Cut resistant gloves are intended to assist staff to work more safely in dealing with a situation where a sharp edged type object is/may be present in an incident of self-harm. They will offer the wearer some protection from such objects but ***will not*** protect the wearer from needle stick or stab wounds from sharp pointed implements. Their protective ability would also be limited if subjected to repeated slashing or sawing actions using a sharp or serrated edged object. The cut resistant gloves do not provide protection from fluids as they are porous and a pair of vinyl should be worn underneath.

Cut resistant gloves should not replace the use of rapport, persuasion, or appropriate negotiation as a means of removing a sharp object from a person. Rather they are seen as a method of protecting all persons involved when all other strategies have been tried and failed, or when it is necessary to remove a sharp object quickly in the overall interests of health and safety for all involved in the management of aggressive/violent behaviours.
Replacement Cut resistant gloves (X5 Glove) can be ordered from Ultimate Industrial Ltd, www.ultimateindustrial.co.uk

NB. These gloves should not be used to manage an incident where a person is threatening to harm others with a sharp object or to attempt to disarm an individual that is brandishing any form of weapon.

Reporting
All staff must appropriately report instances when infection control has been an issue the management of violence and aggression via the trust electronic reporting system. (e.g.ECLIPSE).

Where there is a failure to apply these guidelines such instances should be reported to the ward manager for review and escalated through the line management structure.

Where there is an identified risk history relating to infection control issues during periods of violence and aggression these should inform action plans to manage such behaviors in the future. Where possible, service users should be involved in the development of such actions plans. See: **Care Management & CPA Policy.**

Training support / contacts and advice

Training in the use of protective equipment is delivered on the AVERTS five day program and refreshed annually via the dedicated update. Compliance with training is identified via the Risk Management Fundamental Training Policy.
For advice and information on any part this this guidance can be sought from:
Violence and Personal Safety Advisors on: 0121 301 3977/3979
Advanced Practitioner on: 0121 301 3978
Booking training is administered through LD.Bookings@bsmhft.nhs.uk

Process for review / feedback

This guidance will be reviewed every two years by the Risk and Safety Committee and supported in this process by the Infection Prevention and Control Team.

References

- **Prevention and Management of Violence Policy.**
- **Guidance on the Use of Physical Interventions & Restraint.**
- **Infection Prevention and Control Overarching Policy**
- **Standard Infection Control Precautions**
- **Decontamination Policy**
- **Sharps Safety & Prevention Management of Occupational Exposure to Blood-borne Viruses**
- **Care Management & CPA Policy**

6. Mutual help Meeting

All wards are social communities and the help that service users can give to one another is highly valued.

A voluntary meeting of all service users and staff on duty should be held preferably daily but as a minimum 3 times per week and should have 4 standing agenda items;

- A round of thanks for anything that has been done since the last meeting
- A round of news - anything that has happened or changed or is going to happen.
- A round of suggestions
- A round of requests and offers (for help and assistance)

7. Know Each Other

Forming a therapeutic relationship is the foundation of good care. If staff provide non-controversial information about themselves can help facilitate conversations and relationship building.

This module can be done in reverse with service users also compiling a fact sheet about themselves describing likes and interests which can be given back to the person on discharge or destroyed if that is what the service user wishes.

8. Calm Down Methods

Staff can often identify if a service user is becoming unsettled or distressed. This module encourages individuals to develop and adopt their own coping strategies. Staff will put together a box of equipment that service users can access. Individuals can then identify strategies that may help during times of increased anxiety or distress.

9. Reassurance

Service users can react with fear or anger if there has been an event on the unit such as violence, absconsion, a disturbed service user or arguments. Following an anxiety provoking event every service user should be spoken to individually or in small groups and staff should make increased efforts to be more visible in the clinical areas to offer explanation and support to all service users.

10. Discharge Messages

On the day of discharge, service users are asked to write a message for a display. The message should say what the service user liked about the unit along with some positive and helpful advice for new admissions. This can help reassure new service users and increase feelings of hope.

Ideally service users will put their first name on the message so people can see who they are off. The messages can be displayed in a variety of ways such as on a 'discharge tree' or a notice board.

Further information

Safewards has its own dedicated website which contains further information regarding the Safewards initiative, the model, module guides and other helpful hints and tips.

Here is the website address;

http://www.safewards.net/

Improving mental health wellbeing

RS10 Appendix 6

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Safewards

A Guide for Service Users, Carers and Families.

Safewards is a national initiative designed to help reduce the levels of conflict and containment within in-patient mental health units.

The Safewards model has 10 simple modules that have been clinically proven to reduce the number of aggressive incidents.

BSMHFT have committed to implement Safewards across its in-patient facilities as part of the reducing restrictive practices agenda.

What is Safewards?

Keeping safe is a goal of any community.

The Safewards model is a set of interventions that have shown to contribute to a reduction in incidents on mental health in-patient units.

The model has been developed by Professor Len Bowers following years of extensive research and has demonstrated significant effectiveness in reducing incidents and a reduction in the use of restrictive physical interventions, seclusion and rapid tranquillisation in the UK.

BSMHFT have committed to implement the Safewards model throughout its in-patient facilities as part of the reducing restrictive practices agenda.

Why can units be unsafe?

In-patient units are busy places and are different in their size and layout, where they are located and the resources that they have. Within Safewards, behaviours that service users may exhibit that pose a risk to themselves or others around are referred to as areas of 'conflict'. These behaviours may include; aggression, rule breaking, substance or alcohol use, absconsion, self harm or suicide.

The actions that staff may take to manage 'conflict' are referred to as 'containment' strategies and may involve things such as; an increase in observation levels, PRN medication, Restrictive physical intervention (restraint) or seclusion.

Module Guide

There are ten straight forward interventions identified within the Safewards model .

Units are encouraged to implement the modules in a way that meets the needs of the individuals who are using the service and so you may see units giving modules different names to those identified in this leaflet.

Below is a brief introduction to the ten modules and their official Safewards titles;

1. Clear Mutual expectations

Sometimes, difficult and challenging behaviours are expressed because there is a lack of clarity regarding how individuals (both staff and service users) are expected to behave .

A set of mutually agreed standards will allow for consistency and clarify relationships. These can be reviewed on a regular basis. See Me workers can help work with staff and service users to identify mutual standards of behaviour that should be displayed for all to see.

2. Soft Words

If a service user is acutely unwell they may present staff with challenges regarding care and management. Staff have a responsibility to ensure that care needs are met and that people are kept safe.

This can sometimes result in flash points around limit setting. The soft words module provides ways for staff to avoid potential confrontation and aims to ensure that staff work collaboratively with service users to reduce the potential for hostility or violence.

3. Talk Down

Is a model of de-escalation and is a 3 stage process.

1. **De-Limit** establishing safety and getting started
2. **Clarify** hearing what the person has to say
3. **Resolve** addressing the issue seeking resolution

Whilst implementing 'Talk Down' Staff need to me mindful of their own behaviours and how they can impact upon the situation whilst displaying respect and empathy at all times.

4. Positive Words

At the start of the shift, staff are expected to attend 'hand-over'. In the report of what has happened over the shift, staff can often focus on the exceptional behaviour which may have been difficult to manage or which poses a risk.

In order to redress the balance, during handover, staff should say something positive about what each service user has been doing or draw attention to a positive quality that they have.

5. Bad News Mitigation

Research has shown that service users can impulsively leave services in anger following unwelcome news. Staff should be aware of occasions and events that may generate feelings of anger and decide as a team how support is going to be offered.

Staff should monitor for small signs of distress and offer time in a quiet place to discuss issues and allow individuals time to express their feelings and frustrations. This could be done along with a friendly gesture such as offering a cup of tea or a snack.

Appendix 7

WITHDRAWING SERVICES FROM VIOLENT OR ABUSIVE SERVICE USERS GUIDANCE

Introduction

The Trust has a statutory obligation under the Health and Safety at Work etc. Act 1974 to provide a safe and secure environment for its staff and others, as well as having a moral duty to take all reasonable steps to protect and support its staff of all disciplines and other service users.

This guidance is designed as a step in improving our ability to tackle incidents involving violence and abuse. The aim of this guidance is to detail the behaviours, which are unacceptable and the sanctions that are available to tackle the problem, including a mechanism whereby service users, who are extreme or persistent in their unacceptable behaviour, can as a last resort be temporarily or permanently excluded from services provided by the Trust.

The guidance also details the action to be taken in the event of unacceptable behaviours on the part of visitors/relatives/carers.

Reporting incidents of abuse, harassment and violence

All incidents of abuse, harassment and violence must be reported using the Eclipse reporting system, in accordance with the Trust policies concerned with the reporting and management of untoward and serious untoward incidents.

Incidents of serious abuse, including racial and sexual harassment and where actual harm to individuals occurs should be reported to the police where it is felt appropriate. All serious cases should be brought to the attention of the Executive Team, Associate Director of Governance and Associate Director of Operations.

Clinical application

This guidance applies across all Trust Directorates although it is recognised that the decision to withhold services is extremely complex and may vary in different clinical settings.

In each instance the patient's clinical risk assessment will be considered by the Clinical Team responsible for managing the care of the patient and a decision made regarding whether treatment can continue to be provided in a different way, in a different setting, whether an alternative placement should be sought, or if temporary withdrawal of services is the most appropriate course of action.

When withdrawing services may be required

We recognise that withdrawing services will only be appropriate when the risk or existence of significant threats, abusive or violent behaviour is likely to:

a. Prejudice any benefit that the service user might receive from care or treatment;

b. Prejudice the safety of those involved in the giving care or treatment;

c. Lead the member of staff offering the care to believe that he/she is no longer able to undertake his/her duties properly. (This may include incidents of racial or sexual abuse/harassment);

d. Result in significant damage to trust and personal property by the service user or as a result of containing him/her;

e. Prejudice the safety of other service users present at the time.

Exceptions

The following exceptions will apply:

1. Service users who, in the expert judgement of a relevant clinician, are not competent to take responsibility for their action as they become aggressive as a result of an illness or as a consequence of an injury. Whilst these service users are excluded from the policy in general it may still be appropriate to consider alternative placements, if this is considered to be beneficial to the service user and/or members of staff.

2. Service users who, in the expert judgement of a relevant clinician require emergency treatment. In the event a patient requires admission for emergency treatment, wherever possible, the patient should not be readmitted to the same ward where incidents of violence or abuse have occurred previously to staff which do not relate solely to the persons mental state.

3. Service users who are detained either under the Mental Health Act 1983, including those on Community Treatment Orders. Or, those detained through a deprivation of Liberty.

4. Where service users have dual diagnosis e.g. Learning disability and personality disorder the views of two or more clinicians should be sought.

Unacceptable behaviour

The following, are examples of behaviour which are not acceptable on Trust premises or when providing care in other settings including service users' homes.

This is not an exhaustive list but provides some guidance:

- Threatening and abusive language involving excessive swearing and offensive remarks;
- Derogatory, racial or sexual remarks;
- Racial harassment or abuse to staff or other service users;
- Malicious allegations relating to members of staff, other patients or visitors;
- Offensive sexual gestures or behaviours;
- Abusing alcohol and drugs on Trust premises;
- Illegal behaviour such as drug dealing or theft on Trust premises;
- Wilful damage to Trust or personal property, likely to present risk to others or involve significant financial outlay to rectify;
- Threats or threatening behaviour;
- Violence towards a member of staff, fellow service user or visitor.

Visitors/relatives/carers

Visitors/relatives/carers who display any of the above unacceptable behaviours/actions will be asked to stop and be offered the opportunity to explain their actions. The relevant team leader or local manager would normally undertake this in the first instance.

Action would also be taken against any visitor/relative/carer impeding the service users' recovery, for example people who have abused clients in the past, or are at risk of abusing the patient.

Continued failure to comply with the required standard of behaviour will result in a senior manager/nurse being contacted and where authorised by them, arrangements made for the removal of the offending individual from Trust premises. The excluded individual may request an immediate review of the exclusion by the site manager and should be informed of this.

Any visitor/relative/carer behaving in an unlawful manner will be reported to the police and the Trust will seek the application of the maximum penalties available in law. The Trust will actively support the prosecution of perpetrators of crime on or against service users, staff, Trust property or assets.

The relevant Associate Director / Clinical Director may decide to continue to exclude any individual removed from the premises or restrict their visiting only to specific times and if necessary under escort.

If a visitor/relative/carer is permanently excluded from Trust premises the Trust Legal Advisor, Trust Complaints Department and Trust PALS Officer should be informed.

Key Principles in relation to behaviour of a service user

1. Each case will be looked at individually to ensure that the need to protect staff is properly balanced against the need to provide healthcare to individuals.

2. Sanctions which will apply to violent and abusive service users include:

    a. A verbal explanation by a member of staff of what is unacceptable behaviour and the possible consequences of further repetition. Staff will work with the patient to embed acceptable behaviours into any management plan developed to manage such behaviours thereafter?
    b. A formal written warning with details of Trust procedures on withdrawing of services and a written contract between the Trust and service user is agreed and signed by both parties.
    c. If a patient complies with the terms of the contract, he/she can expect that their clinical care will continue to be provided according to the details of the contract.
    d. As a last resort, a final written explanation, exclusion from the premises and the withdrawing of services sent by the Chief Executive notifying the service user of the period of the ban, copied to the patient's GP and/or provider of local mental health services.
    e. As noted above every case should be reviewed individually and the third level of action only applied in extreme circumstances, and after approval of the action by the Medical Director and Chief Executive.

3. Under exceptional circumstances, and because of the threat of serious and imminent danger or the serious nature of an actual incident, the immediate withdrawing of services may be decided by the clinician concerned, provided that they report their actions immediately to the Clinical Director, and that a more thorough assessment is made by the clinical team as soon as possible.

4. Any decision to withhold services must be based on a robust clinical assessment. Unless the decision to withhold services is made in an emergency situation, all decisions to withhold services must be sanctioned by the Associate or Clinical Director who is clinically accountable for the case..

5. The decision to withhold services will always be a last resort and strategies for preventing and managing violent and abusive behaviour must be in place and implemented.

6. Consideration must be given to the wider impact of restricting a service users access to services, which may increase the risk to society in general. Alternative options such as telephone assistance, written or e-mail contact, and the referral to / use of neighbouring Trust services should be explored.

7. All reasonable steps should b etaken to engage the family or carers, before a decision to exclude is made. Mechanisms for service users, their carers and/or advocates seeking a review of a decision to withhold services will occur via the local Patient Complaints procedure.

8 Services will not be withheld from a patient or service user as a result of the behaviour of the person accompanying or visiting them.

Action to take if an agreement is made to withhold services

1. The decision should be recorded in the service users' relevant case notes and on the patient administration computer system, and the service user must be informed.

2. Written notification should be sent to the service user confirming the withdrawing of services, the details of the suspension of services and an outline of procedures available for appeal, complaints, and/or opportunities for further discussion/review with the consultant psychiatrist clinically accountable for the case.

3. The service user should be given advice on how to contact independent advocacy agencies such as ICAS.

4. PALS may assist and provide direction in these cases but would not be able to represent the appellant.

5. The appeal procedure needs to ensure that a written report of the alleged misconduct is available so that potential advocates are well informed before they undertake to represent those appealing against proposed or actual exclusion.

6. A senior manager from the relevant department should confirm that all procedures have been complied with.

7. Where appropriate, other local service providers and agencies should be informed of the decision to withhold services from the service user. This must include the referring agency.

8. The clinical team responsible for the service users care must review the withdrawing of services decision at an interval no longer than 6 months from when the decision was made. The Service Director is responsible for ensuring this happens.

FLOWCHART OF PROCEDURAL STEPS TO BE TAKEN IN RELATION TO SERVICE USER BEHAVIOUR