

Policy Document Control Page

Title

Title: Violence Reduction Policy: Positive and Proactive Interventions

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- Policy renamed to reflect national guidance & evidence base
- Significant rewrite of all policy areas to include directions set out in Positive & Proactive care DoH (2014) and NG10 : Violence & Aggression The Short-Term Management in mental health, health and community settings NICE(2015)

Originator

Originated By: Chris Heath

Designation: Violence Reduction & CEST Manager

Equality Impact Assessment (EIA) Process

Equality Analysis Assessment Undertaken by: Chris Heath

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Approval and Ratification

Referred for approval by: Chris Heath

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Policy to be uploaded to the Trust's External Website? YES

Review

Review Date: January 2019

Responsibility of: Chris Heath

Designation: Violence Reduction & CEST Manager

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 15th December 2015

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1. Introduction

Violence and aggression are relatively common and serious occurrences in health and social care settings. The majority of these occurrences are reported by NHS staff working in mental health or learning disability settings, most frequently within in-patient mental health settings and in emergency departments. Recorded assaults, although less, are still significant in number within primary care and community settings.

There are complex reasons why a person may become challenging, aggressive and violent. Whilst complex, they can be understood and the aversive outcomes avoided, thereby maintaining safety, security and dignity for all. Personality factors and mental distress are intrinsic factors to be considered, whilst extrinsically, the role of staff attitudes and behaviours, the environment and the application of restrictions that limit choice, freedoms, real or perceived rights, may contribute significantly in generating violent, aggressive and challenging behaviours

Restrictive interventions must be regarded in the same way as any other professional intervention with an individual, (child or adult). At all times the safety, dignity, human and legal rights of children and adults must be of paramount importance. The objective of this policy is to meet the needs of the service user, whilst at the time safeguarding the service user and those involved with their care. Robust risk management underpins the delivery of all violence reduction work undertaken. However the following underpins the violence reduction policy:

- Inclusive, collaborative, person centered risk assessment and care planning;
- Using a graded set of interventions to prevent minor violence from escalating into severe violence;
- Using proactive interventions (not necessarily physical and always using the least restrictive intervention for the minimum time possible) using individual support and behavior support planning ;
- A restrictive intervention reduction programme, inclusive of a service user experience monitoring, is in place across the organization;
- Formal post incident review;
- Consistent recording and the open & transparent reporting of restrictive intervention data, to agreed national standards and guidance

2. POLICY STATEMENT

Pennine Care NHS Foundation Trust is committed to providing a safe environment for all those who provide and those who receive care, treatment and support. Violent or abusive behaviour will not be tolerated and action will be taken to protect staff, patients and visitors.

The trust is committed to providing a safe and secure environment in which anti social behaviour is anticipated, diffused, redirected and minimised. The trust will do anything within its power to support and protect its employees and those receiving care services from becoming victims of aggressive, abusive or violent behaviour.

Where restrictive interventions are used, they must always be done so as a demonstrable last resort, using the least restrictive option and never involve the deliberate application of pain.

The aim of the policy is to provide guidance for the short term management and the long term reduction of violence and aggression in all care settings within the organisation using a restrictive intervention reduction approach

Pennine Care recognises the need to ensure that services remain as safe as possible. As well as the safety and injury factors, anxiety, public perception and loss of confidence from poorly managed restrictive interventions, can also occur.

The restrictive intervention reduction programme will form part of the overarching violence reduction strategy across the organization. The executive board are accountable for this approach, monitoring and approving restraint reduction and behavior support planning interventions.

For the purpose of this document, the use of the term service user will also cover patient, client, resident, user or other individuals as relevant.

The most common reasons for needing to consider interventions are:

- physical assault; verbal abuse,
- dangerous, threatening or destructive behaviour;
- self-harm or risk of physical injury by accident;
- extreme and prolonged over-activity that is likely to lead to physical exhaustion; and
- attempts to abscond (where the patient is detained under the Act).

The intervention method chosen, must balance the risk to others with the risk to the patient's own health and safety and must be a reasonable, proportionate and justifiable response to the risk posed by the patient

In such situations it may be necessary for staff to

- take immediate control of a dangerous situation;
- end or reduce significantly the danger to the service user or others around them; and
- contain or limit the service users' freedom for no longer than is necessary

As with all care interventions, the need for these will be assessed, planned on an individual basis and evaluated. Planning and evaluation should involve service user and /or carers (especially where mental capacity issues affect the service user's ability to be directly involved). Guidance on the prevention and management of clinically challenging behavior in NHS settings, Meeting Needs and Reducing Distress; NHS Protect (2014), also contains risk guidance to be used with individuals not known to service/first contact situations.

This policy requires all services, teams and practitioners to prevent and manage disturbed/violent behaviour within the following approach

- **Primary Prevention** – steps that are taken to improve a service users quality of life and experiences of care, which may reduce the likelihood of challenging behavioural disturbances. Implementation of Safe-wards, No Force First, along with service sector specific strategies such as dementia care mapping, life story and trauma informed care approaches, assist with this. These may be worked out in advance on an individual level through the use of a Positive Behaviour Support plan or an advanced directive;
- **Secondary Prevention** – skills and techniques such as early recognition and intervention using diffusion & de-escalation to prevent behavior from escalating. Again these may be worked out in advance on an individual level through the use of a Positive Behaviour Support plan or an advanced directive;
- **Tertiary Prevention** - guidance and skills for staff and carers to enable skilled de-escalation to continue, summoning assistance, removing environmental stresses and based on risk assessment the use of restrictive manual interventions used in the least distressing way for the minimal time;
- **Post Incident Review and Debrief** – Support and review within a learning lessons framework, should take place as soon as practicably possible following the incident. This should involve staff, service users (Involved in the incident), carers and family where appropriate, other service users and visitors who witnessed the incident. An independent advocate (who may be an experienced ex-service user who has experienced restrictive intervention) and the Violence Reduction Manager/ or Trainer/or the Local Security Management Specialist, where the incident is significant.

The policy is one component of the Trust's approach to provide safe and individualised care. It should be viewed within this wider context and implemented in conjunction with all other relevant Pennine Care Policies and national guidance currently being introduced by the NHS Protect and NICE NG 10

3. Related Trust Policies

- ◆ Section 136 Policy
- ◆ Clinical Risk policy
- ◆ Care Programme Approach Policy
- ◆ Safer Place to Work Policy
- ◆ Risk Assessment Policy
- ◆ Rapid Tranquilisation Policy
- ◆ Lone Workers Policy
- ◆ Observation and Engagement Policy
- ◆ Seclusion Policy
- ◆ Searching Policy
- ◆ Mental Capacity Act Guidance
- ◆ Resuscitation Policy
- ◆ Absent Without Leave Policy

Associated guidelines and documents used in the development and implementation of the policy:

- ◆ The Mental Health Act 1983 Code of Practice (2015)
- ◆ The Mental Capacity Act 2005 Code of Practice
- ◆ NICE Guideline NG10: Violence & Aggression The Short-Term Management in mental health, health and community settings (2015)
- ◆ A Positive & Proactive Workforce. Skills for Care/Skills for Health (2014)
- ◆ Closing the Gap: priorities for essential change in mental health DoH (2014)
- ◆ British Institute of Learning Disabilities Code of Practice for the Use of Physical Interventions
- ◆ DFES/DOH Guidelines on Restrictive Physical Interventions
- ◆ NIMHE policy implementation for Violence & Aggression
- ◆ Nothing ventured nothing gained: risk guidance for people with dementia DoH (2010)
- ◆ Meeting needs and reducing distress: guidance on the prevention and management of clinically related challenging behavior in NHS settings NHS Protect (2014)
- ◆ Safewards; making psychiatric wards more peaceful places
- ◆ Childrens Act 2004
- ◆ Positive and Proactive Care: reducing the need for restrictive interventions DoH (2014).
- ◆ NHS Protect Training Syllabus for staff in the management of violence : Physical Intervention Syllabus

3. Aims of the Policy

Provide staff and service users with a framework, which incorporates high standards of practice and care.

Ensure that risks are minimised in the management of violence and aggression.

Ensure that the management of violence and aggression is based on current national guidance/standards and within a legal framework.

Provide guidance on the prevention and management of aggression and violent incidents

Provide guidance on the governance, transparency, monitoring and oversight procedures, concerning restrictive interventions.

4. Scope of the Policy

This policy applies to:

- 4.1. All service users, including young people, adults of working and adults over 65.
- 4.2. All Pennine Care NHS Foundation Trust staff (Including local authority & seconded staff managed by Pennine Care NHS Foundation Trust)
- 4.3 All Agency and Bank Staff
- 4.4 Visitors, carers and members of the public where directly stated

5. Definitions

5.1 Violence & Aggression

“The use of physical force which may be intended to hurt or injure another person physically or psychologically. It may be goal directed and may have an intention to dominate others; the experience and expression of anger; defensive and protective behavior; verbal abuse, derogatory talk, threats or non-verbal gestures expressing the same; the instrumental use of such threats to acquire some desired goal; damage to objects or the environment, from vandalism through to the smashing of windows, furniture and so on; attempting to or successfully physically injuring or killing another person with or without the use of weapons or forcing another to capitulate to or acquiesce in undesirable actions or situations through the use of force; and inappropriate unwanted or rejected sexual display or contact. ”

NICE NG10 (May 2015)

Whilst this is an expanded definition it is more useful for practice and training purposes and provides greater clarity in respect to operational behaviours in explaining violence and aggression and how it may be perceived by all involved in the care continuum.

5.2 Physical Assault

The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort.

5.3 Non-Physical Assault

The use of inappropriate words or behaviour causing distress or constituting harassment

5.4 Restrictive Interventions

“Making someone do something they don’t want to or stopping someone doing something they want to do”

Skills for Health (2014)

More specific definitions;

‘Restrictive interventions’ are defined 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:
- 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’

Positive and proactive Care: Reducing the need for restraint, Dept of Health (2014)

5.4.1 Manual (Physical) restraint – A skilled hands on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user

5.4.2 Mechanical restraint - The use of an authorised device (e.g. handcuffs, restraining belts) to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control. No mechanical restraint devices (actual or improvised) are authorised for use within the organisation. Service users who have been mechanically restrained by the Police, will be subject to the Policing organisations use and control policies for mechanical restraint.

5.4.3 Chemical restraint - The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour (rapid tranquillisation), where it is not prescribed for the treatment of a formally identified physical or mental illness. The use of medication by the parenteral route (usually intramuscular), if oral medication is not possible or appropriate and urgent sedation with medication is needed. There may be occasions where, due to individual needs, risks and presentation, other routes (e.g. naso-gastric) are the only viable alternative.

5.4.4 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.

5.4.5 Safe Holding/Clinical Holding - The use of direct physical contact (Manual restraint) where the interveners intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person for the primary purpose of delivering personal care or therapeutic care intervention(s), which has been assessed and care planned for; and is subject to the same reporting, documentation and monitoring as all other restrictive interventions.

Other useful definitions;

5.5.1 Advance decision – A written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future;

5.5.2 Advance statement – A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care, An advance statement is not legally binding;

5.5.3 Breakaway Techniques – A set of physical skills to help separate or break away from an aggressor in a safe manner. They do not involve the use of restraint;

5.5.4 Incident – Any event that involves the use of a restrictive intervention – manual restraint, mechanical restraint, chemical restraint, seclusion, safe and clinical holding (but not observation) – to manage violence or aggression;

5.5.5 Observation – A minimally restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with the service user to ensure the service users safety and the safety of others;

5.5.6 Positive engagement – An intervention that aims to empower service users to actively participate in their care. Service users negotiate the level of engagement that will be the most therapeutic

6. Policy Operation

The Management of Violence and Aggression will be operated across Trust services under the following criteria and guidance:

- Environment, Organisation & Alarm Systems (see Alarm Policy)
- Legal Framework
- Prediction (antecedents, warning signs and risk assessment)
- Searching (See Searching Policy)
- De-escalation Techniques
- Observation (See Observation and Engagement Policy)
- Physical intervention
- Seclusion (See Seclusion Policy)
- Rapid Tranquilisation (Mental Health Only - See Rapid Tranquilisation Policy)
- Service User & Diversity Issues
- Personal Safety Awareness
- Secure transport of Service Users (see protocol in MVA Appendix 3)
- Post Incident Reviews and Documentation
- Training

6.1 Environment, Organisation & Alarm Systems

6.1.1. This section relates primarily to violence prevention within in patient settings and represents the current good practice in reducing aggressive/disturbed/violent behaviour. However community and clinic based services can also utilize the following information to minimise the risk of violence and aggression, except where indicated

6.1.2 Service users should be cared for and their behaviour managed in the least restrictive care setting possible. The effect of over restrictive environments in promoting challenging behaviour has an established and growing evidence base. In this context, it is not just the physical environment but the psychological and social environment which can be perceived and sometimes are, as controlling and compliance orientated. The effect of the care environment needs to be assessed on a regular basis (at a minimum of an annual audit) and when there are any service redesign changes. To assist with this process a toolkit is available that all wards should implement annually. The 15 Step Challenge Toolkit and implementation guide is available from the NHS Institute for Innovation and Improvement (2012) via; www.institute.nhs.uk/productives/15StepsChallenge

The environmental assessment should be co-produced involving service users, staff, managers and non-executive directors.

- 6.1.3 All in-patient service areas should provide a de-escalation area or room for the purpose of reducing arousal or aggression. This is not seclusion and the de-escalation area or room will not be a seclusion room. If a seclusion room is used to de-escalate then it could appear threatening and punitive to the service user. Where de-escalation results in the removal of a service user from the main ward population, then the Trust's Seclusion Policy may govern its use. The use of the de-escalation area should follow prior discussion with the service user and be with their prior agreement if possible. The function/purpose of use should be explained to service users and carers as part of the risk management aspect of the service users care plan. De-escalation is a process and need not take place in or be restricted to designated areas.
- 6.1.4 In accident and emergency departments, Pennine Care will work with the partner Acute health provider trust to ensure that the emergency departments where mental health teams (R.A.I.D. teams etc) are based are able to offer mental health triage within at least 1 designated interview room for mental health assessment that:
- is close to or part of the main emergency department receiving area
 - is made available for mental health assessment as a priority
 - can comfortably seat 6 people
 - is fitted with an emergency call system, an outward opening door and a window for observation
 - contains soft furnishings and is well ventilated
 - contains no potential weapons
- 6.1.5 Personal assistance/emergency alarm fobs and alarm systems will be available in all inpatient units (mental health) as standard and by negotiation for other areas (clinics etc) and their use, training, monitoring and installation directed by the local policies/procedures and guidance provided by the Local Security Management Specialist

ROLES AND RESPONSIBILITIES

6.1.6 The Chief Executive Officer

The Chief Executive via the Director of Operations is responsible for ensuring provision of a safe environment for service users and staff across the Trust. This involves ensuring appropriate systems and processes are in place regarding management of Violence and Aggression and the management of risk.

6.1.7 Responsibility of the Trust Board

The responsibility for the provision of appropriate policies and procedures for all aspects of health and safety at work and the management of security rests initially with the Trust Board (Health & Safety at Work Act 1974), Secretary of State Directions (Statutory Instrument 3039/2002)

Additionally, the Trust Board will ensure through the line management structure that these policies and procedures are applied fully and consistently and that all

employees are aware of the standards and behaviours required under them.

The Board will also have the responsibility for approving the restraint reduction and Restrictive interventions (manual restraint) being taught to staff.

Additionally the Board must receive and develop actions plans in response to an annual audit of behaviour support plans.

Non-Executive Directors will also have the responsibility to support environmental assessments of care environments, in particular in patient mental health settings

6.1.8 Responsibility of the Security Management Director.

The Director of Finance is the nominated executive with the responsibility for security management, and will fulfil the function of the Security Management Director (SMD).

The Security Management Director will, through the delegated person/s oversee the introduction, operation, monitoring and evaluation of this policy to ensure comprehensive, fair and consistent application throughout the Trust.

The Security Management Director will, through the delegated person/s ensure the provision of training, guidance and support to line managers on the operation of this policy.

The Security Management Director will, through the delegated person/s ensure that queries in relation to this policy at a local level will be answered and ensure the policy is applied fairly and consistently throughout the Trust.

6.1.9 Responsibilities of the Director of Nursing and Health Care Professions

The Director of Nursing is the nominated executive lead, with Board level responsibility, for the overarching violence reduction strategy and implementation across the organisation. This is to;

- Lead the organisational commitment to restrictive intervention reduction at a senior level,
- Oversee how the use of data relating to restrictive interventions will inform service developments & continuing professional development for staff,
- Ensure models of service which are known to be effective in reducing restrictive interventions are embedded into care pathways,
- Promote service user engagement in service planning and evaluation and lessons learned following the use of restrictive interventions.
- Oversee accountability for continual improvements in service quality through the delivery of positive and proactive care. This will include improvement goals and identify who is responsible for progressing the different parts of the plan.

A key indicator that a plan is being delivered well will be a reduction in the use of restrictive interventions. Other indicators include reduction of injuries as a result of restrictive interventions, improved patient satisfaction and reduced complaints.

6.2 **Responsibility of Directors, Associate / Assistant Directors and Departmental Managers**

Directors / Departmental Managers are responsible for ensuring that this policy is applied within their Directorate/Department. Pennine Care services collaborate within integrated care provision (local authority, third sector agencies, other primary and secondary health providers). Where staff work within an integrated approach, this policy will still apply and be reviewed along with partner agency policies to ensure compatibility of standards, violence reduction and positive/proactive approaches to reducing needs for restrictive interventions

Directors/Departmental Managers will ensure that employees are aware of and understand the requirements of the policy.

Directors/ Departmental Managers will ensure that risk assessments take account of the risk of violence to staff and ensure that appropriate systems are in place to protect the safety of individuals.

6.2.1 **Responsibility of employees.**

All employees are responsible for reporting any incidents of violence or aggression through the Trust's incident reporting system.

All Trust employees (including those on honorary contracts and those working primarily for other organisations but on Trust premises) have a duty in the enactment of the policy.

All employees are responsible for complying with arrangements made under the auspices of this policy.

6.2.2 **Responsibilities of the Violence Reduction Manager**

The **Violence Reduction Manager** will be responsible for establishing leadership and management to a network of Violence Reduction trainers and personal safety advisors in the Trust. The post-holder will ensure that the Trust-wide Training Needs Analysis clearly identifies violence reduction training requirements in order to ensure that sufficient training capacity is put in place to meet demand and also comply with the Secretary of State Directions, NHS Protect & NICE Guidance NG10. The Violence Reduction Manager will be instrumental in leading the practical implementation for the key performance indicators in demonstrating a reduction approach is embedded within the organization, working with the Director of Nursing to do so.

The **Violence Reduction Manager** will develop a system of audit to ensure that the standards of practice and training in the area of Management of Aggression and Violence are high and comply with national standards and best practice. Liaison and participation with relevant national bodies and strategic direction will be required to ensure the Trusts MVA practice remains in line with national guidance and policy drivers.

Working with the Board level lead the **Violence Reduction Manager** will be responsible for increasing the use of recovery-based approaches including, where appropriate, positive behavioural support planning, and reducing restrictive interventions.

- 6.2.3 Community Service managers should assess office bases as part of an annual environmental audit and develop clear guidance as to whether they are for service user contact as well as an office base. Where service users are being seen at community team offices, the team should develop procedures for the safe management of aroused/aggressive behaviour using the following information. For this reason it is essential that Community Teams undertake MVA Environmental Assessments, attend Conflict Resolution (Community Services) or Promoting Safe and Therapeutic Services Training (Mental Health and Learning Disabilities) and involve the Local Security Management Specialist, where the procedures are identified.
- 6.2.4 The audits will be the responsibility of the **Service Manager** and carried out in conjunction with the **Trust Health & Safety Manager** and the **Local Security Management Specialist**. The audits will be received and monitored by the Trust Health & Safety Committee. Audits should be carried out routinely to the following timescales/event indicators: a) When a new facility or service opens, b) Once annually along with the environmental audit, c) If there is a change of use of the environment or service reconfiguration and d) following an incident as directed by the Central Governance and Risk department. Action plans identified from the violence reduction audits will be registered and monitored locally by the Borough Governance and Management Team, and centrally via the Trust Health & Safety Committee and the Executive Team via the Trust Risk Register if a significant issue (rated 15 and above) is identified.
- 6.2.5 In planning or re-provision of acute mental health in-patient facilities, services should designate separate areas to receive service users arriving with Police escorts (Section 136 Suites)
- 6.2.6 Service users should be involved in the design and arrangement of their care environment facilities and organisation of their day. In-patient services should actively engage with service users through activities and initiatives such as protected therapeutic time. Access to basic entertainment facilities will be provided and a range of therapeutic activities that allows the service user to engage in physical exercise, group interaction, therapy and recreation.
- 6.2.7 **All Staff** will monitor and address through Estate services adverse service area environmental issues such as high temperature, ventilation, noise and light. High temperature, low levels of ventilation (access to fresh air) and high noise levels are positively associated with an increase in disturbed/aroused behaviour in in-patient settings.
- 6.2.8 **All Staff** should address service user concerns as part of care plans to proactively manage potential sources of aroused/aggressive behaviour that may arise from inadequate planning around a service users safety needs, privacy and dignity

needs, their gender and cultural concerns, perceptions around physical overcrowding and their social and spiritual expression.

6.2.9 Alarm Systems and their Use: *Please refer to the Pennine Care Alarm Protocol*

6.3 Legal Framework:

*The following applies to **All Staff***

- the Mental Capacity Act 2005 & its Code of Practice
- the principles underlying common law and the doctrine of necessity
- the Health & Safety at Work etc. Act 1974
- the Management of Health and Safety at Work Regulations 1999
- Deprivation of liberty safeguards and least restrictive principles

*The following applies to **Mental Health Services and Community Learning Disability Services Staff Only***

Through training all staff will be made aware of the following legal framework.

- the relevant sections of the Mental Health Act 1983 (Amended 2007) & its Code of Practice (2015)
- the European Convention on Human Rights, including;-
Article 2 (The Right to life)
Article 3 (the Right to be free from torture or inhuman or degrading treatment or punishment)
Article 5 (the Right to liberty and security of a person save in prescribed cases)
Article 8 (the Right to respect for private and family life)
- the principle of proportionality.
- Impact factors and the use of force

The various levels of Violence Reduction Training will incorporate into their syllabi legal framework information for staff.

6.3.1 All Staff will use the guidance in this policy to ensure that their actions will be deemed reasonable and proportionate in response to the risk being posed. Pennine Care NHS Foundation Trust is empowered to respond to challenging/disturbed/violent behaviour in certain circumstances defined by Common Law, the Mental Capacity Act Code of Practice and the Mental Health Act Code of Practice. Failure to act in accordance with best practice may have legal consequences. It is therefore necessary that Pennine Care staff;

- receive regular training on the legal aspects of the management of disturbed/violent behaviour (see Training section)
- complete the Pennine Care documentation record (Incident Report, Client Record for each intervention required to manage the service users behaviour,
- be aware of their duty of care to the service user whilst the persons violent behaviour is being managed and their obligations (in terms of duty of care) to other services users and (Section 3 of the Health & Safety at Work Act) to other staff and any visitors who may witness the intervention.

- 6.3.2 Staff/Multi Disciplinary Teams and Managers are to ensure that lessons and information learnt from physical interventions are used to review the service users care plan. They should ensure that all aspects of the management of violence are reviewed to maintain best practice and assist in demonstrating modifications to plans when dealing with a known /consistently presenting risk of violence.
- 6.3.1 Staff, when electing to use a physical intervention, may on some occasions require access to specialized legal advice. These are most likely to be complex situations. Pennine Care has access to specialist legal advice and it can be accessed through application from a service manager to the Trust Risk Manager, the Trust Governance Manager and/or the Trust Medical Director. Additionally staff in the first instance should use both their line management and the Violence Reduction Trainers as they may have encountered similar situations previously and can act as a source of guidance.

6.3.2 The Mental Capacity Act 2005 & Restraint

The MCA 2005 rules, regulations and Code of Practice provide a complete legislative framework of decision-making for mentally incapacitated adults. Section 6 of the MCA provides the authority to restrain an incapacitated patient subject to three conditions:

- Staff believe that the use of restraint is necessary in order to prevent harm to the patient
- The restraint is a proportionate response to:
 - The likelihood of the patient suffering harm, and
 - The seriousness of that harm
- The restraint is in the patients best interests

A patients best interests must be assessed in accordance with Section 4 of the MCA and if it does not meet these conditions it would be unlawful.

Notably this provision does not provide for the restraint of a person in order to prevent harm to others, such action is authorised under common law powers.

The MCA requirement for the restraint to be a proportionate response is in terms of both the degree and duration of the restraint. It must be the minimum amount and the level of restraint should diminish as the risk of harm reduces.

The following applies to mental health services only;

Section 6 of the MCA does not allow for restraint that amounts to a deprivation of the patients liberty and this would result in a violation of their rights under Article 5 of the European Convention on Human Rights. Any deprivation should lead to a Mental Health Act assessment or a Deprivation of Liberty Safeguards assessment and authorisation. If staff are unclear about this they should contact their local Mental Health Law office in the first instance.

6.3.3 Common Law Powers of Restraint

The ability to restrain or detain a person suffering from mental disorder who is a danger to himself or others has been established by case law and allows for staff to act quickly to prevent a person from causing harm or prevent a breach of the peace. Staff must be able to justify their actions by documenting their belief that the detention or restraint was necessary and it can only be used for a short period of time until crisis subsides. If repeated restraint is likely then clinicians should request a MHA Assessment because the common law powers are not sufficient to be used as an ongoing alternative to the procedures laid out in the Mental Health Act.¹

Additionally the above duty is conferred by Section 3 of the 1974 Health & Safety at Work Act and in a number of Professional Regulation Bodies (e.g. the Nursing and Midwifery Council) codes of conduct and guidance.

6.4 Risk Assessment (Antecedents, Warning Signs and Risk Assessment)

This section should be read in conjunction with the Clinical Risk Assessment and Management Policy

6.4.1 Staff should ensure that a comprehensive Trust Approved Risk assessment is undertaken with each service user, as part of a care plan for the person that addresses any short-term and/or long-term management of disturbed/aggressive/violent behaviour, where such needs are identified.

- The service users own views about their trigger factors, early warning signs and how these should be managed,
- Carers views where appropriate,
- Situational, Organisational and Environmental factors,
- Some Risk factors that may indicate that a person could be violent or aggressive are as follows (*mental health services only*);

In addition to regular CPA/Care Package review, there are key points or events that indicate the need to conduct or review the risk assessment. These are:

- First contact with the specialist mental health or learning disability service
- Significant change in circumstances of the service user
- Care plan reviews (planned or unplanned)
- Hospital admission, leave and discharge
- Referral or transfer to other parts of the specialist mental health or learning disability service
- Discharge or transfer out of the specialist mental health or learning disability service
- Any transition Point –this includes care coordinator change within the same team (Nat CPA Training Package) but also Prison to Mental Health care and vice versa

Risk assessment will be incorporated into the initial screening and

¹ Black v Forsey [1987] SLT 681, R v Howell [1982] QB 416, R (on the application of Laporte) v Chief Constable of Gloucestershire Constabulary [2006] UKHL 55, Abert v Lavin [1981] 3 All ER 878

assessment of the service user. It will involve the consideration and identification of a range of evidence based risk indicators utilising the Trust approved risk assessment tool. Where possible it should draw upon a wide range of available information including the opinions and views of others including relatives and carers.

Where appropriate, risk assessment should be multi-disciplinary, ensuring that risk is owned and shared at ward, team and service level.

- Services may elect to use a combination of risk assessment tools. This can include actuarial tools and structured clinical judgement. Staff should ensure they are used in a consistent method and should include consideration of the following:

Historical/Static	Clinical & Dynamic Variables
<ul style="list-style-type: none"> • Current Young Age • Young Age/First Offence • History of Violent Behaviour • Early Social Maladjustment • History of Substance Misuse • History of Mental Illness • Diagnosis of Personality Disorder • Previous Unstable Relationships • Social restlessness • Previous Use of Weapons • Previous dangerous/impulsive acts • Employment Difficulties • Psychopathy 	<ul style="list-style-type: none"> • Lack of Impulse Control • Antisocial attitudes and beliefs • Anger and Hostility • Suicidal/Self Harm Intent • Sadistic/Violent Fantasy • Homicidal Ideation • Active Symptoms of Mental Illness • Substance Misuse • Unwillingness to engage in treatment • Evidence of recent severe stress, particularly loss event or the threat of loss • Therapeutic Drug Effects (disinhibition, akathisia) • Delusions of control • Agitation, excitement, suspiciousness • Poor collaboration with treatment • Organic dysfunction
<ul style="list-style-type: none"> • One or more of the above in combination with any of the following <ul style="list-style-type: none"> - cruelty to animals - reckless driving - history of bed wetting - loss of a parent before the age of 8 years 	
<p>Situational</p> <ul style="list-style-type: none"> • Extent of Social Network • Immediate availability of a potential weapon • relationship and access to a potential victim • Limit setting & staff attitudes 	

6.4.1 Many of the components identified above are dynamic and changing and need to be reassessed frequently to ensure care and risk management plans remain

accurate and effective. Staff should maintain ongoing risk assessment with respect to violence/disturbed behaviour

- 6.4.2 A risk assessment will be completed on admission/acceptance of referral. Subsequent reassessment will be individually determined. This will be clearly identified within the risk management plan and formulated on the basis of the multi disciplinary team recommendations.
- 6.4.3 Staff will communicate the outcomes of violence and aggression risk assessment to involved agencies in accordance to Trust guidance on the sharing of patient related information and patient confidentiality.
- 6.4.4 Staff should assess and monitor potential antecedents. These will include:
- Anxiety and fear associated with medical situations. They are quite often linked as an antecedent to aggressive situations. The patient may be in a new, frightening or unwanted situation, he/she may be suffering from some perceptual disturbance thus colouring their judgement and misinterpretation may result. This may induce the fight or flight syndrome.
 - Pain that is present, be that continuing or unrelieved, is debilitating and may contribute to frustration, irritation and if not relieved, aggression.
 - Medication that is prescribed to reduce aggressive behaviour can cause some degree of disinhibition, and may result in an individual behaving in ways that normally they would have control of.
 - Confusion that may be of an organic or functional cause. Staff must be aware that the condition can at times be exacerbated by medication, be that prescribed or non-prescribed.
 - Alcohol and drugs are often reported by staff working in health and social care settings as having an association with aggressive behaviour and psychological changes.
 - Boredom and frustration that can be brought about by lack of structure in an individual's care plan can be an antecedent to aggressive behaviour.
 - Emotional Disturbance: The physical impact of violence seems secondary to its emotional impact, especially while the adrenaline is still increased in the body following an attack.
 - Observing personal space
- 6.4.5 Warning indicators that staff should consider as an indicator of imminent aroused/aggressive/violent behaviour include:
- Tense and angry facial expression
 - Increased or prolonged restlessness, tension and pacing
 - General over-arousal of breathing, heart rate, muscle twitching, dilating pupils
 - Increase in tone, volume and rate of speech leading in some cases to reduction of tone, volume and rate of speech
 - Prolonged eye contact/loss of eye contact
 - Non-communication and withdrawal
 - Sideways stance within arms length
 - Verbal threats and gestures

Some staff and teams will because of their duties find themselves in first contact situations where risk information may not be available and the potential service user presents in a raised state of arousal. In such situations staff need good observation and response skills to some of the evident static and situational risk factors, behavioural warning indicators and contact environment considerations. For these reasons it is necessary that identified staff attend Level 2 Conflict Resolution and Promoting Safer and Therapeutic Services training and Level 3 Disengagement/Rescue techniques. It is mandatory for these staff, like all staff who have frontline contact (face to face, telephone or counter) with service users, carers or the public to attend the specific Level 2 courses. It is a requirement that all managers assess their staffs contact status when developing and/or reviewing job descriptions and roles. The above training builds on guidance available for these first contact staff provided by NHS Protect “Meeting needs and reducing distress: guidance on the prevention and management of clinically related challenging behavior in NHS settings” NHS Protect (2014).

6.4.6 Clinical Risk Formulation and Specific Risk assessment

Restrictive interventions training and clinical risk management training will provide experience around formulation and direction for further training for more specific actuarial violence and aggression risk assessment and management training.

Structured clinical risk formulation will be practiced as part of clinical simulation training on all violence reduction courses and as part of basic clinical risk training.

Access to specific and actuarial risk assessment training will be via continuing professional development allocation and educational training funding. This will enable access to specific assessment tool training, such as HCR 20, Broset Violence Checklist etc

It is expected that each service user undergoes a review of risk at regular intervals. Each assessment must be clearly recorded chronologically in the clinical notes and must clearly indicate that a review has taken place, even where no changes were made. The Care Coordinator or allocated key worker is responsible for ensuring regular review of risk and risk management and individual behaviour support plans.

6.4.7 Individual Support Plans

Individualised support plans, incorporating behaviour support plans, **must be implemented** for all people who use services who are known to be at risk of being exposed to restrictive interventions.

Individual support plans will be subject to internal audit programmes including reviews of the quality, design and application of behaviour support plans, or their equivalents.

Individual support plans will also be subject to audit and review through internal audit and external audit via the Care Quality Commission.

6.5 Searching (See Pennine Care Search Policy)

- 6.5.1 Policy guidance on personal, belongings and room searching can be found in the Pennine Care Search policy. In the context of contributing to effective prevention and management of challenging and violent behaviour, staff will be aware of the value of undertaking, where necessary, lawful searches of service users.
- 6.5.1 The policy also contains guidance on the approach to follow if it is felt that searching of carers and visitors is required
- 6.5.3 The policy outlines the training available and the equipment that can be used to assist in maintaining a safer environment. This includes the use of electronic searching equipment for the detection of metal objects (search wands etc) and the use of sniffer dogs. Along with the basic forms of searching, these are also authorized for use within Pennine Care facilities

6.6 De-escalation Techniques

- 6.6.1 Following a comprehensive risk assessment and where aroused/aggressive/violent behaviour is identified as a potential risk, Staff should develop de-escalation strategies for individual service users.
- 6.6.2 Staff should consider using the following de-escalation strategies:
- Proxemics – stance, posture and space
 - Eye contact
 - Respect touch and reactionary gap
 - Facial expression
 - Environment
 - Influence of your appearance
 - Hand gestures/movements
 - Verbal/non-verbal communication
 - Check feelings and acknowledge
 - Start negotiations
 - Seek agreement
 - Distraction
 - Ascertain their needs and where conflict exists
 - Collaboration and encouragement for the service user to recognise their own trigger factors
- 6.6.3 In general one staff member should assume control and attempt to establish rapport with the service user. Solutions should focus on positive cooperation, realistic options and threat avoidance. In doing this the staff member should seek to utilize an appropriate balance of question styles (open, closed, probing, reflective etc) and enquire about the service users concerns, grievances and frustrations.
- 6.6.4 Recognition of the early signs of challenging behavior, understanding causation, de-escalation techniques, non-verbal and verbal techniques, use of advance statements, Safeward interventions and emotional self-regulation for staff are developed within the training courses

The specifics of the conflict resolution approach are covered in the Level 2 Conflict Resolution and Promoting Safer and Therapeutic Services Training. This training also forms part of the restrictive interventions (manual) training for Children, Working Age and Older Adults. (Level 4 courses)

6.6.4 The following approaches should not be taken within de-escalation

- -Distancing ourselves from the person to an extent that effective communication is impaired and it appears that we are intimidated by their behaviour.
- Behaving in an aggressive manner towards an angry person.
- Ignoring the person - appearing unconcerned or disinterested.
- Offering ultimatums.
- Being sarcastic or patronising the person.
- Becoming confrontational - tone of voice, body language, pointing at the person, invasion of personal space.
- Reinforcing inappropriate or undesirable behaviour.
- Offering bribes i.e. "behave for me and I'll..."
- Shouting at an angry person.
- Making demands.
- Threatening the person.
- Getting involved in an argument.
- Making promises on behalf of other staff.
- Keep referring back to an incident, which has been resolved.

6.7 Observation (See Pennine Care Observation and Engagement Policy CL5)

6.7.1 Effective observation and where appropriate, engagement are key techniques in reducing levels of aroused and aggressive behaviour. Staff should use observation strategies in incident prevention and post incident management to reduce the risk of further episodes of arousal and to facilitate early use of de-escalation techniques.

6.7.2 Observation can be a provocative experience for service users and staff need to understand and balance the skilled approach, bearing in mind that, as a practice it can also increase sense of isolation, frustration and dehumanization.

Providing the service user with an explanation why they are being observed and what the staff are trying to achieve may diffuse some of those feelings, along with an indication of how long it will last for. Observation should be minimally intrusive but must balance perceived risk with dignity and privacy.

6.8 Physical Intervention (Team Physical Interventions – In Patient Mental Health and Learning Disabilities staff)

As a general rule, manual restraint should only take place once non-physical, de-escalation techniques have been tried and have failed. All physical interventions in response to violent and aggressive episodes must be recorded as incidents in line with the Pennine Care NHS Foundation Trusts' incident reporting policy. Some of these interventions may be categorized as serious untoward incidents and require an immediate high-level response. Some will be continuing risk management with a

service user and may only need local review at team level in handover and/or patient care team meeting. Staff will be able to make decisions through categorizing what actually happened against the grading criteria contained within incident reporting policy.

- 6.7.1 If an aggressor is suspected of having a weapon do not engage, isolate them and call the police. If the person indicates that they wish to surrender the weapon, they should be requested to leave it in a neutral place where it can be collected after the person has left the area. A weapon is classed as an object that is being used for its intended purpose i.e. actual weapons, or being used for potential harm, not as its intended use i.e. improvised weapon

Deterrence, prevention and detection are important strands in promoting a zero tolerance culture to the carrying of weapons (actual or improvised). Clear signage stating that weapons are prohibited and involvement of the Police may be considered by a service area if weapon carrying/presentation is a risk. The development of the Pennine Care Weapons Policy will provide clear direction and procedures that covers definition, deterrence, prevention, detection, Police Liaison, Searching for Weapons, Confiscation, Disposal, Reporting and Confidentiality

- 6.7.2 Staff should also be aware and take active steps to risk assess all service users with respect to physical interventions being used. It is the responsibility of the care team and staff involved to ensure that medical considerations and physical assessment takes place prior, during and post physical intervention. This applies to all service users regardless of health and/or disability status but special consideration needs to be demonstrated in the following circumstances

- Physical disability
- Pregnancy
- Sensory disability
- Obesity
- Children & Adolescents
- Presence of Drug and Alcohol Use
- History of Sexual Abuse/Assault
- Learning Disability
- Where the service user has been behaviourally aroused over a prolonged period of time (physical exhaustion)
- Where fluid and food intake is not known or known to be minimal
- Where the service user has a cardiac, thoracic or respiratory condition
- Where the service user has been recently started on a new therapeutic drug regime.

*It is necessary that **all staff** required to undertake physical interventions attend a Trust approved training course that will inform how to risk assess for the specifics of the criteria listed above.*

Additionally Learning Disability services utilize a specific pre intervention risk assessment focusing on known risk issues associated with specific learning disabilities.

6.7.3 When a person observes a situation which is not usual and which has the potential to develop into a physical confrontation, assistance is requested immediately. Also

- On no account should a situation be addressed by one person.
- Staff should summon assistance by activating their personal alarm where applicable.
- Staff should summon assistance by use of the telephone.
- Nominated members of ward/unit teams/trained staff will respond to these situations.
- Every effort will be made to deal with the situation in a non-confrontational manner.
- The response team will be available to respond after evaluation and under direction.
- The member of staff directly involved will attempt to de-escalate the incident.
- If a situation is occurring in an area where other people are present, the area should be cleared.
- Staff involved directly will remove either the patient from the stimuli or the stimuli from the immediate environment.
- If the situation remains unresolved the emergency bleep holder should be alerted and Security (where available), informed of a potentially difficult situation arising.
- If situation remains unresolved the bleep holder will contact the Police for emergency assistance.
- Once the situation is under control, reassurance must be given to other patients who may have witnessed or been directly involved.
- The incident should be fully recorded in the patient's notes; both nursing/medical and an incident form are completed.
- All service users involved in a restraint situation will be physically examined by the duty doctor. Details of any injury will be fully recorded in the patient's medical notes.
- The patient's responsible clinician is informed and immediately comes out, in line with the incident policy, to modify the Care Plan and Individual Behaviour Support Plan, if necessary.
- The level of observation and care plans to be reviewed for the management of the individual.
- The post incident review will be discussed fully and openly with all members of staff at the next hand over in order to assess the appropriateness and effectiveness of the situation.
- At the earliest opportunity (this could be immediately if a serious incident has taken place or via the usual review processes in the event of incidents in the context of longer term risk management) the incident will be discussed with the service user and with permission the relatives. Disclosure may be a difficult area for some service users to agree to and the service user has a right to confidentiality. However staff have a duty to balance consent with disclosure when reporting aggression and violence, for example, accurate reporting of violence and aggression in mental health act review tribunal reports. Where staff have discussed the incident with the service user or relatives/carers then they should document it in the service users healthcare record.

6.7.4 Response Teams

Occasionally, a ward or service area may require extra assistance in the management of actual aggression and violence. Where wards/service areas do call for assistance from other ward teams and/or security the following **MUST** be in place;

- A **written and agreed**, Local Response Team Protocol, which defines who will respond and the support they will offer;
- Where possible, response teams should be negotiated locally to support similar care group services e.g. adult in patient care to adult in patient care. Where this is not possible then the description of the support they will offer in the response protocol needs to be clear and understood by all team members;
- Where general hospital security are to be involved in responding (check local service level agreements), they must be trained to the standards defined in Positive and proactive, reducing the need for restrictive interventions DoH (2014) and NICE NG10, Violence and aggression: short term management in mental health, health and community settings.NICE (2015). They should never lead, (or act as a head person), a physically restrictive intervention with a known and/or detained service user in an in-patient mental health setting, but they can assist.
- Where a response team is used, a member of the service users, host ward team, who knows their risks, medical risks, advance statement, behavior support plan and who the service user (even if only recently admitted) **must** lead the team and the manual restraint intervention.

This is to reduce risk for all involved by ensuring that early diffusion and a least (identified) restrictive intervention is used for the minimal time, based on the staffs knowledge of the service user and their associated care or behavior support plan

6.7.5 Manual Restraint: Physically Restrictive Intervention Procedures

The procedure outlined below should only be followed when

- a) A person observes a situation, which has the potential to develop into a physical confrontation.

Or

- b) De-escalation and diffusion have not had the desired effect and the situation develops into a potentially violent confrontation and there is a significant risk of injury to staff or the individual

And

- c) Three members of staff responding to the situation have undergone Team Physical Intervention Training (Level 4).- Mental Health Services

The designated number of staff that have undergone a BILD accredited training program will respond in Learning Disability Services

Staff will ensure that the following best practice guidance is adhered to throughout manual restraint intervention procedures:

- Manual restraint intervention should be avoided if at all possible and should not be used for prolonged periods. It is a formal requirement that ANY manual restraint should be reviewed after 10 minutes. Restraint should not be routinely used for periods longer than this. Staff should consider the use of rapid tranquilization and seclusion (mental health services only where there is a designed seclusion facility) to bring a physical intervention to an end at the earliest opportunity.
- Any position during physical intervention (seated, kneeling, prone – on stomach, supine – on back and standing) carries potentially serious risks, therefore avoidance of prolonged restraint and monitoring of the service users health state are priorities for staff involved.
- Avoid taking service users to the floor where possible and support their descent to the floor if the manual standing restraint becomes unstable and begins to collapse.
- In **all cases** where there has been a traumatic collapse to the floor, a falls risk assessment and the service users medical welfare should be attended to as a priority. It may be a useful point to stop the manual restraint and focus on care and welfare as an expressed care intervention to assist in diffusing the situation.
- **Descent to the floor is not taught as a technique with older adults training** but they may still collapse and **a supportive procedure is defined and taught** in such circumstances. **In all cases with older adults** who descend to the floor, **the falls assessment procedure will be applied** before any attempt to move them further
- The level of force used during manual restraint must be at all time justifiable and the responsibility is placed on the team involved to ensure that the force being used throughout passes the test of reasonableness.
- During higher level manual restraint; supine (face up) and prone (face down), one team member should be responsible for protecting and supporting the service users head and neck, at all times (mental health services only). This staff member will be responsible for leading the team through the manual restraint process, and for ensuring that the service users airway and breathing are not compromised and that vital signs are monitored.
- During physical intervention, under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. The overall physical and psychological well-being of the service user should be continuously monitored throughout the process.
- Where a decision is taken to go down to holding on the ground (Controlled descent) or where there is an uncontrolled descent a staff member will protect the service users head and neck at all times. (Mental Health Services only). This technique is not used within learning disability services.
- Every effort should be made to utilize skills and techniques that do not use the deliberate application of pain. 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 from severe outcomes, as justified through common law..

- Following the Independent Review of Restraint in Secure Training Centres (Smallbridge 2008) the government adopted the recommendations across the care sector (Adult and Young Person/Children) regarding the higher level hold (Wrist flexion with thumb and forefinger engaged). The hold is still permissible with children and adults in emergency situations and where sanctioned through care planning that determines the service user requires that level of holding. This means that staff are required to identify this level of hold and the reasons for its use within an individualised care plan addressing the service users management of their behavioural arousal. Additionally for CAMHS services only, a weekly review of the use of the higher level hold must take place with the involvement of the local safeguarding lead.

N.B. Only the techniques taught are permissible.

6.7.6 Monitoring the Service User involved in Physical interventions

- The member of staff leading the intervention will allocate team members and a non-physically involved staff member to undertake and record observations respectively
- Observations of the service users vital signs will begin
 - a) immediately when the situation is stabilized (service user in the prone, supine or seated) position where known risk factors are evident (6.7.2) and continue every 3 minutes throughout the intervention
 - b) after 3 minutes into a stabilized position and continuing every 3 minutes throughout the intervention
- Monitoring will end by team decision after the physical intervention is completed and the service user has been medically examined.
- Post restraint, vital sign monitoring must be continued, until medical examination, however, evidence (NICE NG10 2015) indicates a higher risk remains and that restraint can exacerbate underlying health conditions, substance misuse effect, so the decision to end monitoring must consider these factors
- Observations to be undertaken and recorded in the service users care record
 - *Pulse*
 - *Respiration Rate*
 - *Consciousness (Using the A.V.P.U. – G.C. Scale)*
 - *Heart Output (Using Capillary Refill Test)*
 - *Temperature*
 - *Blood Pressure when applicable*

6.7.7 Wherever possible individual members of staff should not be involved in physical interventions for longer than a period of 20 minutes without a break but must only

be relieved by someone else who has been fully trained in the use of physical interventions.

6.7.8 When the situation is under control and the person's compliance has been obtained allow the person to regain their autonomy as soon as is practicable.

6.7.9 Staff will complete required documentation in accordance with Health and Safety Policy and the Incident Reporting Policy

6.7.10 Complete the Incident Report and forward copies to the identified recipients.

6.7.11 The multi-disciplinary team will then discuss the future management of the service user, which will be fully documented in the care plan and regularly reviewed.

6.7.12 The person taking charge of the manual restraint intervention will instigate debriefing as soon as is practicable following any incident

6.7.11 Any physical intervention used should

- a) be reasonable and proportionate in the circumstances
- b) apply the minimum force necessary to prevent harm to the patient or others
- c) not include the use of mechanical restraint as the Trust does not currently utilize any specifically designed or improvised forms of mechanical restraint.
- d) be used for only as long as is absolutely necessary
- e) be sensitive to equality and diversity issues
- f) staff should be aware of the alternative methods of restraint to be used with the Elderly/Frail service users

7 Post Incident Reviews and Documentation

7.1 Once the situation is under control the incident will be fully documented using the Pennine Care NHS Foundation Trust Incident Reporting system and in the service user care records and will include

- a) details of the events leading up to the restraint being used
- b) the names of the staff involved in the restraint
- c) the length of time that restraint was used.
- d) Details of any situations where staff were unable to be relieved after 20 minutes of continuous restraint and the reasons why this was not possible.

- e) active physical observations (respiration rate, blood pressure, pulse, alertness, temperature and hydration) during and post physical intervention

N.B. the doctor will be contacted following any incident of restraint to examine the patient. This examination will be fully documented in the medical notes. The doctor will also sign the incident report form.

7.1.1 A review of the incident will be carried out by the multi-disciplinary team as soon as is practicable. Where necessary a risk management plan will be produced which explicitly states;

- a) under what circumstances restraint may be used in the future
- b) what form the restraint can take and how its application will be reviewed
- c) additionally where rapid tranquilisation has been used the service user will be offered a debrief and an opportunity to record their views as defined by the audit for NICE Schizophrenia Algorithm CG82

7.1.2 An audit of the use of manual restraint interventions will be carried out annually and or/as required

7.1.3 Post incident review should be a process and address what happened during the incident, trigger factors around the incident, each involved persons role, perceptions, feelings and concerns. As these are dynamic factors it is not appropriate to confine it to a one off session and use of other formats such as supervision may be used to pick up on recommendations arising from the incident review.

7.1.4 **Formal external post-incident review**

It is recommended that formal post incident review involves and is led by a service user who is expert by experience around physical restriction. This will be a development task within Pennine Care.

Both Service Users and Staff involved in manual restraint or an incident of aroused behaviour whether in an inpatient facility, community or clinic setting should be afforded the opportunity to review what happened. They should be told of their right to talk about the incident with an independent advocate (which may include an independent mental health advocate or independent mental capacity advocate), family member or another representative. However service users should not be compelled to take part in post incident reviews

Reviews may take several forms and should be seen as a distinct and separate process from counselling/support. The review process has the following aims;

- To produce an accurate description of the incident and the events leading up to the incident
- To ensure all necessary action has been taken after the incident to

ensure service user and staff safety (this may include referral for medical examination, documentation and notification of others: relatives, Police etc)

- To identify information that can be used to modify the services users risk assessment and care management plan
- To ensure that everyone involved has had an opportunity to talk, reflect, identify any remaining psychological distress and learn
- To ensure that documentation and statements made about the incident clearly identify the impact factors, level of aroused behaviour and level of force utilized by the team.
- To ensure that the service user has been given the opportunity to record their opinions, views and comments about the manual restraint. (Nice Guidance NG10)
- To ensure that others who witnessed the incident (other service users, carers, students, members of the public, other staff who were present etc) have an opportunity to express and record their views.

7.1.5 The post incident review should take place as soon after the incident as possible, but in any event within 72 hours of the incident ending.

Service Managers are responsible for ensuring that adequate support is provided for staff and others involved, immediately post incident.

7.1.6 Occasionally, staff and service users may experience longer term effects of being exposed to or involved with violence and aggression as a result of a single incident or ongoing exposure to actual or perceived levels of risk. It is the responsibility of the named health professional in working through 7.1.4 to identify these related needs for service users and care plan accordingly. A staff counselling and support service is available for staff who experience longer term effects. This can be accessed via the Human Resource and Occupational Health services

8. Seclusion (See Pennine Care Seclusion Policy CL26) Applies only to mental health services

8.1 Only people detained under the MHA should be considered for seclusion. If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to protect others from risk of injury or harm, then it should be used for the shortest possible period to manage the emergency situation and an assessment for detention under the MHA should be undertaken immediately. The MHA Code of Practice lays down clear procedures for the use of seclusion including its initiation, ongoing implementation and review.

8.1.1 The seclusion of a person under the MHA in a community setting (for whom neither a Deprivation of Liberty authorisation nor a Court of Protection order under the MCA to authorise the deprivation of their liberty is in place) is also likely to amount to an unlawful deprivation of liberty. If the circumstances of a person's care resemble seclusion, it is seclusion whatever it is called locally. An assessment should be undertaken promptly to determine whether the person should be detained under the MHA immediately.

9. Chemical Restraint: Rapid Tranquillisation (See Rapid Tranquillisation Policy CL14- Applies only to mental health services)

- 9.1 Please refer to the above policy supplemented by the NICE NG10 guidance. If the service user has any indication of cardiovascular disease, including a prolonged QT interval, or no ECG has been carried out, avoid intramuscular haloperidol combined with intramuscular promethazine and use intramuscular lorazepam instead.
- 9.2 The use of medication to manage acutely disturbed behaviour must be a very short-term strategy designed solely to reduce immediate risk; this is distinct from treating any underlying mental illness. The associated term 'rapid tranquillisation' refers to intramuscular injections and oral medication. Oral medication should always be considered first. Where rapid tranquillisation in the form of an intramuscular injection is required, the prescriber should indicate the preferred injection site having taken full account of the need to avoid face down restraint.
- 9.3 Face down, prone restraint should be avoided where possible and minimised when not able to avoid its use. In assisting with chemical restraint or in any other circumstance, face down, prone position (on any surface, floor or bed), restraint must be under 5 minutes in duration with turning into supine position (face up) as soon as the intra muscular injection is provided
- 9.4 Chemical restraint should be used only for a person who is highly aroused, agitated, overactive, aggressive, is making serious threats or gestures towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour.

10. Service User & Diversity Issues

- 10.1 Pennine Care recognises that service users have an important role to play in the management of violence and aggression. Also, strategies to reduce violence and aggression create a system and culture of safety that extends to staff, service users and all who engage with services. Services that promote inclusion and personalization are important in reducing aggression and violence.
 - 10.1.1 Being informed and consulted with are important means through which staff can demonstrate to service users that they are being treated with dignity and respect. This should take place regardless of culture, gender, diagnosis, sexual orientation, disability, ethnicity or religious/spiritual beliefs.
 - 10.1.2 The provision of information to service users in a suitable format is an important way in which staff can proactively reduce the risk of aroused/violent behaviour. Staff should ensure that along with the general information about their care, service users also receive:
 - the opportunity to have their needs and wishes (with regards to management of their behaviour) recorded in the form of an advanced directive (See Pennine Care Advance Directives policy) which states what interventions they would and would not wish to receive.

- The opportunity to have their needs and wishes expressed and considered in the form of an advanced statement
- A copy of their care plan containing a record of the risk assessment and behavior support management plan with respect to the service users and staff views in the management of the service users' behaviour.
- Information being provided in ways that support a person, who may not be able to verbalize, comprehends, read or use obvious communication methods. Positive and total communication strategies can assist in reducing challenging and aroused behaviour.

10.1.3 Following a physical intervention, staff (ideally were not involved in the process) should make attempts to ensure the service user understands why it happened.

10.1.4 Management of violence and aggression training programmes will be underpinned with values training and diversity awareness strategies, developed and supported by the Trusts' Diversity Awareness Team

10.1.5 Practical application of diversity training outcomes will be implemented within the Violence reduction training levels.

10.1.6 Through the use of training and MVA Incident audit the use of physical interventions will be routinely monitored to chart when they are used and with whom. There has been nationally a growing evidence base that restraint has been used disproportionately amongst some ethnic minority, gender and age specific groups using services. The ability to monitor the use of physical interventions within the Trust is a fundamental requirement in enabling services to identify if trends are developing. This in turn will be used to inform training, education and strategies to reduce aggression and violence where possible.

10.1.7 Managing violence and aggression in emergency departments (A&E)

If a service user with a mental health problem becomes aggressive or violent, do not exclude them from the emergency department. Manage the violence and aggression in line with the restrictive interventions guidance within this policy, including up to manual restraint, but do not use seclusion.

10.1.8 Managing violence and aggression in children and young people

A specific training course exists for CAMHS in patient staff which can be built into adult courses as extra learning outcomes. This addresses; understanding child development and challenging behavior, using restrictive interventions with this age group, adapting manual restraint techniques in accordance with the younger persons age, physical build and strength

11 Personal Safety Awareness

11.1 Personal Safety Awareness can do much to keep staff safe, in a variety of settings. Personal Safety Awareness for In Patient, Community and Clinic settings will be available under Level 2/3 Violence Reduction Training Programmes. Also the trust Think Campaign and the Local Security Manager will act as a resource for staff in this capacity.

11.2 Working with Violent and/or Aggressive Service Users in the Community

The procedures set out within section 6 “Policy Operation” should be followed in community settings with the exception of the following which would not be expected to be used in community settings:

- Physical intervention
- Seclusion
- Rapid Tranquilisation

Physical techniques in the form of disengagement/breakaway/rescue techniques can and should be used where necessary in community settings.

11.3 The law may allow services to be withdrawn from a patient where s/he or someone caring for him/her has been abusive, aggressive or threatening to someone providing those services. This also applies whether the services in question are provided in a hospital or in the community. However, before any decision is taken to withdraw services in such circumstances the Trust should be able to clearly demonstrate that it has attempted to resolve the situation by, for example, issuing formal warnings to the patient; considering sending two members of nursing staff if the service user is in the community or, for example, issuing the community staff who will be visiting with an alarm or mobile telephone, etc.

Legal advice should be obtained in such situations **before** the stage is reached where a decision is made to withdraw services.

12. EXPECTED STANDARDS OF BEHAVIOUR.

The following are examples of behaviours that are deemed to be **unacceptable** on Trust premises and within any site where staff are delivering services.

- Excessive noise, e.g. loud or intrusive conversation or shouting;
- Threatening or abusive language involving excessive swearing or offensive remarks;
- Harassment of another;
- Any derogatory, racial or sexual remarks;
- Malicious allegations relating to members of staff, other patients or visitors;
- Offensive sexual gestures or behaviours;
- Abusing alcohol or drugs whilst in receipt of services (However, all medically identified substance abuse problems will be treated appropriately);
- Drug dealing;
- Wilful damage to Trust property;
- Theft;
- Threats or threatening behaviour;
- Violence.
- Failure to adequately control animals/pets

12.1 SANCTIONS

The following sanctions will apply to individuals whose behaviour is in contravention of the Trust's expected levels of behaviour (Please see Section 12 above):

Visitors

- Visitors and relatives who display any of the above behaviours will be asked to desist and be offered the opportunity to explain their actions.
- Where visitors or relatives behaviour threatens staff whilst delivering services within their home. Concerns must be shared fully with the service user and relative. If the behaviour persists a plan to control exposure to this behaviour will be developed in consultation with the line manager.
- Commitment to continuation of patient care will be maintained, however, if there is a continued failure to comply with the required standard of behaviour then:
 - If at any Trust site, the offending individual should be asked to leave the Trust property. If they refuse to leave, assistance should be sought by calling the police direct to support the ejection of the offending individual.
 - Sections 119–120 of the Criminal Justice and Immigration Act (CJIA) 2008 create **a new criminal offence of causing a nuisance or disturbance on NHS premises and a power for NHS authorised staff** to remove a person suspected of committing this offence. This power can only be used on NHS hospital premises. The aim is to tackle low-level antisocial behaviour before it escalates to more serious offences such as assault. This is in line with the NHS Security Management Service (NHS SMS)'s commitment to protecting NHS staff from violence and, where appropriate, taking action against those who abuse, or attempt to abuse, them.

What is nuisance or disturbance behaviour?

Any form of low-level antisocial behaviour on NHS premises that breaches the peace. This can include:

- using foul language and verbally abusing NHS staff
- using intimidating gestures towards NHS staff, patients or visitors
- creating excessive noise in waiting areas or wards
- obstructing thoroughfares.

Who can be removed under the new powers?

The offence of causing a nuisance or disturbance and the power of removal apply to NHS hospital premises only. ***Patients or those seeking medical advice, treatment or care cannot commit the offence or be removed under the CJIA powers.***

- Any visitor behaving in an unlawful manner will be reported to the police and the Trust will seek the application of the maximum penalties and redress available in law. The Trust will prosecute all perpetrators of crime on or against Trust property, assets and staff.

- The relevant Director or Associate / Assistant Director, Manager / Senior Nurse may decide to continue to exclude any individual removed from the premises or restrict their attendance only to specific times and if necessary, under escort.

Service Users *(For mental health and learning disability the responsible clinician must be consulted for their clinical opinion on the service users behaviour and legal advice sought before the decision to use the sanction approach is made).*

- Following any incident the immediate manager or department head (or their deputy) will explain to the service user that his/her behaviour is unacceptable and explain the expected standards that must be observed in the future.
- If the behaviour continues, the responsible manager or clinician will give an informal warning about the possible consequences of any further repetition. This consists of a standard letter, which includes an acknowledgement of responsibilities agreement. The standard letter is available from the Health, Safety and Security Advisor/ Risk manager.
- Failure to subsequently desist will result in the application of what will hereafter be referred to as the Procedure for Care of Individuals who are Violent or Abusive. This will be by way of a formal written warning of the consequences of such behaviours. This consists of a standard letter, which includes a final written warning. The standard letter is available from the Health, Safety and Local Security Management Specialist / Risk Manager.
- If a service user complies with the terms of the Procedure for Care he/she can expect the following:
 - That clinical care will not be affected in any way.
 - That, where substance abuse has been identified, appropriate assistance will be provided.
 - That a copy of the Confirmation of the Procedure for Care of individuals who are violent or abusive will be filed in the Trust risk management office and a copy will also be kept in the patient's note indefinitely. A system for flagging will be developed, and once in place, use of the Procedure for Care will be highlighted on this system.
 - That the Health, Safety and Local Security Management Specialist / Risk Manager and the site managers will be informed.
 - Pennine Care will fully investigate all valid concerns raised by the patient.

- That the Procedure for Care will lapse after one year.
- Failure to comply with the Procedure for Care will, at the request of the relevant Director and the Director of Operations (or their nominated deputies) results in exclusion from the Trust. This consists of a standard letter, which includes the details of withholding treatment. The standard letter is available from the Health, Safety and Local Security Management Specialist/Risk Manager. **This does not apply to patients under the age of 18.**
- Such exclusion will last one year, subject to alternative care arrangements being made; the provision of such arrangements will be pursued with vigour by the relevant clinician.

For Example

A clinician will be required to refer the excluded individual to the alternative access to services arrangements and refer them to the conditions stipulated in the Procedure for Care.

- In event of an excluded individual presenting at the Trust's Walk in centre for emergency treatment, personnel will adopt appropriate measures to ensure their safety. The individual will be treated, stabilised and where possible, they would then be transferred immediately.
- Any patient behaving unlawfully will be reported to the police and the Trust will seek the application of the maximum penalties available in law. The Trust will pursue the prosecution of all perpetrators of crime on or against Trust property, assets, and staff.

13. Implementation and Training

- 13.1 Pennine Care provides a range of training options to ensure staff has the appropriate skills to manage disturbed/violent behaviour.
- 13.2 The Trust Training Needs Analysis (TNA – see Appendix 1) identifies who should receive what level of training, refresher periods and outlines the techniques each level will focus on for the Management of Violence and Aggression. Periodic risk assessment and review of risk data will continue to inform training as to what is taught and to whom.
- 13.3 All Conflict Resolution and Promoting Safer and Therapeutic Services Training will be provided by Trainers who have undertaken the relevant familiarization training with NHS Protect. Along with the Violence Reduction Trainers, this will include accredited Local Security Management Specialists
- 13.4 Pennine Care Violence Reduction Physical Intervention Trainers will work to nationally agreed syllabus (when available) and will be accredited to provide training by the national regulating body (when announced). Currently all trainers

will hold either the DipCRI (ENB) or the General Services Tutor Certificate. The syllabus content of the current courses is based on the NIMHE syllabus guidance.

- 13.5 Pennine Care Learning Disability Physical Intervention Trainers will work to a BILD Accredited Training Program and hold an instructors qualification from the course providers. A local Client Focussed Physical Intervention Training Protocol is utilized to manage all aspects of this training within learning disability services.
- 13.6 All Violence reduction training levels will have a values training session incorporated to foster acceptable and responsible attitudes to the use of physical interventions for each participant undertaking the associated competencies. The values base will be a working document displayed and revisited throughout each training course.
- 13.7 The Violence Reduction trainers will work proactively with Trust service Improvement groups to ensure that service user representation around MVA training is achieved.
- 13.8.1 The following training courses are also required for staff undertaking Manual Restraint Physical Interventions
 - Diversity awareness training
 - Clinical Risk Assessment training
 - Observation Training
 - Immediate Life Support – for qualified staff who administer or prescribe rapid tranquilisation (mental health staff only)
 - Basic Life Support – for those staff who undertake physical interventions
 - Seclusion Use Training (mental health staff only)
 - Search Training
 - Mental health Law training
- 13.9 Staff and Service Managers will use the IPDR process to ensure that the staff member accesses the appropriate mandatory violence reduction training courses within the timescales given.
- 13.10 Application to attend training courses will be accessed via the Pennine Care Workforce and Organisational Development service
- 13.11 Service Managers are responsible for ensuring that staff have the capability to undertake physical intervention and physical intervention training courses. Where staff are employed in a clinical area it is assumed that the ability to undertake the appropriate level of physical intervention forms part of the essential criteria for employment in that area.

Where staff cannot meet the capability requirement advice from Occupational Health about the persons suitability to undertake training will need to be sought with the member of staffs involvement.

Staff who are unable, for whatever reason, to take part, attend manual restraint training or violence reduction training (appropriate to their work role), must be considered in the context of being unable to meet the needs of their work role and appropriate management support plans and outcomes be put in place. This may include redeployment, performance management and appropriate workforce management policies.

Staff who do not remain compliant with violence reduction training may be subject to pay progression policies and /or other disciplinary procedures.

- 13.12 Before booking on a physical intervention course (Level 2/3 and Level 4 Courses) the nominating manager must use the risk screening tool (see Appendix 2). If the staff member being nominated to train identifies any of the listed risks as an issue for them, they must be referred to occupational health by the nominating manager for advice on both fitness to undertake training and fitness to perform physical interventions (and possibly other duties) in practice. Where occupational health identify that the person is fit to attend training the person must attend and bring along with them any specific guidance about their fitness to train provided to them by occupational health. MVA trainers will not provide any health or training related health advice. They may suggest amendments to techniques or training pattern to assist a staff member to successfully complete. Without a clear risk screen or advice from Occupational Health **ALL** staff will be turned away from training. The risk screen will be completed again on the first day of training to pick up Occupational health advice and any risks that have arisen between booking and attendance. Again if a new risk arises the staff member could be prevented from training.

14.0 Monitoring

- 14.1 Violence Reduction Trainers will work closely with clinical areas, incident reviews and service managers to monitor the efficacy of training strategies.
- 14.2 The Workforce & OD service will notify the authorising manager of any non attendance at any pre booked training via email. It will be the responsibility of the authorizing manager to ensure that further dates are arranged to attend the required training by the staff member.
The Learning and Development Department will produce monthly reports with details of staff attendance at the required training to service line managers. The MVA Manager will produce annual reports identifying levels of staff trained to each element of MVA training, attendance, non attendance to the Educational Governance Group (EGG). The EGG will ensure that any concerns arising from these reports an action plan is negotiated and taken to the Risk and Clinical Governance Committee and Divisional Governance Groups. Divisional Governance Groups will monitor the implementation of the any actions and update the Risk department accordingly.
- 14.3 Monitoring of support arrangements post incident is reviewed by the weekly Patient Safety Improvement Group meeting. At this meeting the Initial Reports (IR) for Serious Untoward Incidents (SUI) are reviewed. This will include the completion and quality of risk assessments and safety of staff in relation to Lone worker incidents and therefore Lone worker arrangements. Learning themes and actions

will be shared with the Training Department to inform future training arrangements for staff. Any actions arising from the SUI will be implemented by service areas and monitored by monthly Divisional Governance arrangements. The Risk department will receive updates on completion of action plans.

15 Audit

The policy and training will be audited annually using the criteria set out in NICE NG10 “The Short Term Management of Violence and Aggression in Mental Health, Health and Community Settings” and implementation is identified in the following table. The audit will include the completion of appropriate risk assessments The audit results will be reviewed by the Trust Risk and Governance group and an action plan agreed and monitored by this group also.

Audit Tool (Violence Reduction)	Frequency	Sample	Responsible
NICE CG 10 Audit*	Annually*	Trust wide In Patient Areas – mental health	Trust Clinical Audit Department & Violence Reduction Team
Data Informed Care: Safeguard report into frequency, type, duration of manual restraint across PCFT*	Quarterly	Trust wide In Patient Areas – mental health	Integrated Governance Violence Reduction Team Internal CQC inspection Team
Review of Violence Reduction Approach and Techniques*	Annually	Board Report & development plan	Executive Board Director of Nursing Violence Reduction Manager
High Quality Individual Support/Behaviour Support Plans, Audit*	Annually	Board Report & development plan	Trust Clinical Audit Department & Violence Reduction Team Internal CQC inspection Team
Environmental Assessment*	Once Annually/or new service commissioning or service reconfiguration and following serious untoward incident.	Trust wide All Service Areas	Individual Service Manager
Mental Health Act Code of Practice Criteria (2015)	Annually or by Serious Incident review	Trust wide All Service Areas	Mental health Law manager
Screening, Training and Documenting of physical intervention care plans – Learning Disability	Once Annually	Learning Disability Services	Learning Disability Physical Intervention Training Lead

*Under the DoH Guidance and NICE NG10, these audits, reports and data findings must be made available to service commissioners and will be a focus for CQC inspection.

16 COUNSELLING & SUPPORT

Being subject to a violent or aggressive situation can be a traumatic experience. Counselling and/or advice will be made available for staff who have been affected by a violent or aggressive incident which has occurred in the workplace.

The LSMS will provide support to staff following a violent or abusive incident until investigation or other action has been concluded, A persons line manager will arrange counselling; occupational health services or along with the LSMS visits to court if necessary.

The Trust will support the member of staff to progress the incident through the judicial system, allowing appropriate time-off to seek legal advice/attend court and providing evidence.

Further support and advice is also available from :

- Line Managers
- Staff-side Representatives
- Occupational Health Service
- Staff Well Being service

Staff will also be supported by the Trust in applying for compensation through the Criminal Injuries Compensation Authority where they have been injured by a member of the public.

The Trust will also deal with any press enquiries in relation to reported incidents to ensure that the privacy of the staff member is maintained.

Appendix 1 Training Needs Analysis

Training levels

MVA Level 1 – Induction, ALL STAFF WILL COMPLETE BEFORE COMMENCEMENT OF DUTIES. Refresher: NONE Objectives MVA Policy Awareness, Key People, Role of Local Security Management Specialist and next steps in terms of further training and local induction.

MVA Level 2 – Conflict Resolution Training. All COMMUNITY SERVICES STAFF (**Not** Mental Health or Learning Disabilities Staff) who work with service users, carers, relatives or the public in any capacity (including telephone calls) will complete within 3 months of starting employment. Refresher: Every 3 Years. Objectives: National Non-Physical Syllabus to the 10 national objectives set by NHS Protect.

MVA Level 2 – Promoting Safe and Therapeutic Services. ALL MENTAL HEALTH & LEARNING DISABILITY STAFF. who work with service users, carers, relatives or the public in any capacity (including telephone calls) will complete within 3 months of starting employment. Refresher: Every 3 Years. Objectives: National Non-Physical Syllabus to the 10 national objectives set by NHS Protect. For Mental Health staff Physical Disengagements (Level 3) are combined with this course.

MVA Level 2 – Personal Safety and Lone Working. COMMUNITY MENTAL HEALTH STAFF ONLY at current time where majority of role is spent in lone working situations. Refresher: Every 3 Years. Objectives National PSTS Syllabus with focus on personal safety and lone working

MVA Level 3 – Physical Disengagements/Rescue Skills. MENTAL HEALTH STAFF ONLY at current time. Refresher Every 3 years. Objectives Breakaway Skills. This course runs in conjunction with Level 2 PSTS and Level 2 Personal Safety & Lone Working.

MVA Level 4 – Team Physical Intervention (Adult & Young Person) Mental Health. All Mental Health In Patient Nursing Teams (Other professions by local agreement) where team restraint is required. Refresher: Every 12 months. Objectives: NIMHE Physical Intervention Standards and NICE standards. Must Complete appropriate level 2/3 course prior to attending.

MVA Level 4.1 – Team Physical Intervention (Older Adult) Mental Health. All Mental Health In Patient Nursing Teams (Other professions by local agreement) where team restraint is required. Refresher: Every 12 months. Objectives: NIMHE Physical Intervention Standards and NICE standards. Must Complete appropriate level 2/3 course prior to attending.

MVA Level 4.2 – Team Physical Intervention (Adult & Young Person) Learning Disabilities. All Community Services Learning Disability Staff where team physical interventions are required. Refresher: As stated in Program. Objectives: British Institute of Learning Disability Accredited Standards/Outcomes.

MVA Level 5 – Personal & Area Searching and Secure Vehicle. All Mental Health In Patient Teams (each team are required to have identified a number of staff to undertake the role) who are required to search individuals, their property etc and/or use the Secure Vehicle. Learning Disability teams by negotiation. Refresher: None but staff may be required to refresh if complaint or incident occurs around the subject area. Objectives: Consent, legality, search Patterns and vehicle/driving familiarisation.

Appendix 2: MVA Level 2/3 and 4 training Risk Screening Tool

PREVENTION AND MANAGEMENT OF VIOLENCE AND AGGRESSION

PARTICIPANT RISK SCREENING

The management of violence and aggression is a clinical operational requirement that requires staff employed to carry out such duties to be physically able to when required. The following is to be used to review a staff member fitness and prior to booking onto a level 2/3, 4, 4.1 or 4.2 course. It is only a prompt sheet requiring a referral to Occupational Health for assessment to carry out MVA duties and/or to attend a course where a health issue is identified. Where a staff member indicates a health issue exists they will not be allowed to train unless specific Occupational Health advice is provided (in written form to the PMVA Instructors) prior to or on the first day of training. A Line Managers' recommendations regarding health and MVA training will not be acceptable as adequate risk management for attendance at training. If a staff member attends without specific Occupational Health advice regarding training and/or operational participation in MVA duties, they will not be permitted to train. This has to be repeated at each attendance at a Level 2/3, 4, 4.1 or 4.2 training course or a change to health status with respect to day to day operational PMVA duties.

The PMVA Team can often amend or adapt techniques if they are provided with the risk information from Occupational Health and the extent of the health issue on the persons' physical abilities are fully disclosed and discussed by the staff member prior to training with them. For this reason and to capture any change in health from booking onto and actual course attendance, the screening will be carried out again and risk management advice provided on the first day of every course.

This form should be completed between the Line Manager/Person booking the staff member onto the Level 2/3, 4, 4.1 or 4.2 PMVA Training Course and the nominated Staff Member

PLEASE ANSWER YES OR NO IF YOU HAVE A HISTORY OF, OR CURRENTLY SUFFER FROM ANY OF THE FOLLOWING:

	YES	NO
Epilepsy		
Diabetes		
Dizziness/Light Headedness		
Anaemia		
Joint Pain		
Back Pain/Injury		
Weight Related Issues affecting your mobility (standing/kneeling)		
Heart Condition		
Chest Complaint		
Asthma		
High or Low Blood Pressure		
Fracture past 12 months		
Surgery past 12 months		
Pregnancy now or past 12 months		
Any other Health issue that you feel will affect your ability to undertake physical intervention duties or the training course?		
Currently using prescribed medicines?		
Have you seen a Doctor or any other Health Care Professional in the last 3 months for any reason, which you feel may affect your ability to undertake this training course?		

Appendix 3 - Secure Transport Protocol

Aim

- To provide guidance, information and operational procedures for the safe and secure transfer of service users within Pennine Care Trust services and to external services as required.

Purpose:

- To provide a safe and secure transport environment for service users, staff and other road users
- To ensure the balance of security with the privacy, dignity and respect for the service user during transport
- To describe training requirements for the safe operation of the vehicle.
- To identify the procedures for vehicle maintenance, storage, documentation and operational readiness.
- To identify risk management required for the clinical and operational use of the vehicle
- To describe the supervision and audit procedures for secure transport use and its management.

This protocol reflects some of the planned developments around security, safety and MVA training. Where these planned developments are referred to they are displayed in ***Bold, Italics***.

1. Use of the vehicle

- The secure transport will be only used for the transport of patients who require it based on their individual level of assessed risk.
- The following risk assessments should be referred to and completed prior to any transport taking place.

For the Patient

- TARA (Trust Approved Risk Assessment)
- Transport Risk Assessment (TP1)

For the Team and Patient

- Transport Risk Assessment (TP1)

2. Criteria For Use

The vehicle will be used for:

- Transferring patients detained under the 1983 Mental Health Act from in-patient facility to another facility.
- Transferring patients who have been risk assessed as identified in 1

- Transferring above patients within the Pennine Care NHS Foundation Trust Footprint.
- Transferring the above patients outside of the Pennine Care NHS Foundation Trust Footprint.

Informal patients who present increased levels of risk may be transferred in the vehicle but this would be occasional and infrequent.

Escort and supervision of patients within the High Support and Forensic Directorate who are attending court, returning to other places of detention etc and who have been designated at risk of absconding.

The vehicle will not be used for

- The conveyance of patients from home to hospital under the Mental Health Act (1983) following assessment in the community, A&E etc. The vehicle is not covered by the conveyance responsibilities of the ASW or the Police under this and section 136 statutory duties.
- Transferring patients who do not meet the risk criteria and those who are medically compromised. Most often where intravenous rapid tranquilisation has been utilised an emergency ambulance will always be used. Where patients have undergone rapid tranquilisation by intramuscular injection, their vital signs should be monitored for a minimum of 45 minutes prior to using the transport with no exceptional signs noted.
- Rehabilitation, social or non-secure use trips. This is to maintain the readiness of the vehicle for use when required.

Only the patient and escorting team will be transferred. The vehicle is not designed for relatives, carers, friends or any others to be present in the secure compartment of the vehicle.

As students are not expected to display team physical intervention skills or indeed trained, they will not occupy the secure compartment, however as a functional training competence/ reflective experience it may be valuable for student to observe the process. With the senior nurse managers obtained agreement and as a learning objective, a student may occupy the driver's compartment with the driver.

Escorting Staff

There will be a minimum of 3 escorts in the secure compartment. This does not include the driver. A completed risk management plan will advise the clinical team if extra escorts are required.

The escorts will primarily be nursing staff and the driver from the list of registered drivers

A minimum of 3 escorts with at least 1 of them a registered nurse will be required to effect safe and secure escort. The escorts can include members Pennine Care

safety/security officers where they have received appropriate Level 4 & 5 MVA training and are within accreditation date.

Where this cannot be achieved the senior nurse will use line management resources to agree and source extra staff to support the transfer.

All escorting staff will be MVA level 5 Transport Team Trained and within accredited period of training.

Driver and Team

- *Training Package*
- *Minimum of level 5 Transport and Escort Team Training (3.5 hours.)*
- *Physical Intervention Procedures*
- *Driving and Journey Protocols*
- *Securing Patient.*
- *Out of Vehicle Walking Escort*
- *Documentation of Secure Transport use and procedures*

Additionally authorised personnel only are permitted to transfer patients – at least one person must be a qualified First Aid trained escort.

The driver remains in communication with base station for emergencies only via mobile phone, observing the Pennine care driving protocol

The lead escort has a separate locking release fob for emergency situations. The driver will always carry the other locking release fob/controls in the driver's compartment.

- Log of Drivers to be maintained as part of MVA and Oldham Crisis Team who will manage the vehicle on a daily basis, however they are not responsible for locating escorts and/or drivers. This should come from the requesting service.

Protocol for Vehicle Management

1. Vehicle Insurance, Road Fund Tax, Parking Permit Pennine Acute NHS Trust) MOT, Fuel Purchasing and Servicing.

Registration, servicing and eventual MOT testing will be facilitated by the Pennine Care Estates and Facilities Transport Fleet Manager.

A Fuel Purchasing card will be set up for use with the vehicle via the transport manager and be stored with the vehicle user pack.

2. Vehicle Storage

The secure vehicle will be stored and returned after each use to a designated parking space at the Royal Oldham Hospital Mental Health Unit site. The parking space is within barrier controlled parking for the hospital site and covered extensively by CCTV. This will aid security for the vehicle itself.

3. Weekly and in use checks.

The condition and readiness checklist will be used before and after each journey by the driver and once weekly (if not used in a one week period) by a member of the MVA training team. This arrangement will be reviewed after 12 months with a view to transferring the responsibility to the established Safety Officer team and/or the care group utilising the transport most frequently.

Completed checklists will be stored in the vehicle user packs, reviewed by the MVA team weekly. It is essential though that any fault conditions that arise with the vehicle are reported immediately to the Trusts Estates Department and the Oldham Crisis team:

See Condition and Readiness Checklist

4. Incident Reporting

The vehicle will have its own incident book as directed by Pennine Care Risk and Incident reporting policies. The purpose of this is to provide a direct audit trail of incidents relating to its use. Incident forms will be completed by the users and processed as per Pennine Care policy

The incident book will be part of the vehicle user pack.

5. Risk Assessment Checklist

The following risk assessments will be required:

- a. Most recent completed TARA Risk Assessment that documents issues around the behaviour requiring the person to be transferred.
- b. Transport risk assessment for the service user.

See Transport Risk Assessment

6. Fully Charged Mobile Phone

A mobile phone (Number: 07771611923) is available for use by the driver. The phone will be held with the vehicle users pack.

The phone is only to be used in emergencies and/or to contact the escort teams base if a change of route or significant time delay is incurred. The phone will be charged each week as part of the weekly vehicle inspection.

7. Booking Procedure

Between 09:00hrs – 16:00hrs

It is anticipated that and teams should strive to ensure that secure vehicle transfers take place during the above hours except in extreme situations where transfer outside these hours is required immediately.

Transfer between these hours will ensure that more staff are available to undertake and to support the procedure. The MVA team will also support these transfers where possible during these hours through the provision of a driver/coordinator.

Contact the Oldham Crisis Team and state the transfer information i.e.

- a. Name of Staff requesting transfer
- b. Name of Patient to be transferred
- c. Point of departure, d. Destination
- e. Names of Authorised Escorts (Confirm at least one RMN & First Aid Trained person)
- f. Completed Risk assessment & management plans for the transfer
- g. Relevant information e.g. level of arousal/medication used and
- h. Completed Journey Planner

The Driver Coordinator will pick up the vehicle and carry out a user check prior to starting the transfer. This will include fuel level check.

On arrival at the departure point the Driver Coordinator, Clinical team and Authorised Escorts will review the risk information and update any changes in the service users presentation. The level of escort, escort patterns and physical intervention (should it be required) should be set at this point.

Where IM rapid tranquilisation has been used the clinical team will ensure that vital sign observations have been carried out for 45 minutes prior to leaving the hospital site to start the transfer.

Where the service user has been aroused, struggling or undergone team physical intervention for more than 45 minutes, the person must be assessed by a doctor who should agree that the person is fit to be transferred by secure vehicle or whether another more suitable vehicle should be used e.g. Paramedic Ambulance. The transfer by secure vehicle should not go ahead where the service user displays any sign of respiratory distress, physical ill health, late stage pregnancy, dehydration, lowered and/or decreasing consciousness i.e. not responding to verbal prompts or where the RMO has stated that it is not suitable.

The patient should be escorted to the vehicle and seated using the MVA Level 4 and 5 competencies as trained.

Everyone in the vehicle must use the seatbelts provided.

Any luggage must be stored behind the seating at the tailgate of the vehicle.

The receiving unit will be telephoned by the services users ward and informed that the escort team have left with the patient.

The route followed will be that stated and documented with the ward. 1 copy will go to the senior staff at the departure point and one will be carried by the driver for reference. Any departure from the route due to unforeseen circumstances will be reported back to the departure point for them to convey to the receiving unit.

On completing the transfer, the driver coordinator will complete the user check, refuel if fuel levels are low and return the vehicle to its designated parking space at Tameside Mental Health Unit.

ALL incidents should be reported to the Risk Department via the incident reporting system and to the MVA Manager.

8. Journey Planner

- A –Z of Greater Manchester is supplied with vehicle to assist with route planning
- Route Planning via free online internet resources e.g. route master/route planner if printed out are acceptable as documented route plans
- A satellite Navigation System is available for use with the vehicle
- For longer journeys a copy should be submitted to the Borough-On-Call manager (Departing Borough) if out of normal hours work is going to be incurred.

9. Extended journey protocol

- Where a single leg of a transfer is more than 45 miles/1.5 hours in duration the driver/coordinator should (if needed) make, as part of journey planning a scheduled rest/toilet break. As breaks and escorts out of the secure transport increase risk of absconding these should be kept to a minimum.
- Food and hydration should be considered for journeys over 3 hours. Pre packed/ bought sandwiches and drink should be obtained observing service users requests and diversity issues
- The driver/coordinator should report by mobile phone hourly regarding the progress of the transfer to the nominated senior staff at the departure point, observing Trust protocol on safe driving.
- A second drive/coordinator should be present on longer transfers (over 200 miles) to prevent driver fatigue and share the driving tasks

Audit.

1. *Annual report taken from logs*
2. *Distance*
3. *Incidents*
4. *Maintenance*

Environment.

1. *Valeting procedure*
2. *Cleaning cost*
3. *Deep clean team*
4. *First Aid Kit*

These issues will be highlighted by the vehicle user checks and action to redress facilitated via the transport manager. It is the responsibility of ALL staff using the vehicle to maintain basic cleanliness.

Secure Vehicle

USER PACK: Transfer Risk Assessment

The following assessment and management plan is designed to ensure that the patient, team and other road users remain safe during the transfer of a potentially behaviourally aroused person. It should be used as a series of prompts and action planning to collect and manage known risk information regarding the patient in specific relation to the transfer task.

Patients name:

Date:

Assessor:

	<i>Risk Issue</i>	<i>Prompts/Action</i>	<i>How will this be managed and by who?</i>
Patient Factors	the patient have known medical risks related to restraint?	der: Obesity, Acute & Chronic Respiratory Conditions, Pregnancy, Head Injury, Cocaine based Drug use, Sensory Impairment	transfer team must be MVA Level 4 Competent and in date with accreditation (CHECK WITH TEAM). in charge of the transfer
	the patient undergone ground prone or seated flexed restraint in the last 24 hours?	change to vital signs during or after restraint been observed?	Yes, however if adverse reactions have been observed (Respiratory rate below 12 per minute/ Consciousness drop to Unresponsive) then Paramedic Ambulance to be used. Paramedic intervention team escorting the patient.
	Rapid Tranquillisation or PRN (Oral or Intra muscular) medication been given to the patient prior to transfer?	patient MUST have vital signs observed & documented for at least 45 minutes BEFORE the transfer begins	Assign someone to vital sign observations and document to MVA and Rapid tranquillisation policy standards before and throughout the transfer. Paramedic intervention Team Head Person.
	IV. Rapid Tranquillisation been administered, by a Doctor, to the patient prior to transfer	medication has been used the patient can ONLY BE TRANSFERRED BY PARAMEDIC AMBULANCE	Paramedic Ambulance Transfer. Nurse in charge of the Transfer
	the patient walk unaided to the vehicle (see below on restraint and escort requirements)	patient is so sedated that they need to be carried then Paramedic Ambulance to be used	Paramedic Ambulance Transfer. Nurse in Charge of the Transfer
	the RMO stated that the Patient is medically fit to be transferred by the secure vehicle?	RMO's guidance and consent.	Paramedic Ambulance Transfer. Nurse in Charge of the Transfer
	the patient have an absconding risk history?	incidents especially under escort absconding transfers involve a scheduled break (Over 45 miles/1.5 hours in duration)	Level 5.1 Escort Patterns Paramedic Ambulance Transfer. Nurse in Charge of the Transfer
	the patient been searched for potential sharps or weapons?	Ensure sharps and weapons from being taken into the secure vehicle. Remember Person and luggage should be stored behind the seating in front of the rear tailgate	Level 5 Search Competencies Paramedic Ambulance Transfer. Nurse in Charge of the Transfer
Team & Transfer Factors	the Journey been planned and route details left with ward/unit & MVA Manager?	trips the proposed route to be filed with ward and MVA Manager	Paramedic Ambulance Transfer. Nurse in Charge of the Transfer
	the transfer team MVA Level 5.1 trained?	appropriate numbers are in the team for short and longer distance transfer (including second driver)	Paramedic Ambulance Transfer. Nurse in Charge of the Transfer
	the door lock fob been assigned to the transfer team (not driver)?	of vehicle emergencies where the driver is unable to unlock the rear compartment	Paramedic Ambulance Transfer. Nurse in Charge of the Transfer
	all the required vehicle checks been carried out and recorded?		Paramedic Ambulance Transfer. Nurse in Charge of the Transfer

Secure Vehicle USER PACK: Weekly/In Use Checklist

This form is to be completed before and after every journey by the authorised Driver Coordinator for the transfer.

Date: _____ Driver/Coordinator: _____
 Time: _____ Transfer details: _____ (Please note do not record patient details just
 Borough, Start _____ and end destination details)

Mileage: _____

Item	Condition (state if damaged, tick if okay)	Action Required	Reported to & date	Date Completed
Fuel	E H F			
Rear View Mirror				
Driver Wing Mirror				
Passenger Wing Mirror				
Headlights (Full & Partial beam)				
Front Indicators				
Rear Indicators				
Interior Lights				
Air Conditioning				
Tyres (Indicate Which)				
Water Washer level				Weekly Check Only
Engine oil level				Weekly Check only
Radiator water levels				Weekly Check only
Internal Cleanliness				
External Cleanliness				
Damage: Visual Inspection				
Horn:				
2 Way Radio Check:				
Other:				

Time Transfer Completed: _____

Signed _____

Print Name & Designation: _____

Incidents: (Record Incident Log Number) _____

Please leave this form in the Vehicle User Pack Folder