Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
Title:	**Placing a Risk of Violence Marker on Electronic and Paper Records**
Version:	**3**
Reference Number:	**CO080**

Scope:

This policy applies to all staff within the organisation.

Purpose:

The purpose of the risk of violence marker system is to:

- Provide an early warning for NHS staff of a particular individual or situation that represents a risk to them, their colleagues or other patients
- Provide security warnings and handling advice to NHS staff to avoid or minimise the risk
- Help reduce the number of violent incidents at the local level
- Assist in creating a safe and secure environment for staff, patients and visitors

Requirement for Policy

Best Practice

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Data Protection Act 2018

GDPR - Changes

Owner:

Security Management Specialist & Police Liaison Officer – Karl Adderley

Individual(s) & group(s) involved in the Development:	
This document has been developed in collaboration with the following interested parties: • Sarah Brown • Paul Byrne	
Individual(s) & group(s) involved in the Consultation:	
The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly: • Health and Safety Committee	
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Responsibility of:	Security Management Specialist & Police Liaison Officer

Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
IG009	Paris Alerts Policy
CO038	Violence Reduction Policy Positive and Proactive Interventions V7
CO009	Health and Safety
CO019	Working Alone Policy

CO010	Incident Reporting, Management and Investigation Policy
IG005	Information Security
CL003	Care Programme Approach Policy (CPA)
Policy Associated Documents:	
TAD_CO080_01	Examples of the types of incident that may warrant a marker
TAD_CO080_02	Decision-making process flowcharts
TAD_CO080_03	Risk factors checklist
TAD_CO080_04	Sample proforma for risk of violence
TAD_CO080_05	Template for marker notification letter
TAD_CO080_06	Template for notification of the removal of a marker
TAD_CO080_07	Procedure for Placing a Risk of Violence Marker on Electronic and Paper Records
Other external documentation/resources to which this policy relates:	
	GDPR 2018 plus the Information Commissioner's Office (ICO) guidance on the DPA and use of violent warning markers
	Secretary of State Directions to health bodies on dealing with violence against NHS staff (2003) and security management measures (2004)
	Health and Safety at Work Act 1974
	The Management of Health and Safety at Work Regulations 1999
	Safety Representatives and Safety Committees Regulations 1977 (a) and The Health and Safety (Consultation with Employees) Regulations 1996 (b)
	The Corporate Manslaughter and Corporate Homicide Act 2007
CQC Regulations **This guideline supports the following CQC regulations:**	
Regulation 17	Good governance
Regulation 12	Safe care and treatment
Regulation 13	Safeguarding service users from abuse and improper treatment

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1. INTRODUCTION

Policy intention and aims

The purpose of the risk of violence marker[1] system is to:

- Provide an early warning for NHS staff of a particular individual or situation that represents a risk to them, their colleagues or other patients
- Provide security warnings and handling advice to NHS staff to avoid or minimise the risk
- Help reduce the number of violent incidents at the local level
- Assist in creating a safe and secure environment for staff, patients and visitors

It is important to note that the marker is not a mechanism for attributing blame, but is intended to alert staff to the risk of violence.

2. DEFINITIONS

Health and Safety Executive definition

The Health and Safety Executive (HSE) definition of work-related violence is as follows:

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

NHS Protect definition

NHS Protect's definition of physical and non-physical assault are laid out in Secretary of State Directions and used for incident reporting purposes.

1) Physical assault: *'The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort.'*
2) Non-physical assault: *'The use of inappropriate words or behaviour causing distress and/or constituting harassment.'*

In addition it is useful to note the definition of a Hostile Environment:

Hostile Environment – 'home visits where there may be a high level of gangs or congregation of individuals, unruly children/dogs, frequently asking intrusive or suggestive questions, intimidating language, isolated housing.

[1] A marker is notation on an electronic system or paper record which denotes a risk to staff

3. ROLES AND RESPONSIBILITIES

Security Management Director

The Trust Security Management Director's (SMD) is responsible getting the support of the Board for security management strategies and initiatives, including a scheme for placing risk of violence markers on patient records.

Security Management Specialist

The LSMS is responsible for:

- Investigating incidents of violence
- Gathering evidence from victims and witnesses
- Contributing to a risk assessment
- Making the recommendation and/or decision on the need for a marker
- Ensuring that all relevant staff have access to the necessary information, particularly those working off-site or outside office hours

The role of the LSMS is not to establish whether the act was intentional or based on an underlying clinical condition, treatment or care, but to assist staff in managing future risks.

Senior Clinicians

The role of Senior Clinicians in relation to this policy is to provide advice to the LSMS as required, where an individual's medical condition or medication has contributed to an incident of violence or aggression to inform the wording of the alert.

Departmental / Line Managers

All managers should ensure that staff who work under them report all incidents of violence and are aware of the policies and procedures in place regarding risk of violence markers.

Managers will be responsible for contributing to the risk assessment which is undertaken following an incident involving one of their staff members and before the decision is made whether to mark an individual's record.

Staff

It is the responsibility of all staff to take reasonable care of themselves, to familiarise themselves with all relevant policies and procedures, to take preventative measures when they identify a potential risk of violence, and to report all incidents of physical and non-physical assault to the LSMS for follow-up investigative action.

When a marker is placed on an individual's records, staff should know what is expected of them. This includes being aware of the risks associated with the individual and necessary handling information and advice on putting in place preventative measures.

Where staff do not have direct access to health records it is the responsibility of the Senior Service Manager to cascade the information to them.

External Health Bodies

It is anticipated that information about risk of violence markers is to be shared with the other bodies e.g.: GP Practices, Acute Trusts, or any other body where it is necessary to do so to manage the risk.

Where information is shared then it is the responsibility of the Service Manager sharing the information to ensure that information is provided in accordance with this policy and in line with the relevant legislation. Where information is shared with any of the above then this must be clearly noted within the patient's record.

4. CRITERIA FOR A MARKER

Types of Incident

TAD_CO080_01 provides examples of the types of incident which may warrant a Violent Patient marker.

The same principles apply whether placing a marker on the records of a patient or a patient's associate (carer, relative or friend).

Reporting and Investigating

Following the report of an incident where a marker is being considered the LSMS will review the various sources of information available before making a decision about whether a record should be marked. These include:

- Incident reports
- Investigation of the incident
- Consultation with the victim, their line manager and other relevant staff
- Statements taken from witnesses

Any decision to use a marker will be based on a specific incident and not personal opinion or hearsay.

In certain circumstances where there is a severe or imminent risk to staff it might be necessary for the LSMS to make an immediate decision before the completion of a full investigation.

Risk Assessment

Where an incident has occurred which may require a marker or a risk assessment has been undertaken which identifies a need for a marker the following risk factors should be considered:

- Nature of the incident (i.e. physical or non-physical)
- Degree of violence used or threatened by the individual
- Injuries sustained by the victim (including psychological)
- The level of risk of violence that the individual poses
- Whether an urgent response is required to alert staff
- Impact on staff and others who were victims of or witnessed the incident

- Impact on the provision of services
- History of any previous incidents and/or the likelihood that the incident will be repeated
- Any time delay since the incident occurred
- The individual has an appointment scheduled in the near future
- Whether staff are due to visit a location where the individual may be present
- Whether the individual is a frequent or daily attendee (e.g. to a clinic or out-patients) or an inpatient
- Whether staff may come into contact with the individual while working alone
- Whether the incident, while not serious itself, is part of an escalating pattern of behaviour
- The medical condition and medication of the individual at the time of the incident.

A risk assessment regarding the marking of records should include these factors, as well as additional information provided by health and safety or staff-side/union representatives.

Risk assessments should be in accordance with the Trust's risk management policy.

See TAD_CO080_03 for a checklist which may assist in the risk assessment.

5. DECISION-MAKING PROCESS

LSMS

It is the role of the LSMS to make the final recommendation on the need for a marker based on information gathered and the results of the risk assessment.

No action required

There may be circumstances where, following an investigation and risk assessment, the LSMS decides that it is not appropriate or necessary to mark the record. In some cases, this may override a senior clinician's decision.

The decision not to mark a record should also be recorded.

6. PLACING A MARKER ON RECORDS

Access to patient records

The LSMS has access to electronic patient records for the purpose of using markers to warn staff of the potential risk of violence. However, there may be occasions where a patient's notes are not held on a system. In this case the LSMS will need to liaise with the Trust's health records manager, data protection officer and/or information governance manager in order to access and appropriately mark those records.

Essential Information

All markers must have appropriate and essential information recorded[2]. It is recognised that the Trust current clinical electronic systems do not allow for much detail to be recoded. It is anticipated that where a marker has limited detail then the staff member will contact the SMS for further information. However, the marker should include:

- Who, or what the marker applies to
- A brief classification of the type of incident (see TAD_CO080_01)
- Date the marker is effective from
- Whether the individual has been notified
- Essential and relevant handling information or advice to staff
- Date for review

Additional information to help staff manage the risks may include:

- A brief description of the incident, e.g. physical or non-physical assault
- Information relating to an individual's medical condition, treatment and care if relevant
- Advice that the individual should not be denied treatment and care.
- Security warnings, specific areas of risk or trigger factors
- A relevant contact or actions for staff who work off-site or out of hours and whom they should contact if another incident occurs (e.g. LSMS, security personnel or police).

Paper records

Where The Trust uses paper-based records, then any marker should also contain the essential information.

TAD_CO080_04 provides a template risk of violence marker to be used in paper records. This serves as an example, and it is expected that the template will be adjusted based on local requirements, provided that it includes all of the necessary information listed above.

Patient's associate

Where an incident was committed by a patient's associate, a marker will be placed on the associate's record if their identity is known and their records are available to the Trust.

When a marker is also placed on the records of the patient with whom the violent individual is associated, it will be made very clear whom the marker applies to, in order not to stigmatise the patient.

In certain circumstances it may be appropriate to use photo or CCTV video in the markers to make the relevant staff aware of the identity of the associate? In each case the relevance of the data will be discussed with the Information Governance Manager before any action is taken.

[2] It is recognised that the Trust current clinical electronic systems do not allow for this level of detail to be recorded. It is anticipated that where a marker has limited detail then the staff member will contact the SMS for further information.

Dangerous Animals

Where an animal is involved in an incident (e.g. a dangerous dog) and the patient is responsible for the animal, their records should indicate this and will include relevant information relating to the animal e.g. any discussions or agreement held with the patient.

7. IMPLICATIONS FOR STAFF

Training

User guides will be disseminated to all staff advising of procedure and protocols for both paper and electronic records.

8. NOTIFYING THE INDIVIDUAL

The LSMS, in consultation with those associated with the patients care, will decide whether or not it is appropriate to notify the patient of the record marker

Notification letter

The LSMS will be responsible for sending a notification letter to the individual following the decision to place a marker on their records? Any decision should be communicated to the patient where appropriate within four weeks of the decision being made.

Where the incident is committed by an associate of the patient, a letter should be sent to both the patient and the associate. The LSMS will consult the IG Manager in making this decision.

The individual must be made aware of what that information associated with a marker may be shared, with whom, and for what purpose. The individual will also be notified that the information shared is within and subject to data protection laws.

A sample is attached at TAD_CO080_05 which may be amended according to local needs.

Decision not to notify

The LSMS May decide it is not appropriate to notify the patient of the marker where:

- informing the individual may provoke a violent reaction and put staff at further risk; or
- notification of a marker may adversely affect an individual's health.

All decisions will be maintained on the Trust database for scrutiny.

9 INFORMING THE VICTIM

Where it is appropriate the LSMS should inform the victim of the assault when a decision has not been reached about placing a risk of violence marker. If it is decided that a marker is not required, the LSMS will explain the reasons to the victim and offer any further assistance if necessary.

This information will be shared with the individual as soon as is practicable following the decision being made.

10. INFORMATION SHARING

Principles

The following circumstances may make it permissible and legitimate to share information contained in risk of violence markers among staff and with other providers or health bodies? e.g.:

- There are identified risks of violence which may affect staff who come into contact with the patient, internally or externally
- The processing is fair and justified
- Disclosures should be proportionate and limited to relevant details.

Current data protection legislation – the ICO's Guide to Data Protection and *'Data Protection Good Practice Note - The use of violent warning markers'*, as well as any other guidance published by the regulatory and professional bodies, will be considered.

Risk Assessment

A risk assessment process will be used to determine with whom the information contained in risk of violence markers needs to be shared will be completed by the LSMS and relevant staff. This should cover all external people or organisations that may come into contact with the patient and/or their associate e.g.:

- All NHS staff who are involved in the care of the individual
- Other NHS trusts and ambulance services
- GP practices
- Community pharmacies
- Social Services

Process

Relevant internal and external staff with access to electronic or paper patient records will be alerted to the existence of a marker and associated information via the LSMS and relevant managers.

This information will be securely shared by email.

11. REVIEWING A MARKER

Procedure

When making a decision to place a marker on a patient record consideration will also be given to the length of time the marker will be on that record. Markers will be reviewed every six months to ensure they are up-to-date and remain relevant. Review dates can be extended by the Trust if the Marker is an ongoing one and has been in place for more than 18months. The maximum period between reviews can be 12 months.

The procedure for periodic review of markers to ensure they are still necessary and up to date will be that the LSMS will contact appropriate staff member up to one month before the review date to assess whether there are any continued concerns. The incident reporting system will also be reviewed to ascertain if there have been any additional incidents.

Where a decision is taken that the individual's behaviour gives no further cause for concern and there is no longer a risk. The LSMS is responsible for ensuring that a marker is removed.

Criteria

When reviewing the marker the LSMS and relevant staff should consider the same criteria as when the marker was first placed on the record following the incident e.g.:

- The severity of the original incident and the impact on the staff member
- Any continuing risk that an individual may pose
- Any further incidents involving the individual
- Any indication that the incident is likely to be repeated
- Outcome of further investigations
- Any action taken by other agencies, e.g. police or the courts
- Other developments since the original incident

Notification

Where the decision to remove the marker is taken then the LSMS is responsible for contacting the individual. This should be no later than four weeks after the decision has been made. Other agencies who were notified about the marker will be informed by the LSMS.

TAD_CO080_06 provides for a template letter notifying an individual that the marker is being removed.

Where a decision is made to retain the marker on the record, the next review date should be recorded.

12. HANDLING COMPLAINTS

In the event that an individual wishes to complain about a decision made to place a marker on their records then they should be given the number of the Trust Complaint Department or Complaints Leaflet.

13. RECORD KEEPING

A list of all individuals with a marker on their records will be held securely by the LSMS

14. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure

15. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

16. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

17. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

18. MONITORING

The effective application of this policy, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

19. REFERENCES

Equality Act 2010

Freedom of Information Act 2000

GDPR 2018 plus the Information Commissioner's Office (ICO) guidance on the DPA and use of violent warning markers

Secretary of State Directions to health bodies on dealing with violence against NHS staff (2003) and security management measures (2004)

Health and Safety at Work Act 1974

The Management of Health and Safety at Work Regulations 1999

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