MANAGING VIOLENCE, AGGRESSION AND CHALLENGING BEHAVIOUR IN ADULTS

1. INTRODUCTION

1.1 Chesterfield Royal Hospital NHS Foundation Trust (the Trust) attaches great importance to the well-being and welfare of its patients and staff. Patients may become aggressive and/or violent to themselves and others during the delivery of care and treatment with an increased risk of harm to them and healthcare staff. Whether the aggression and violence is a result of an acute/chronic physical or mental illness or not it is important that the response and management of these incidents is prompt, reasonable and proportionate to ensure the safety of patients, staff and visitors.

1.2 Violent and abusive visitors will not be tolerated and action will be taken to protect staff, patients and other visitors. The Trust recognises that many roles within the workforce require physical contact with patients as part of their treatment and care. It is also acknowledged that staff can be placed in situations where holding a patient may be necessary to successfully carry out therapeutic/diagnostic and personal care activities when the patient lacks capacity and is unable to give informed consent.

1.3 This policy is supported by NHS Security Management Standards (work to tackle violence against staff and professionals who work in or provide services to the NHS). The Security Management Standards include the following measures to tackle violence and aggression across the NHS.

- A national reporting system, for reporting security incidents.
- A nominated Security Management Director (SMD) at board level in all health bodies, with overall responsibility for security management work and leading work to tackle violence against staff.
- A network of highly trained and professionally accredited Local Security Management Specialists (LSMS) across the NHS, to lead local security management work. The Security Adviser fulfils this role in the Trust.
- A national definition of non-physical assault.
- Creation of a Legal Protection Unit (LPU) to work with health bodies and provides them with advice on cost-effective methods of pursuing a wide range of sanction against offenders.

2 POLICY STATEMENT

2.1 Staff have the right, through both common law and statute, to defend themselves and/or others including healthcare staff from physical attack using reasonable force. Where required, either Security Staff and/or the Police are to be contacted to support them in dealing with a violent or aggressive incident.

2.2 The Trust recognises that on occasion patients who may lack capacity may need to be held safely and in a controlled manner to deliver clinical care and treatment to protect them from harm and/or harming others. This holding should be proportionate and should always be viewed as a last resort following full consideration and use of avoidance strategies where appropriate.

2.3 The aim of this policy is to provide:

- Guidance on undertaking risk assessments in the prevention and management of violence and aggression and challenging behaviour;
- A procedure informed by legal, professional and ethical guidance for staff to follow when responding to actual or potential aggressive and violent incidents, to ensure that the response and any resulting action is reasonable, proportionate and safe for patients, staff and others;
- Incident reporting procedures to relevant authorities: NHS Protect, Police and the Health & Safety Executive (HSE);

- Guidance on physical holding skills to be used as the situation dictates.

3. DEFINITIONS

3.1 Physical assault

"The intentional application of force against the person of another without lawful justification resulting in physical injury or personal discomfort." (NHS Security Management Service, 2007)

3.2 Non-physical assault

"The use of inappropriate words or behaviour causing distress and/or constituting harassment." (NHS Security Management Service, 2007)

3.3 De-escalation

De-escalation refers to short-term techniques used to aid in calming disruptive behaviour and preventing more violent behaviour occurring, it is also referred to as defusing or talking-down. The aim is to avoid confrontation, observe for signs of anger and agitation. The techniques include:

- Approaching the person in a calm, controlled manner;
- Reducing the tone and volume of the voice;
- Ensuring the patient's dignity is maintained;
- Moving the patient to an area that is calmer;
- Using individual communication/interaction skills.

3.4 Rapid tranquilisation

Rapid tranquilisation describes the use of medication to control severe mental and behavioural disturbance, including aggression, associated with the mental illness of schizophrenia, mania and other psychiatric conditions. It is used when other techniques e.g. de-escalation have failed. It usually involves the administration of medication over a time-limited period of 30-60 minutes, in order to produce a state of calm, light sedation (NICE, 2005: 27; Policy ECare166 Management of Acutely Disturbed Adult Patient).

3.5 Restraint

Restraint is the intentional restriction of a person's voluntary movement or behaviour; stopping the person doing something they appear to want to do. There are different types of restraint:

- Physical: holding, moving a person or blocking their movements to stop them leaving.
- Mechanical: the use of specifically designed equipment e.g. mittens or the use of furniture or belts to prevent a person getting out of a chair. Controls on freedom of movement e.g. keys and keypad.
- Technological surveillance: includes, tagging, pressure pads, closed circuit TV, door alarms used to trigger restraint, for example, when a person tries to leave.
- Chemical: the use of medication.
- Psychological: telling a person not to do something or that what they want to do is not allowed or dangerous, depriving them of lifestyle choices, depriving them of their individual equipment such as walking aids, glasses with the intention of preventing them from leaving (RCN, 2008).

3.5.1 Restraint is not inherently unacceptable or wrong but requires careful consideration of legal, ethical, professional and practical factors to ensure the measures taken are appropriate, legal and safe, the specific circumstances of care need to be considered to judge whether the action taken constitutes restraint. Currently there is no central guidance on the use of restraint in acute care for adult patients. There is, however, relevant legislation and related professional guidance. It is important that healthcare staff are aware of the risks involved and professional responsibilities in relation to restraint to ensure the delivery of prompt, appropriate and safe care. The law governing restraint arises from both civil and criminal law (RCN, 2008):

- Offences Against the Person Act 1861
- Human Rights Act 1998
- Mental Capacity Act 2005.

3.5.2 The use of restraint is covered by the Mental Capacity Act 2005 and explained in more detail in the Mental Capacity Act 2005 Code of Practice (2007). An individual is using restraint if they "use force-or threaten to use force-to make someone do something that they are resisting, or restrict a person's freedom of movement, whether they are resisting or not" (p 105-6).

3.6 **Clinical Holding**

The use of safe restrictive physical interventions which enable staff to effectively assess and deliver clinical care and treatment to people who are unable to comply. See appendix X for Clinical Holding Training.

4. MANAGING VIOLENCE AGGRESSION AND CHALLENGING BEHAVIOUR - PATIENTS

4.1 Sections 4.2 - 4.10 and Appendices 1 - 4 identify the procedure for managing potential/actual aggression and violence.

4.2 Anticipation and risk assessment

4.2.1 Patient behaviour can be unpredictable. However, for some patients there may be specific triggers for and/or warning signs of behavioural disturbance. Every effort should be made to ensure that information about a patient's behaviour, where this is known, is discussed with family or carers on admission and handed over/followed up by nursing and medical staff. All relevant information should be incorporated in the patient's care plan and any referrals made by clinical staff for specialist advice. The patient's care plan should identify:

- Specific communication methods;
- Physical needs;
- Behavioural triggers;
- Mental health status/needs e.g. patient detained under a section of the Mental Health Act 1983.

4.2.2 Risk assessment (RA)

Where a patient's behaviour is violent and aggressive this should be reported using the incident reporting process and a RA should be undertaken using the clinical risk assessment form or the clinical risk assessment form for patients potentially requiring 1 to 1 nursing:

- Matron should complete the RA identifying the hazard(s), measures taken to control the risk, current risk rating and any action required to minimize the risk.
- In cases of patient on patient assault a RA for each patient should be completed;
- Review the RA daily to demonstrate progress with the identified actions and any change to the management of the risk until the actions are complete;
- File the RA in the patient's healthcare record and send a copy to the Patient Safety Team and Safeguarding Adults Lead;
- Ensure the patient's capacity is assessed and the need for a Deprivation of Liberty Safeguards (DoLS) is considered;
- Update the patient's care plan.

4.2.3 Ward/unit risk assessment

Where it is identified that increased resources are required to manage and/or prevent violence and aggression a RA should be completed by the Matron as above and sent to the senior matron/management team for inclusion on the directorate risk register.

- Matron should complete the RA identifying the hazard(s), measures taken to control the risk, current risk rating and any action required to minimize the risk.
- Review the RA daily or less frequently depending on the level of risk and control measures in place;
- Send the completed RA to the Senior Matron – it should be discussed at the divisional clinical governance group for inclusion on the risk register;
- Review of the RA and follow-up of actions identified should be undertaken monthly at the

divisional clinical governance group during a review of the risk register.

4.2.4 Division/department managers with the assistance of the Security Adviser will carry out security risk assessments which includes the management of violence and aggression relating to patients and visitors (see also section 5.6):

- Risk assessments will be completed and reviewed on a yearly or two yearly basis dependent on risk or as identified by the manager if there has been a change to the environment.
- The Security Adviser will summarise the findings on the H&S risk assessment form and discuss and agree with the manager the recommendations for action, the manager is responsible for completing the action sheet with person responsible and timescales for completion
- The status of department risk assessments and action sheets is reported to the Health & Safety Management Committee on a bi monthly basis.

4.2.5 Patients may attend hospital from H.M. Prisons, in the custody of the Police or from other institutions such as secure units please see: Receiving Patients who are brought from H.M. Prison or police custody Organisational Policy 1.19.

4.3 Communication

4.3.1 Ensure information about a patient's potential or known risk for violent behaviour is communicated as appropriate to the following:

- Ward staff and visiting health professionals; ,
- Matron of clinical area,
- Division management team,
- Security staff,
- On-call Executive where there is a serious escalation.

4.3.2 Where an incident occurs nursing staff must ensure that family are informed and can visit the patient as appropriate, dependent on the circumstances.

4.3.3 There may be occasions where the aggression/violence is unrelated to the patient's physical or mental health. Where the patient has been medically assessed and does not require any medical treatment the Senior Matron/Matron should refer to the Withhold Treatment & Exclusion from Premises of Violent and Abusive Patients policy Organisational Policies 2.22, for possible local sanctions.

4.4 Clinical management

4.4.1 Violent behaviour may occur as a result of physical or mental illness. It is important that the patient's care and treatment is reviewed promptly to ensure the medical management is optimal and specialist advice/referral is undertaken where necessary.

4.5 De-escalation (see section 3.3)

4.5.1 Where possible, communication techniques to calm the patient and defuse the situation should be used in the first instance. It may be possible to avert any deterioration in the patient's behaviour and every opportunity to do so should be taken before using any restraint techniques.

4.6 Rapid tranquilisation (see also Appendix 3)

4.6.1 Rapid tranquilisation should only be used following:

- Discussion with the consultant / review of the patient's clinical condition and
- Administered as per the guidance in Appendix 3.

4.7 Restraint: patients with mental capacity

4.7.1 The following describes circumstances where restraint may be used.
As part of a planned programme of care where informed and voluntary consent is given:

- Mechanical restraints e.g. circumferential belts on an x-ray table may be used for the duration of a procedure to prevent excessive movement and a potential fall.
- Where mechanical or physical restraint is used to prevent the patient from inadvertently harming themselves this should be explained to the patient prior to the procedure and documented in the patient's records.

4.7.2 Circumstances where a professional duty of care to prevent a greater risk of harm to the patient, or to avoid a foreseeable risk of harm occurring to others:

- Where a patient who is detained under section for assessment and treatment under the Mental Health Act 1983 attempts to abscond.
- Healthcare staff are responsible for maintaining the safety of all the patients in their care and reasonable action to prevent harm to other patients and/or visitors may be necessary.

4.7.3 Where the healthcare worker is attacked or at risk of physical harm reasonable force can be used to prevent harm to the member of staff (RCN, 2008).

4.8 Restraint: patients without mental capacity

4.8.1 The restraint of a **person who lacks capacity** will be protected from liability if the following are met:

- "the person taking the action must reasonably believe that restraint is **necessary** to prevent **harm** to the **person who lacks capacity**, and
- the amount or type of restraint used and the amount of time it lasts must be a **proportionate** response to the likelihood of seriousness of harm" (Mental Capacity Act 2005 Code Of Practice: 106).

4.8.2 A **person lacks capacity** when they have an impairment of or disturbance in the functioning of their mind or brain and are unable to make a specific decision because they are unable to understand, retain or use the information for long enough to weigh up the options and consequences and communicate the decision.

Necessary – objective reasons to justify the restraint must be demonstrated.

Harm – will vary depending on the individual circumstances, risk assessments can be used to identify the harm and appropriate action to prevent the risk of harm.

Proportionate – the minimum amount of force necessary for the shortest possible time.

4.8.3 Appropriate use of restraint falls short of deprivation of liberty (Ministry of Justice, 2008).

4.8.4 **Safe restraint techniques: Clinical Holding**
Where the need for clinical holding is anticipated or used the ward /site matron must be informed. The Nurse in charge should carry out a risk assessment and document the following in section 7 of the Risk Assessment and Care plan (Maintaining a Safe Environment). The risk assessment must identify:

- Hazards to the patients, staff and others;
- Potential health risks of clinical holding to the patient;
- Control Measures taken to reduce risk to include level of restriction (low, medium or high);
- Trained staff (CH3 Advanced Clinical Interventions), where no trained staff are available contact the Duty Matron, Security team, Security Advisor or Manual Handling Advisor for assistance.

See Appendix 4 Clinical Holding Procedure.

Where Clinical Holding is used it must be:

- Documented in the patient's healthcare record noting the frequency, period and effect on the patient and Deprivation of Liberty Safeguards should be considered;
- Reported as a patient safety incident.

4.9 Patient observation and monitoring

4.9.1 Violent, aggressive and challenging behaviour must be documented in the patient's healthcare record. Where restraint techniques are used the following must be documented:

- Capacity assessment;
- Period of restraint;
- Number of staff involved;
- Techniques used;
- Patient's vital signs and response, see Appendix 1 & Appendix 2;

4.9.2 Assess for Deprivation of Liberty Safeguards, contact the Safeguarding Adults Lead bleep 560.

4.10 Informing senior management and potential police involvement

4.10.1 The divisional management team and executive on-call must be informed where the:

- There is a risk of harm to patients, staff and others;
- De-escalation and other techniques have failed and external assistance to control the situation is deemed necessary by senior nursing/medical, and security staff;

Following discussion of the circumstances a decision will be taken regarding calling the Police.

4.10.2 Patient on patient assault:

- Patient (victim) has capacity - discuss with the patient whether they wish to take the matter further by making a report to the police;
- Patient (victim) does not have capacity - inform: senior staff, exec on-call, police, family. Contact Safeguarding Adults Lead to review the circumstances regarding potential for safeguarding procedures.

4.10.3 The police must be informed if healthcare staff sustain a physical assault where:

- The patient has capacity and the assault is unrelated to their medical condition;
- The assault is committed by a visitor.

The police must also be informed where healthcare staff sustain a non-physical assault by a patient (who has capacity) or visitor, that is racially or religiously aggravated.

5. MANAGING VIOLENCE AGGRESSION AND CHALLENGING BEHAVIOUR - VISITORS

5.1 Appendix 5 details the procedure to be followed when dealing with abusive or violent visitors.

5.2 There are sanctions that can be considered when dealing with visitors who carry out physical and non-physical assaults against employees of the Trust.

5.3 Where the Police are pursuing an incident the Trust will request that the offence be dealt with under criminal proceedings.

5.4 Where the Police do not pursue an incident the Trust will consider applying its own sanctions:

- Civil Proceedings;
- NHS Protect legal protection unit and/or
- Local policies and sanctions.

5.5 Where a visitor has displayed unacceptable behaviour the Trust reserves the right to exclude

them from the Trust (see Withholding Treatment and Exclusion from Premises of Violent and Abusive Patients Organisational Policies 2.22). The executive on-call must be contacted who has the authority to exclude visitors. The exclusion does not stop the individual attending the hospital as a patient.

5.6 Risk assessment

5.6.1 Department/ward risk assessment that covers both patients and visitors see section 4.2.4.

5.6.2 Where staff suspect that a violent or aggressive visitor will visit the Trust the staff must:

- Contact the Security Adviser/Head of Environmental Compliance in hours or Security out of hours;
- Matron, Site/Night Matron.

6. INCIDENT REPORTING AND REVIEW

6.1 Incidents of violence and aggression must be reported using the Trust incident reporting system;

- Full details of the victim(s) and assailant(s);
- Events and action taken;
- Involvement of the police and any witnesses must be recorded.

Depending on the nature of the incident, legal action against the patient/visitor may result. Where this is the case the Security Adviser will liaise with healthcare staff, providing support throughout the process.

6.2 Episodes of care where physical restraint is used:

- Must be reported using the Trust incident reporting system;
- Where any injuries are sustained medical photographs must be taken;
- Inform the Safeguarding Adults Lead to ensure a review of Deprivation of Liberty Safeguards and any potential safeguarding factors.

7. ROLES AND RESPONSIBILITIES

7.1 Chief Executive: corporate responsibility for ensuring that policies and procedure are in place.

7.2 Director Nursing & Patient Care & Medical Director: review, report and monitor related patient safety incidents through the Trust's risk management committees, reporting to the Executive Team and Board of Directors where appropriate.

7.3 Director of Allied Clinical & Facilities Services: nominated SMD for security management and is responsible for leading the work in tackling violence and aggression against staff. To support this duty, the Head of Environmental Compliance and Security Adviser have certain responsibilities delegated to them.

7.4 Head of Environmental Compliance/Security Adviser

- Report all incidents of physical assaults annually via the violent assault statistics to NHS Protect.
- Review all reported incidents of violence and aggression on the Datix® risk management system.
- Act as a point of contact for any NHS Protect or police enquiries or investigations.
- Communicate information from any NHS Protect or police investigation and /or legal actions to the relevant Divisional Management Team.
- Investigate all reported incidents of physical assault.
- Provide training in the management of violence.
- Day to day management of security staff.
- Undertake risk assessments with department/divisional managers in response to reported incidents or staff request.

- Monitoring of the risk assessment process see section 8.1.

7.5 Divisional Directors, General Managers & Heads of Nursing

- Ensuring that staff comply with this policy and the policy 'Withhold Treatment and Exclusion from Premises of Violent and Abusive Patients.
- Reporting all incidents involving violence and aggression in line with the Trust incident reporting procedure and when necessary, reporting to the HSE under the Reporting of Injuries, Disease & Dangerous Occurrence Regulations (RIDDOR).
- Raise completed ward risk assessments (as per 3.2.3) on the divisional risk register and review at clinical governance group.
- Ensure staff with patient/public contact attend the 'Conflict Resolution Training Course' as per the Trust's risk management training needs analysis (TNA).
- Support is provided to staff that have been assaulted.

7.6 Department Managers and Matrons

- Staff are informed of the requirements of this policy and the policy 'Withhold Treatment and Exclusion from Premises of Violent and Abusive Patients'.
- Follow the guidance in this policy to manage aggressive and violent incidents and maintain the safety of patients staff and others in liaison with clinical, security and senior management.
- Undertake risk assessments as appropriate to the situation/circumstances; these may be completed with the Environmental Compliance Team and/or Patient Safety Team.
- Send completed risk assessments (as per 3.2.3) to divisional senior management for review at divisional clinical governance group and inclusion on the risk register.
- Investigate all reported incidents of violence and aggression, ensuring all facts are recorded and send the report to the Security Adviser as soon as possible.
- Ensure all staff involved in a violent incident are debriefed and supported, and if required refer staff to the staff counselling services.
- Risk assessments in wards and departments are completed / reviewed every 2 years.

7.7 Patient Safety Team

- Support staff in undertaking risk assessments as requested.
- Monitoring of the patient risk assessment process see section 9.1.

7.8 Safeguarding Adults Lead and Learning Disabilities Lead

- Advise and support staff in with risk assessments as requested.
- Review of patient circumstances for potential Deprivation of Liberty Safeguards and safeguarding factors.
- Liaison with the multidisciplinary team.

7.9 Manual Handling Adviser

- Advise and support staff in undertaking risk assessments and the use of clinical holding procedures.
- Liaison with the multidisciplinary team.

7.10 Employees

- When requested attend the relevant training as per the Trust's training needs analysis.
- Comply with this and other policies related to the management of violence.
- Report all incidents of violence and aggression.

8. TRAINING

8.1 As identified by the risk management training needs analysis (Risk Management Training policy Organisational Policy 2.24).

9. MONITORING

9.1 Implementation of the policy will be monitored as detailed in the table below.
H&SMC Health & Safety Management Committee
ECT Environmental Compliance Team

Policy element	Content to be monitored	Monitoring process
Incident reporting incidents of violence and aggression	Incidents logged on the Datix® risk management system	Bi-monthly reporting of qualitative and quantitative data to the HSMC by the Head of ECT. Action identified will be monitored by the H&SMC until complete
Ward/department risk assessments (patients and visitors) with Security Adviser	Process for completing risk assessments for violence and aggression every 2 years and follow-up of action plans (3.2.4)	Annual report to the HSMC by the Head of Environmental Compliance detailing the number of: • risk assessments completed & for which areas • outstanding risk assessments to be completed • risk assessments where actions are incomplete and the action required. Any deficits arising will be monitored by the H&SMC until complete and where relevant identified as an organisational security risk.

10. KEYWORDS

10.1 Restraint, de-escalation techniques, rapid tranquilisation.

11. REFERENCES

Department of Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice. TSO, London.
Department of Health (2008) Code of Practice Mental Health Act 1983. TSO, London.
National Institute for Health and Clinical Excellence (NICE) (2005) Violence: the short term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. RCN, London.
DoH Secretary of State (2003) Directions on Work to Tackle Violence against Staff & Professionals who Provide Services in the NHS.
NHS Security Management Service (2003) A Professional Approach to Managing Security in the NHS.
NHS Security Management Service (2004) Conflict Resolution Training National Syllabus.
NHS Security Management Service (2007) Tackling Violence against Staff.
Royal College of Nursing (2008) "Let's talk about restraint" Rights, risks and responsibilities. RCN, London.

12. RELATED POLICIES

Adult Patients Detained under the Mental Health Act 1983 Organisational Policies 1.25
Deprivation of Liberty Safeguards Policy Organisational Policies 1.21
Emergency Department: EC166 Guidelines for the Management of the Acutely Disturbed Adult Patient
Falls Prevention: Inpatients Staff and Visitors Organisational Policies 3.8
Lone Working Policy Organisational Policies 2.6
Mental Capacity Act (2005) Policy Organisational Policies 1.24
Receiving Patients who are brought from H.M. Prison or Police Custody Organisational Policy 1.19.
Risk Management Training Policy Organisational Policy 2.24
Safeguarding Vulnerable Adults Policy Organisational Policy 2.16
Security Policy Organisational Policies 2.5
Withholding Treatment and Exclusion from Premises of Violent and Abusive Patients Organisational Policies 2.22

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For review by:	Senior Matron Patient Safety Security Adviser Safeguarding Adults Lead Manual Handling Adviser Learning Disabilities Lead
Director responsible:	Medical Director Director of Nursing Director of Facilities Services

Appendix 1

MANAGING VIOLENCE AGGRESSION AND CHALLENGING BEHAVIOUR IN ADULTS

Risk Assessment

Complete a risk assessment to identify level of risk, controls in place and action required/taken e.g. moving location on ward, extra staffing

Obtain information from family/carers about normal routines for the patient and potential triggers for behaviour that may put the patient/others at risk of harm

Document in care plan if patient requires increased level of supervision/assistance

Document relevant risk assessments e.g. falls risk assessment

Inform Security about patients who may abscond or for whom a rapid response may be required
Inform medical staff and raise concerns early

N.B. cotsides must never be used to restrain a patient

Assess for Deprivation of Liberty Safeguards - contact Safeguarding Adults Lead bleep 560

Management

Use de-escalation techniques / communication skills to defuse the situation and calm the patient

Move the patient to a different area on the ward/unit
Where possible and appropriate involve family/carers to communicate and assist in calming the patient

Assess and record a mental capacity assessment where appropriate

Agree treatment/management plan & obtain specialist advice/assessment where necessary e.g. mental health assessment/manual handling

Monitor behaviour and response to treatment e.g. medications

Inform consultant / consultant on-call & review the patient & management plan

- **Organic cause:** ensure optimal treatment/management plan. Consider appropriate medication: oral, intramuscular or intravenous
- **Organic cause excluded:** contact mental health team consider rapid tranquilisation - see guidelines

**Security Staff

Assess & use physical restraint techniques as directed by medical/nursing staff where necessary to prevent the patient harming themselves/others.

The level of force used must be appropriate, reasonable & proportionate & applied for the shortest time possible.

NEVER apply direct pressure to: neck, thorax, abdomen, back or pelvic area.

Communication & Re-assessment

Inform medical staff, Matron / Site/Night Matron and family

Call Security 7777** for assistance if patient's behaviour is becoming increasingly violent &/or unpredictable

In hours inform Senior Matron/General Manager.
Arrange for 1:1 nursing supervision where necessary

Assess for Deprivation of Liberty Safeguards call Safeguarding Adults Lead bleep 560

Complete/update risk assessment as appropriate.

N.B.

Where aggressive/violent incidents are not related to a patient's physical or mental illness:

- Call Security** for assistance
- Inform Matron/Senior Matron / Site/Night Matron who will consider implementation of Withhold Treatment & Exclusion from Premises of Violent and Abusive Patients Organisational Policies 2.22
- Where patients/visitors/staff are at risk of harm call the Police
- Inform police where staff sustain a physical assault or a non-physical assault that is racially or religiously aggravated.

GUIDANCE ON THE USE OF PHYSICAL RESTRAINT

- Ensure that all other less restrictive options have been considered and documented
- Do not engage in physical restraint unless trained to do so - see Clinical Holding procedure
- The level of force used must be justifiable, appropriate, reasonable and proportionate to the situation
- Only use for the minimum time necessary
- **Never** apply direct pressure to the neck, thorax, abdomen, back or pelvic area
- Regular medical and nursing assessment and review of the patient while restraint is in use
- Assess for Deprivation of Liberty Safeguards - contact Safeguarding Adults Lead bleep 560

Nursing

Allocate a nurse 1 to 1

Document rationale for use of any physical restraint & discussions with multidisciplinary team
Record timings: Security attended, restraint applied, periods when restraint not used but Security** in attendance
Number of staff involved when restraint applied

Record vital signs every **15 mins**: temperature, pulse, blood pressure, respiratory rate, SpO2.
(If a full set of vital signs cannot be recorded because of the patient's behaviour note the time on the observation chart and document the observations that can be recorded)

Review restraint measures every **15 mins** and document assessment

Keep family/carers informed, facilitate visiting & involve where possible

Complete a Datix® incident form

Medical

Complete a mental capacity assessment

Document behaviour and response to rapid tranquilisation if used or any other medication given

Review every hour

Liaison with intensivists re clinical management & consider whether patient requires care in HDU

Assess for Deprivation of Liberty Safeguards - contact Safeguarding Adults Lead bleep 560

**Security

Will take instruction from nursing and medical staff regarding the need for physical restraint

Control is not achieved

Matron Site / Night Matron will inform Divisional Management Team & Executive on-call where:

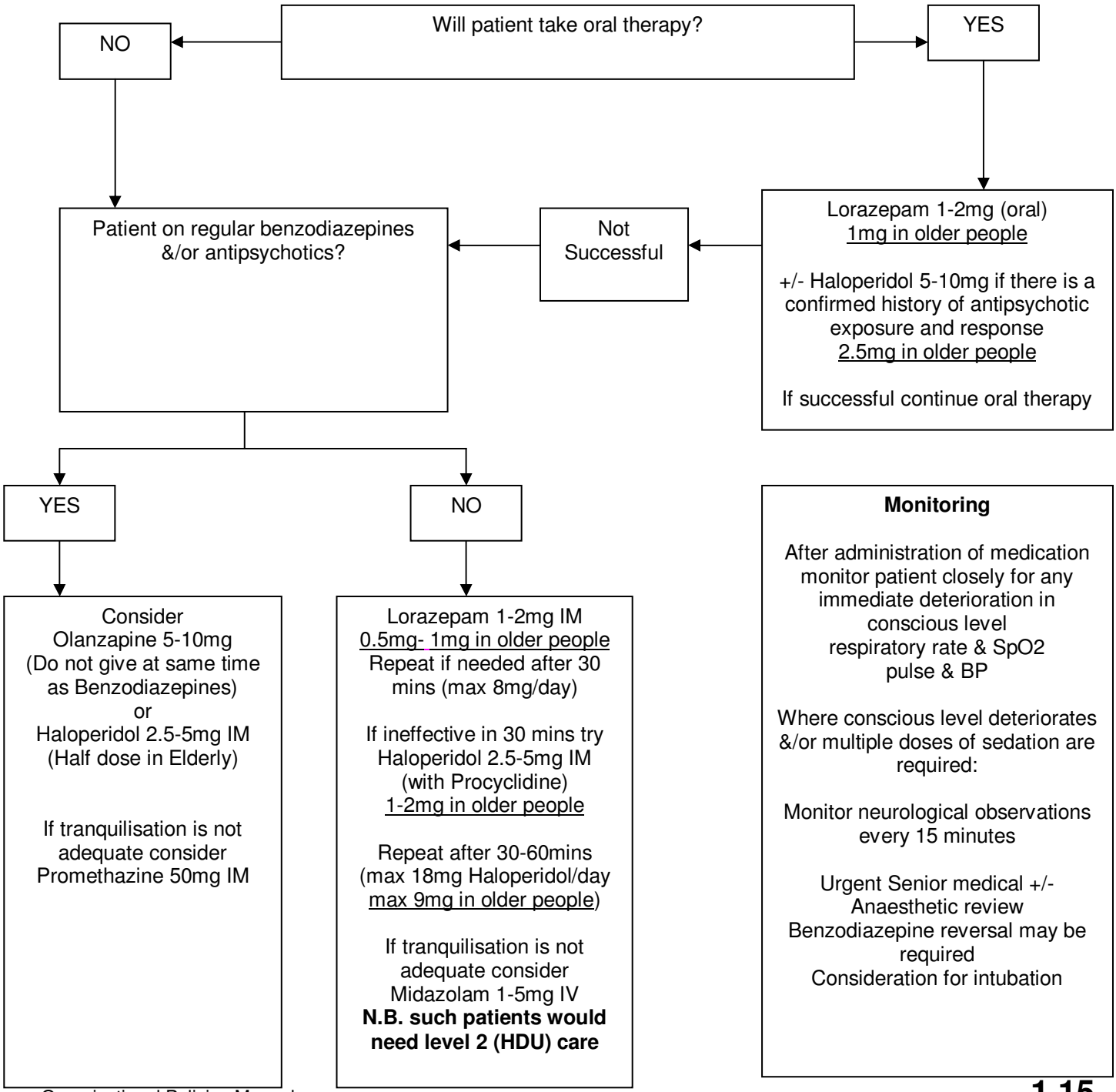
- The level of violence is serious & sustained, there is significant risk of harm to patients, staff & others
- Police attendance is assessed as necessary by senior nursing/medical & Security
- Assess for Deprivation of Liberty Safeguards - contact Safeguarding Adults Lead bleep 560

Police attend

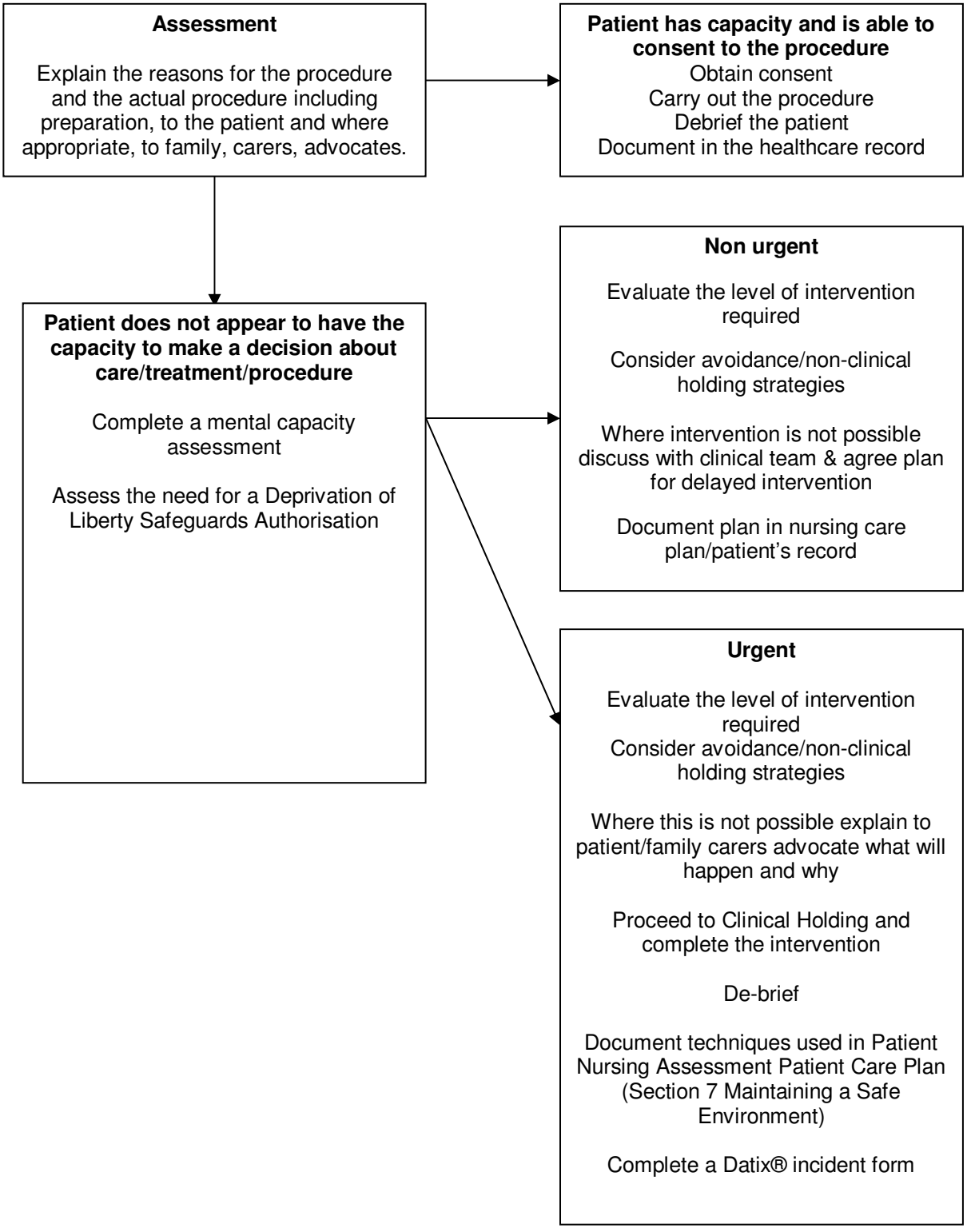
- Nurse in charge/medical staff to inform police of the risks in relation to the patient's condition
- Police **must** discuss the potential use of mechanical restraints with senior nursing/medical staff
- If mechanical restraints are used:
    - Application must be the shortest time possible & never attached to any fixtures or fittings
    - The police **must** stay with the patient
    - Document the type of restraint used & time applied/removed
    - Document patient's vital signs and overall condition every **15 mins** while restraints are in use
- Should any problems arise the Matron Site / Night Matron should contact the Duty Reactive Inspector

RAPID TRANQUILISATION GUIDELINES FOR ACUTE DISTURBED/VIOLENT BEHAVIOUR
CAUTION IN OLDER PATIENTS WITH DELIRIUM - Delirium should be excluded.
If delirium diagnosed follow NICE guidelines

- Look for organic causes such as:
  - Hypoxia
  - Low blood sugar
  - Drug use including alcohol
  - Drug withdrawal including alcohol
  - Sepsis
- Try non-drug measures see Managing Violence Aggression and Challenging Behaviour flowchart
- Contact consultant
- Consider physical restraint see Guidance of the Use of Physical Restraint flowchart



CLINICAL HOLDING PROCEDURE



Clinical Holding Training

CH3 Advanced Clinical Interventions Training is available to all front line clinical staff. The Training is accredited by Crisis Prevention Institute (CPI) and British Institute of Learning Disabilities (BILD)

The training is delivered in house by the Manual Handling and Environmental Compliance Teams.

Training requirements will be identified as part of the Security Risk Assessment based on risk and patient groups.

The aims of Clinical Holding training are:

- To enable participants to hold an individual safely during clinical assessment and treatment procedures.
- To enable participants to make evidence based decisions about the use of clinical holding.

Training will:

- Describe reasoned decision making evidenced against legal and professional benchmarks for risk reduction.
- Explain risks associated with the use of restrictive holds.
- Demonstrate verbal and non verbal de escalation strategies.
- Demonstrate use of holding skills consistent with a set of physiological principles that may be used in varying clinical environments to restrict movement and minimise risk to patient and staff whilst undertaking essential treatment.
- Demonstrate how to disengage from holds

Appendix 5

DEALING WITH ABUSIVE OR VIOLENT VISITORS

You do not have to follow all stages of this flow chart if the situation warrants immediate action