Policy for the Management of Violence and Aggression

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# Policy for Management of Violence and Aggression

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VIOLENCE & AGGRESSION

1. Introduction

1.1. Wirral Community NHS Trust Board is committed to promoting and improving a safe and secure environment for those who work in or use the NHS so that the highest standards of clinical care can be made available to patients.

1.2. This document sets out the framework for managing violence and aggression within Wirral Community NHS Trust.

1.3. It is based upon directions from the Secretary of State for Health to tackle violence against staff and professionals who work or provide services to the NHS on 20th November 2003.

2. Definitions

2.1. The Health and Safety Executive (HSE) definition of work-related violence is: ‘Any incident in which a person is abused, threatened or assaulted in circumstances relating to their work. This can include verbal abuse or threats as well as physical attacks.’

2.2. The NHS definition of physical assault used for incident reporting purposes is: ‘the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort.’

2.3. The NHS definition of non-physical assault used for incident reporting purposes is: ‘The use of inappropriate words or behaviour causing distress and/or constituting harassment.’

2.4. Inappropriate behaviour is not defined but some examples are given below:

- Offensive or abusive language, verbal abuse and swearing which prevents staff from doing their job or makes them feel unsafe;
- Loud and intrusive conversation;
- Unwanted or abusive remarks;
- Negative, malicious or stereotypical comments;
- Invasion of personal space;
- Brandishing of objects or weapons;
- Near misses i.e. unsuccessful physical assaults;
- Threats or risk of serious injury to a member of staff, fellow patients or visitors;
- Bullying, victimization or intimidation;
- Stalking;
- Spitting;
- Alcohol or drug fuelled abuse;
- Unreasonable behaviour and non-cooperation such as repeated disregard for NHS policy i.e. visiting hours, smoking on premises, or
• Any of the above which is linked to destruction of or damage to property.  

NB: It is important to remember that such behaviour can be either in person, by telephone, letter or e-mail or other form of communication such as graffiti on NHS property. An incident form must be completed and the matter reported to the appropriate line manager or head of service.

3. Statutory Responsibilities

3.1. NHS Protect, formerly known as the NHS Counter Fraud and Security Management Service, was established in April 2003 with statutory responsibility for the management of security within the NHS (Statutory Instrument 3039/2002). These delegated responsibilities are exercised on behalf of the Secretary of State for Health, through the issuing of Secretary of State Directions. For foundation trusts, these arrangements are replicated under schedule 13 of the standard NHS contract. Directions outline the responsibilities of NHS bodies to manage security and provide a safe and secure environment for staff, patients and visitors.

3.2. The Health and Safety Executive (HSE) is responsible for the regulation and enforcement of workplace health, safety and welfare, underpinned by the Health and Safety at Work etc Act 1974. Employers have responsibilities under the Health and Safety at Work etc Act 1974 to ensure, as far as is reasonably practicable, the health, safety and welfare of employees at work.

3.3. The Management of Health and Safety at Work Regulations 1999 require employers to assess risks to employees and non-employees and make arrangements for effective planning, organisation, control, monitoring and review of health and safety risks. Where appropriate, employers must assess the risks of violence to employees and, if necessary, put in place control measures to protect them.

3.4. The NHS Litigation Authority (NHSLA) handles civil legal liability claims and works to improve risk management practices in the NHS in England. The NHSLA has a risk management programme to help raise standards of care in the NHS through Risk Management Standards for acute, mental health, ambulance, primary care and foundation trusts and independent providers of NHS care to reduce the number of incidents leading to claims. Risk Management Standards include an assessment of the policies providers have in place covering violence and aggression in respect of good risk management, governance and assurance.

3.5. The Care Quality Commission (CQC) was established under the Health and Social Care Act 2008 as the independent regulator for health and adult social care in England. This Act outlines the types of service that must be registered with the CQC and the Registration Requirements Regulations 2009 outlines what service providers have to do to become registered. As part of registration, the CQC will develop a Quality and Risk Profile (QRP) for each provider to assess.
The CQC will continue to check and monitor service providers to ensure that they continue to meet the essential quality and safety standards, including preventing violence against staff.

4. **Roles and Responsibilities**

4.1. **Wirral Community NHS Trust Board** has overall responsibility for organisational strategy to tackle violence and aggression and ensuring compliance with health and safety statutory requirements.

4.2. **Security Management Director** (SMD) will lead and communicate at board level on strategies to tackle violence against staff. This should take into account the NHS SMS document; ‘*A professional approach to managing security in the NHS (2003) and relevant health and safety legislation.*’ The SMD (who is also the Director of Finance) works with a non-executive director (NED) to promote and champion strategies at board level which will tackle violence and aggression.

4.3. **Local Security Management Specialist** key priority is preventing and managing violence and aggression, in accordance with Secretary of State Directions. The LSMS provides a link with NHS Protect and will work with key colleagues, such as the Risk Manager, Health and Safety Advisor and staff representatives, to manage violence and aggression.

4.4. The **Risk Manager** is responsible for developing and rolling out the Trust’s health and safety strategy and will liaise with the LSMS on the management of violence and aggression across all services.

4.6. **Divisional Heads of Services and Managers** will take a leading role in promoting and developing a safe and secure environment. They should ensure risk assessments are being completed and liaise with the LSMS, Risk Manager, Health and Safety Advisors to develop arrangements to protect staff from violence and aggression which will be tailored to the needs of their unit and the staff that work within it.

4.7. **Health and Safety Advisor** has a duty under the Health and Safety at Work Act 1974 to consult with health and safety representatives, to enable them to represent employees and ensure their health and safety. Their statutory role is to be included in the risk management process, including the risk of violence and aggression and the implementation of measures to protect staff.

4.8. All **Trust employees** have a responsibility to ensure that security procedures are observed at all times.
5. How the organisation carries out Risk assessments for the Prevention and management of Violence and Aggression following an Incident

5.1. In any incident of violence or abuse towards NHS staff the line manager must ensure that the employee is safe after the incident and where appropriate consider a referral to Occupational Health and/or the staff counselling service to ensure that the best available support is given to the employee.

5.2. The victim of any incident of violence or abuse should be informed of the progress of any investigation or action taken and offered full support and counselling services that are available in the circumstances.

5.3. Following any incident of violence or aggression the line manager is required to carry out a risk assessment which should be completed in accordance with the Procedure for Risk Identification and Management Policy GP45.

5.4. This should take into account the past, present and future;

- **Past** any previous incidents or known history.
- **Present** the environment and any existing arrangements in place to manage the hazards faced by lone workers, such as the equipment available, communication systems in place and training.
- **Future** the risk inherent in the task to be carried out such as any threats that have been made as to future behavior and the process to be followed in the event of an incident.

5.4. Managers must take account of the extent that existing controls are being followed.

5.5. Information on the outcome of risk assessments must be fed back to staff as part of the risk assessment process.

5.6. Staff should also be encouraged to seek advice / assistance if they are unsure about a situation or to report any problems / concerns via a line manager.

5.7. Having undertaken the risk assessment, recorded and implemented all necessary controls, it is important that all risks and any associated action plans are monitored and reviewed in line with the procedure for Risk identification and Management GP45
5.8. Each case of physical assault resulting in an injury upon any member of the NHS in the course of their duties must be reported to the police. This applies to all employees, including volunteers, contractors, and employees of other organisations working on behalf of the Wirral Community NHS Trust.

5.9. Such incidents must be immediately reported to the Line Manager of the employee concerned, or the appropriate On-call Manager.

5.10. An incident form should be completed via Datix in line with the Incident Reporting Policy GP8 and the LSMS informed, as soon as possible.

5.11. Managers and staff should discuss what actions they should take in the event of an incident. The flowchart at appendix ‘B’ outlines action when confronted with an incident of violence or abuse.

5.12. The LSMS is responsible for investigating and reporting the incident to NHS Protect using a national incident reporting system. This is known as the Security Incident Reporting System (SIRS). This system is intended to track and monitor cases from report to conclusion, to increase the prosecution rate of offenders, where appropriate, and to provide feedback and support to those who have been assaulted.

5.13. It is important that patients, relatives and visitors are dealt with in a fair and objective manner. However, whilst staff have a duty of care, this does not include accepting abusive behaviour.

6. **Patient Specific Risk assessments**

6.1. Patient-specific risk assessments should be completed or reviewed if:
- the patient has a history of unpredictable, challenging, violent or aggressive behaviour
- the patient displays challenging, violent or aggressive behaviour
- an incident occurs or a patient, relative or visitor becomes aggressive

6.2. Service Leads should ensure that risk assessments have been undertaken in accordance with the Procedure for Risk Identification and Management Policy (GP45).

6.3. The LSMS can also provide specific information on violence prevention and staff safety measures.

6.4. The patient-specific risk assessments may take into account:
- What is the mental, emotional and physical condition of the patient?
- Is the patient’s behaviour related to his or her medical conditions or ingestion of drugs, alcohol or medicines?
- Is the person facing high levels of stress?
• Has the person got a history of challenging, violent or aggressive behaviour?
• Does the person consider you a threat?
(Please see appendix ‘A’ for Risk Assessment Tool Template)

6.5. The prevention measures identified by the risk assessment must be recorded in the patient’s care plan and this information must be brought to the attention of all staff who are likely to be involved with the patient. This should include all staff, not just medical staff, e.g. domestics. Where clinical IT systems are in operation e.g. Adastra, EMIS, a flag should be put on the system in relation to the patient identifying any concerns.

6.6 Service Risk assessments

Service Leads must review operations/locations to identify situations where employees may be exposed to foreseeable risks etc, verbal abuse, physical assault or a work related safety hazard. Where a risk of violence of aggression is identified a risk assessment should be produced and reviewed in line with GP45 The procedure for Risk identification and Management.

In certain circumstances it may be appropriate to produce a generic risk assessment e.g., Community Worker Home Risk assessment or a risk assessment for a specific environment e.g. Walk In Centres. These risk assessments apply to a particular activity/environment and summarise the control measures in place that apply collectively to a range of staff or environments.

Having identified any hazardous situations, managers must determine whether any existing controls are adequate or whether more needs to be done. This should be formally documented using the Risk Assessment Form to record the risks to which people are exposed. This assessment should take into account the risk inherent in the task, the environment, any other additional risks associated with the building or unauthorised persons and should consider any existing arrangements in place to manage the hazards faced.

Managers must take account of the extent that exiting controls are being followed / implemented. In the event that further action is required managers are responsible for developing an action plan in conjunction with the LSMS. The completion of the action plan will be monitored at Divisional Governance meetings.

Information on the outcome of risk assessments must be fed back to staff as part of the risk assessment process.

6.7 Staff should also be encouraged to seek advice / assistance if they are unsure about a situation or to report any problems / concerns via a line manager.
6.8 Having undertaken the risk assessment, recorded and implemented all necessary controls, it is important that all lone working situations are monitored and reviewed at a frequency determined by the risk assessment and action plan in line with the procedure for Risk identification and management GP45.

7. Preventing violence and aggressive behaviour

7.1. Where appropriate this section should be read in conjunction with the Lone Worker Policy (HS6). This may include the way a service operates to reduce the risks of violence, for instance taking into account whether the patient is arriving by car as a visitor or by ambulance as a patient. Common triggers of aggression to consider when completing risk assessments may include:

- parking issues/costs
- queuing at reception and waiting times
- lack of communication about reasons for delay
- not knowing where to go and not having anyone to ask
- highly stressful injuries not being dealt with as a priority
- poor communication between professionals and patients
- lack of facilities
- poorly planned appointments.

7.2. Addressing or implementing control measures to manage the above issues could significantly reduce the number of incidents that occur.

7.3. The LSMS in conjunction with the Health & Safety Advisor, has responsibility for providing advice, guidance and support to managers in developing local arrangements under this policy and the Local security Management Policy.

7.4. The appropriate response to such incidents will depend upon the individual circumstances of each incident. Managers must recognise that action is appropriate where non-physical assault or abusive behaviour is likely to:

- Prejudice the safety of staff involved in providing the care or treatment; or lead the member of staff providing care to believe that he/she is no longer able to undertake his/her duties properly as a result of fearing for their safety; or

- Prejudice any benefit the patient might receive from care or treatment; or

- Prejudice the safety of other patients; or

- Result in damage to property inflicted by the patient, relative, visitor or as a result of containing their behaviour.
8. Secondary prevention

8.1. Secondary prevention is focused on reducing the prevalence of the problem by minimising known or suspected risk factors and by early intervention i.e. when violence is perceived to be imminent or immediately post-incident. This knowledge can be used proactively to plan positive interventions such as training staff to recognise warning signs and in de-escalation strategies so they can defuse a potentially violent incident.

8.2. This involves staff using a dynamic risk assessment immediately before an incident occurs or while it is occurring. A dynamic risk assessment can be defined as a continuous process of identifying hazards and risks and taking steps to eliminate or reduce them in the rapidly changing circumstances of an incident. The dynamic risk assessment involves staff:

- being alert to warning signs as covered in conflict resolution training
- carrying out a '10-second risk assessment'; if staff feel there is a risk of harm to themselves, they should leave immediately placing themselves in a position to make a good escape
- making a judgement as to the best possible course of action – for example, whether to continue working or withdraw. At no point should a staff member place themselves, their colleagues or their patients/service users at risk or in actual danger
- utilising appropriate physical security measures e.g. triggering panic buttons to call assistance from staff nearby/security/the LSMS/the police, or using a lone worker device such as Identicom.
- ensuring that when they enter a confined area or room, they make sure they can operate the door lock in case they need to make an emergency exit
- avoiding walking in front of a patient/service user, and not positioning themselves in a corner or in a situation where it may be difficult to escape
- remaining calm and focused during an incident in order to make rational judgements.

8.3 Staff should be aware of their body language (as well as that of the patient/service user). There is a risk of exacerbating the situation by sending out the wrong signals, particularly; if there are cultural, gender or physical issues to consider. Body language and other forms of non-verbal communication and mannerisms play an important role in how people perceive and behave towards others. Specific training in non-physical intervention skills, customer service and de-escalation is essential and all front-line staff must be trained in the national syllabus for conflict resolution, with additional training provided over and above this, depending on the risks faced and individual needs.
8.4. Initially, this involves notifying the police, LSMS or health body security staff. The manager responsible for the staff involved and the doctor on call or person in charge of the patient’s care should also be notified. These individuals all have their own responsibilities in the event of an incident:

8.5. The police – if appropriate, to make an arrest, take witness statements, gather evidence, conduct an investigation and secure the area if required.

8.6. The LSMS – to conduct an investigation, gather evidence and identify security breaches and any failures in systems and processes. The LSMS should complete a PARS report if there is a physical assault.

9. **Conflict Resolution and Lone Worker Device Training**

9.1. Conflict resolution and lone worker device training is carried out by the Local Security Management Specialist in accordance with the Training Needs Analysis. For further information please contact the Local Security Management Specialist.

All core mandatory training is recorded centrally by the Quality and Governance service. Quarterly monitoring reports are prepared for the Learning and Development Group to monitor attendance rates. Full details of the processes in place for managing and monitoring attendance are set out in the Policy for Learning and Development GP46.

10. **Reporting incidents of violent and aggressive behaviour**

10.1. All incidents involving violence and aggression must be immediately reported to a Line Manager and using the Datix Incident Reporting System in accordance with the Incident Reporting Policy (GP8).

11. **Sanctions**

11.1. Measures that can be taken as the result of a report of non-physical assault may include the following:

- A verbal warning

- Acknowledgement of responsibilities agreement (ARA) or Behaviour Agreement – an intervention designed to engage an individual in acknowledging his or her antisocial behaviour and its effect on others, with the aim of stopping that behaviour.

- A written warning letter signed by a senior member of staff deemed to have the suitable level of authority. A warning letter may also be sent by the NHS SMS Legal Protection Unit if appropriate.
• The use of secure environments or security chaperone

• Civil injunctions and Anti-Social Behaviour Orders (ASBOs),

• Criminal prosecution and police bail conditions

11.2. **Verbal warnings** are a method of addressing unacceptable behaviour with a view to achieving realistic and workable solutions.

11.3. They are not a method of appeasing difficult patients, relatives or visitors in an attempt to modify their behaviour, or to punish them, but used instead to determine the cause of their behaviour so that the problem can be addressed or the risk of it recurring minimised.

11.4. Every attempt should be made to de-escalate a situation that could potentially become abusive or worse. Where de-escalation fails, the patient, relative or visitor should be warned of the consequences of future unacceptable behaviour.

11.5. Where it is deemed appropriate to speak to a patient, relative or visitor in respect of their behaviour, this should (where practicable) be done informally, privately and at a time when all parties involved are composed.

11.6. The aim of the verbal warning is twofold:

• to ascertain the reason for the behaviour as a means of preventing further incidents or reducing the risk of it reoccurring; and

• ensure that the patient, relative or visitor is aware of the consequences of further unacceptable behaviour.

11.7. A meeting should be arranged and conducted in a fair and objective manner.

11.8. A formal record should be made and maintained, utilising the Datix Incident Reporting System.

11.9. Collective responsibility, partnership working and local ownership is essential to the creation of a pro-security culture and it is therefore important for managers to ensure that all relevant parties are involved in the development or review of local procedures and arrangements. Local procedures should therefore reflect:

• the views of staff and their union safety representatives or professional representatives;

• the view of patients, service users and their representatives;
• clear links to other relevant procedures and policies; and

• clear outlines of responsibilities and lines of accountability in respect of any action to tackle non-physical assaults.

11.10. Members of staff should never be prevented or discouraged from reporting non-physical assaults to the police. In appropriate cases the clinical condition of the assailant should be considered as part of the decision making process.

11.11. The following is a list of possible aggravating factors which should be considered when deciding to report an incident to the police.

• The effect on the victim and/or others present;

  (However, the fact that none of the individuals present are adversely affected does not mean that a criminal offence has not been committed or that the incident should not be reported to the police).

• The assailant’s behaviour is motivated by hostility towards a particular group or individual on the ground of race, religious belief (or lack of), nationality, gender, sexual orientation, age, disability or political affliction;

• A weapon, or object capable of being used as a weapon, is brandished or used to damage property;

• The incident was an attempted, incomplete or unsuccessful physical assault;

• The incident involves action by more than one assailant;

• The incident is not the first to involve the same assailant(s);

• There is an indication that a particular member of staff or department/section is being targeted;

• There is a serious concern that any threats made will be carried out;

• There is a concern that the individual’s behaviour may deteriorate or that other NHS bodies should be advised or alerted;

• The response to the incident has caused significant additional expenditure.

• All incidents involving firearms should be reported to the Police.
12 Equality Impact Assessment

During the development of this policy the Trust has considered the needs of each protected characteristic as outlined in the Equality Act (2010) with the aim of minimising and if possible removing any disproportionate impact on employees for each of the protected characteristics, age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation. No detriment was identified.
**Appendix ‘A’**

Prevention and management of violence and abuse

Assessment tool template

*This assessment tool is designed to help nursing staff assess patients with a potential for violence or a history of violence and abuse against NHS staff, and to achieve a consistent approach. It should be used in conjunction with the information and strategies outlined in these procedures. The tool may be used on its own or as part of an overall nursing assessment and the information gathered used to inform the patient’s care plan.*

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<th>Guidance Notes</th>
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| **1** Assess patient’s potential for violence and abusive behaviour through history, patient interview (or interview with family and friends, if patient is unable to communicate). | • Before meeting with the patient, examine their medical and nursing notes to check for any incidents of violence and abusive behaviour that have been documented and how they were managed.  
  • Introduce yourself and explain any procedure in plain and simple terms. Try to build a rapport with the patient to put them at ease during the assessment interview.  
  • If appropriate and safe to do so, explore the patient’s history with them and explain the health body’s policy regarding violence and abuse against staff. |
| Where possible, refer to medical and nursing notes and information provided from other relevant organizations or individuals, such as Social Services, patient’s GP etc. |                                                                                                                                               |
| **2** Assess whether patient has any communication difficulties and explore possible reasons for this (e.g. sensory impairment, learning disability or English not being their first language). | • If there are communication difficulties, try to arrange for a family member or significant other person to be present to assist during the assessment. You should always try to obtain the patient’s consent for this first.  
  • If the patient’s hearing is impaired, ensure that hearing aid equipment is set and working properly or arrange for a BSL interpreter to be present for the assessment.  
  • If the patient’s first language is not English, it may be appropriate to arrange for an interpreter to be present. |
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<td><strong>3</strong> It may be useful to engage with family and/or friends to <strong>establish if there is any history of violence or abusive behaviour within the family</strong>. To maintain patient confidentiality, establish whether or not the patient has advised any significant persons/family, of their condition. However, be aware that family dynamics may be a cause of patients' violence and judge whether or not to proceed with engaging with family. Establish level of support available to the patient from family or other significant person.</td>
<td>• Encourage family members and significant persons to enforce message that violence or abuse is not tolerated within the healthcare environment.</td>
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| **4** **Assess patient’s attitude to treatment and medical condition.** | • Answer any questions the patient may have concerning their admission, treatment or diagnosis and try to alleviate any anxiety.  
• Arrange for the patient’s doctor, or other relevant members of the multi-disciplinary team (MDT), to discuss their condition with them if necessary. |
| **5** **Assess patient’s current physical and mental health, current medication and any substance use and misuse.** | • If there are any concerns about the patient’s mental health, refer to the on-call psychiatrist, psychiatric liaison nurse or mental health team.  
• If there are any signs of substance use or misuse, discuss with the patient the health body policy on the use of substances. Refer the patient to the substance misuse team, if appropriate.  
• If appropriate, set boundaries with patient and employ the use of a behaviour agreement  
• If there are any organic or other physical health concerns, refer to the appropriate member of the MDT.  
• Explain policy regarding prescribed medication. |
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| **6** Assess whether patient has any previous known episodes of violence and/or abuse, including *any trigger factors or antecedents such as a recent bereavement.* | • Establish from medical records/nursing notes whether patient has had any previous episodes of violence and/or abuse against NHS staff.  
• When engaging with the patient, be alert to any information that they disclose about incidents in their personal life that may have precipitated previous violent behaviour, such as medical/psychiatric diagnosis, change to marital status, bereavement, redundancy etc. This can be achieved through general conversation rather than a direct questioning process.  
• Ensure that all staff, including the multi-disciplinary team, new staff and agency/bank staff, are aware of patient’s history and how to care for them in a safe manner.  
• Observe for warning signs and triggers, and manage appropriately on the scale of de-escalation and resolution to calling for assistance.  
• Promote an environment that provides safety and reduces agitation. |
| **7** If known history of violence or abusive behaviour, *establish whether there is a history of using weapons, hostage taking etc.* | • Ensure that all staff, including the multi-disciplinary team, new staff and agency/bank staff, are aware of patient’s history and how to care for them in a safe manner.  
• Ensure that all staff are aware of what to do in the event of a violent or abusive incident.  
• Observe for warning signs and triggers, and manage appropriately on the scale of de-escalation and resolution to calling for assistance. |
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<th>As regards any previous episodes of violence or abusive behaviour, establish the following if possible: <strong>how previous incidents were managed</strong>; which interventions were successful and which were not; how long the episode of violence or abusive behaviour lasted; if medication was used to resolve the situation; if the police were involved; and what sanctions, if any, were applied.</th>
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<td>• If in previous episodes of violence, particular interventions worked, review these for application locally. If particular interventions did not work, review these for lessons to be learned and ensure that all of the multi-disciplinary team, new staff and agency and bank staff are aware of these.</td>
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<td>• Observe for warning signs and triggers, and manage appropriately on the scale of de-escalation and resolution to calling for assistance.</td>
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<td><strong>Where possible, use appropriate advanced directives</strong>¹ determined by the patient.</td>
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<td>• Staff may wish to consider previous incidents recorded and decide whether it would be helpful to discuss known trigger factors and any preferred intervention with the patient.</td>
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<td>• Staff may wish to consult their mental health colleagues for advice before engaging in such a discussion with the patient.</td>
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<td>• Ensure that any advanced directives are communicated to all staff caring for the patient.</td>
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¹ An advanced directive is a document that contains the instructions of a patient, setting out their requests in the event of a relapse of a condition or an incident of disturbed/violent behaviour etc. It sets out the treatment that they do not want to receive and any treatment preferences that they may have in the event that they become violent. It also contains the names of people whom they wish to be contacted and any other personal arrangement that they wish to be made.
Appendix B

MANAGEMENT OF VIOLENT / ABUSE INCIDENT

Incident of violence or abuse occurs

Immediate Or imminent danger

Primary tasks:
- Do not take risks
- Look for hazards
- Decide who might be harmed and how
- Decide whether existing precautions are adequate
- Decide whether to continue or evacuate
- Discreetly remove objects that could be used as weapon

Contact:
(a) Police (if appropriate)
(b) Local Security Management Specialist.

Secondary tasks:
- Notify manager & complete incident report

Manager to provide support & assistance on dealing with immediate situation until resolved.
Initiate post-incident review

Initial incident dealt with

Line Manager to begin a post-incident review process
- Establish if a medical review is required
- Investigation & review (as appropriate)
- Provide counselling/support
- Follow up on all witnesses to the incident
- Conduct a risk assessment and a develop strategy for ensuring safety

Provide feedback on process/systems in place, any identified weaknesses and Lessons learned
Review by Divisional Governance Group
## MONITORING TOOL

<table>
<thead>
<tr>
<th>Minimum requirement to be monitored</th>
<th>Process for monitoring (e.g. audit)</th>
<th>Responsible individual / group / committee</th>
<th>Frequency of monitoring</th>
<th>Evidence</th>
<th>Responsible individual for development of action plan</th>
<th>Responsible committee for monitoring of action plan and Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duties</td>
<td>Review of the policy</td>
<td>Health Safety Wellbeing Group (HSW)</td>
<td>Annual or in event of breach of security</td>
<td>Policy complies with NHS Protect guidance directly referring to all applicable standards</td>
<td>LSMS</td>
<td>Education and workforce</td>
</tr>
<tr>
<td>How the organisation carries out risk assessments for the prevention and management of violence and aggression</td>
<td>Risks are identified and conveyed to staff so that ‘post incident’ lessons are learnt. Assurance reports to HSWE</td>
<td>Service Leads</td>
<td>Annual or if significant changes</td>
<td>Risk Assessments Minutes HSWE</td>
<td>Service Managers / Team leaders liaising when necessary with LSMS</td>
<td>Service Lead</td>
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<tr>
<td>Timescales for review of risk assessments in relation to violence and aggression</td>
<td>Review of risks at Divisional Governance meetings</td>
<td>Divisional Governance meetings</td>
<td>Annually</td>
<td>Risk Flyers Minutes</td>
<td>Service lead and Divisional manager</td>
<td>Quality, Patient Experience and Risk Group (QPER)</td>
</tr>
<tr>
<td>How action plans are developed as a result of risk assessments</td>
<td>Discussed with relevant staff and seen to be effective and where appropriate polices amended</td>
<td>Appropriate Service Manager / Team Leader</td>
<td>Annual or sooner if significant changes</td>
<td>Risk Assessments Minutes</td>
<td>Divisional Heads / Managers of departments</td>
<td>Divisional Governance meeting</td>
</tr>
<tr>
<td></td>
<td>Review of Divisional Risk Register</td>
<td>Divisional governance meetings</td>
<td></td>
<td></td>
<td>Divisional manager</td>
<td>QPER</td>
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<td>How action plans are followed up</td>
<td>Annual security plan</td>
<td>LSMS</td>
<td>Annual</td>
<td>Annual security plan is commensurate with annual security report and follows guidance from NHS Protect Meeting minutes</td>
<td>LSMS</td>
<td>Security Management Director</td>
</tr>
<tr>
<td></td>
<td>Review of Risk assessments at Divisional Governance meetings</td>
<td>Divisional Governance Groups</td>
<td>Monthly</td>
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</tr>
<tr>
<td>How the organisation trains staff in line with the training needs analysis</td>
<td>Attendance Reports prepared for the Learning and Development Group Divisional Governance Groups via Summary L&amp;D reports</td>
<td>Head of Nursing, Quality and Governance Divisional Managers</td>
<td>A minimum of four times a year</td>
<td>Attendance reports</td>
<td>Reviewed by Learning and Development Group and by updates in Quarterly Reports for E&amp;WC</td>
<td>Attendance Reports prepared for the Learning and Development Group Divisional Governance Groups via Summary L&amp;D reports</td>
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