Policy and Guidelines for the Prevention and Non-Physical Management of Aggression and Violence (PMAV) in the Workplace.

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Author: Moving and Handling Training Advisor
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If you would like this document in an alternative language or format, please contact Corporate Services on 01595 743069.

Registration Reference Number: HRSSPOL005

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Proposed groups to present document to:
- Health and Safety Committee
- Area Partnership Forum
- Staff Governance Committee

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<td>CHMT</td>
<td>Discuss Rapid Tranquilisation</td>
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Examples of reasons for presenting to the group
- Professional input required re: content (PI)
- Professional opinion on content (PO)
- General comments/suggestions (C/S)
- For information only (FIO)

Examples of outcomes following meeting
- Significant changes to content required – refer to Executive Lead for guidance (SC)
- To amend content & re-submit to group (AC&R)
- For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
- Recommend proceeding to next stage (PRO)

*To be attached to the document under development/review and presented to the group
Please record details of any changes made to the document on the back of this form
<table>
<thead>
<tr>
<th>DATE</th>
<th>CHANGES MADE TO DOCUMENT</th>
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<tr>
<td>September 2013</td>
<td>Received comments from CMHT, Addition of Rapid Tranquillisation Guidelines</td>
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<td>October 2013</td>
<td>Received Comments from Occupational Health</td>
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<tr>
<td>March 2014</td>
<td>- <strong>1.0 Introduction</strong>, Policy aims includes that NHS Shetland will consider withholding treatment in specific cases</td>
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<td></td>
<td>- <strong>2.0 Roles and Responsibilities</strong>, now includes Director of Human Resources and Support Services, Human Resources, Safety and Risk Support Team and Staff Development</td>
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<td>- Added a section on <strong>3.0 Legislative Framework</strong></td>
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<td>- <strong>4.0 Procedure</strong> now includes information on reporting using DATIX and support for victims</td>
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<td>- <strong>5.0 Monitoring and Reviewing</strong>, now includes indicators for success</td>
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<td>- <strong>6.0 Guidelines</strong>, using DATIX to record and debriefing</td>
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<td>- <strong>8.0 Restraint</strong>, now includes chemical restraint</td>
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<td>- Policy now links with a number of new and updated policies and others which are in draft</td>
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<tr>
<td>May 2014</td>
<td>- Policy title has been changed to highlight this is “Prevention and Non-Physical Management of Violence and Aggression.”</td>
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<td>- This will be reflected in the context of the policy.</td>
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<td>- In support of the forthcoming Restraint Policy, information and clarification around some restraint issues are included. <strong>8.0 Restraint</strong> mechanical restraint is included for clarification although the management of this is not within the scope of the policy the group agreed this should be included for reference.</td>
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<td>June 2014</td>
<td>- 1.1 Include non-physical in the policy outline.</td>
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<td>- 6.3 Managing the situation - putting your colleagues safety first.</td>
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<td>- 6.3 Managing the situation – should not put yourself at risk to prevent damage to property or equipment.</td>
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<td>- 6.8 include review must take place asap and Occupational health can support the review.</td>
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<td>- 7.0 Acknowledge the purpose of the policy is for the Organisation to support staff to take appropriate action.</td>
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<td>- 7.1 Recognise that witnesses are not always present.</td>
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<td>- 8.0 Restraint is for information not part of the policy</td>
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1.0 Introduction

1.1 Policy Outline

This policy describes NHS Shetland’s approach to the prevention and non-physical management of adverse events where employees (including temporary and agency staff), contractors, volunteers, students and those on work experience are exposed to aggression and violence from users of NHS Shetland services. The policy applies to all situations in which violence at work may occur. It should be read with the accompanying good practice guidelines. This policy forms an integral part of NHS Shetland Health and Safety Policy and applies along with any specific local guidance for preventing and managing violence and aggression in the workplace.

NHS Shetland takes seriously the health, safety and welfare of its entire staff. We believe that aggression, abuse and violence towards employees is unacceptable and that staff have a right to be able to perform their duties without fear of aggressive, abusive or violent acts.

1.2 Definition

NHS Shetland defines aggression and violence as follows:

“Any situation, in which a person working in the healthcare sector is verbally abused, threatened or assaulted by a patient or member of the public in circumstances relating to his or her employment.”

(Violence and Aggression to Staff in Health Services, (HSE) 1997)

This definition includes bullying, harassment and intimidation of any nature involving any person. Events of this type are addressed in the NHS Shetland Eliminating Bullying and Harassment Policy. This document describes the approach to managing bullying and harassment by managers, colleagues, patients, carers, relatives, visitors and/or advocates and staff from other agencies.

http://www.shb.scot.nhs.uk/board/policies/hr-EliminatingBullyingHarassment.pdf

It could also include serious damage to the environment such as breaking windows, fabric of buildings or throwing furniture.

1.3 Purpose

This Policy aims to:

- Promote good practice that will protect those covered by the policy in line with current legal responsibilities.
- Promote and support the development of a culture where the prevention of aggression and violence is embedded in everyday practice.
• Provide a framework for those covered by the policy through risk assessment, education, training and comprehensive adverse event reporting thereby supporting the development of a safe culture and environment for all.
• Provide a framework for audit through monitoring and reviewing violent and aggressive adverse events, ensuring audit of risk assessments and safe systems of work including the provision of support available to staff involved in such events.
• Monitor and review Policy and Guidelines, ensuring they are up to date and compliant with current legislation, research evidence and best practice.
• Recognise that NHS Shetland will consider withholding or refusing treatment if aggressive or violent behaviour would:
  o Prejudice the safety of those providing or receiving treatment.
  o Negate any benefit the recipient may receive from the treatment.
  o Lead staff to believe they are unable to perform their duties.

2.0 Roles and Responsibilities

2.1 Chief Executive is responsible for:

• Making sure there are arrangements for identifying, evaluating and managing risk associated with violence and aggression at work.
• Providing leadership in the development of a positive safety culture.
• Ensuring, so far as reasonably practicable, adequate resources for the implementation of safe working practices and that appropriate control measures are put in place in relation to aggression and violence.
• Ensuring there are arrangements for monitoring adverse events involving aggression and violence, risk assessments and safe systems of work and that the Board regularly reviews the effectiveness of the policy.
• Delegating these responsibilities as appropriate.

2.2 Director of Human Resources and Support Services is responsible for:

• Leading the strategic approach to the prevention and management of aggression and violence.
• Ensuring that resources and expertise are available to support the implementation of this policy as far as is reasonably practicable.
• Ensuring that an appropriate risk assessment framework is in place at both corporate and departmental level and that this is used to capture and monitor all risks in relation to aggression and violence.
• Ensuring that the effectiveness of the risk assessment framework is monitored via the Risk management Group (RMG).
• Ensuring that issues of patient safety and patient care are considered in relation to the policy.
• Ensuring the organisation has access to competent advisors regarding aggression and violence risk.
2.3 Heads of Departments and Senior Charge Nurses/Sisters/Team Leads are responsible for:

- Ensuring that all staff are aware of the Policy and Guidelines and this includes local procedures.
- Ensuring that risk assessments are in place and that safe systems of work are implemented in order to eliminate, reduce and control the exposure to aggression and violence of those covered by the policy.
- Ensuring that those identified as being at risk are given appropriate information, instruction, training in Management of Actual and Potential Aggression (MAPA) personal safety and foundation programmes (including updates and refreshers when necessary) and supervision which is evidenced in personal development plans.
- Ensuring that appropriate support is given to anyone involved in any adverse events of violence and aggression, including high frequency low impact adverse events.
- Recognising not only physical impact but also psychological impact on individuals exposed to violent or aggressive adverse events.
- Monitoring the effectiveness of preventative measures, using the DATIX system reporting function to analyse adverse events occurring in their area and ensure the continuing validity of departmental risk assessments.
- Ensuring liaison with other agencies as appropriate.

2.4 All staff are responsible for:

- Taking reasonable care of themselves and other people who may be affected by their actions.
- Cooperating by following systems and procedures designed for safe working.
- Reporting all adverse events and near misses involving verbal abuse, threats and physical assault to their line manager and recording the event on the Datix system.
- Reporting any unsafe working practices to their line manager.
- Reporting any injuries caused through the use of restraint or restrictive physical interventions to their line manager and recording the event on the Datix system.

2.5 The Safety and Risk Support Team are responsible for:

- In conjunction with line managers, notifying the Health and Safety Executive (HSE) of any adverse event that meets the criteria for reporting under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.
- Collating adverse event reports and distributing statistics to the organisation.
- Providing advice on specific health and safety topics, support for staff in the use of the Datix system and help with risk assessment and recording and adverse event review.
2.6 **Occupational Health Service** is responsible for:

- Ensuring appropriate support is available to staff exposed to aggression and violence, following self-referral or a referral to Occupational Health by the staff members line manager.

2.7 **Human Resources Department** is responsible for:

- Providing information to staff about accessing information on existing compensation mechanisms and benefit schemes.

2.8 **Organisational and Staff Development** is responsible for:

- Delivery of appropriate accredited training to staff to meet the learning needs identified.

2.9 **Staff Governance Committee** has the responsibility to:

- Monitor progress towards attaining national standards, specifically standard 5: *staff are provided with a continuously improving and safe working environment promoting the health and wellbeing of staff, patients and the wider community* (NHS Staff Governance Standard 2012).
- Respond appropriately to the results from the national staff survey based on staff responses and experiences with regard to questions on violence and aggression. The results from this survey may be used organisationally to formulate key outcomes in the Staff Governance Action Plan.

3.0 **Legislative Framework**

The legislative framework within the UK and Scotland places obligations on all employers to protect those covered by the policy from violence at work. There are several key pieces of legislation associated with violence at work. These include:

- RIDDOR 2013.
  - Place a responsibility on employers to ensure that risk assessments are carried out on manual handling operations.
  - Any planned or emergency restrictive physical intervention will be viewed as a manual handling operation and due regard must be given to those regulations and the Moving and Handling Policy.

4.0 **Procedure for the Prevention and Management of Aggression and Violence (PMAV)**

4.1 Prevention of Violence and Aggression through Risk assessment

Risk must be assessed in all work areas where violence and aggression pose an actual or potential risk to staff. The assessment will involve identifying situations where acts of violence and aggression could occur. It should identify who will be
affected and how, and what control measures are needed to eliminate or reduce risk to the lowest level reasonably practicable. A risk assessment should be carried out and entered onto the departmental risk register recorded on the Datix system. The following details should be recorded:

- The extent and nature of the risk and who is affected.
- The factors that contribute to the risk – including job content and work environment.
- Existing preventative measures.
- An evaluation of remaining risks.
- Any additional preventative or control measures identified.
- The safe systems of work to be followed to eliminate or reduce the risks.

These details should be communicated to staff and risk assessments reviewed and updated regularly, or immediately if circumstances change.

4.2 Reporting an Adverse event

Staff must report all instances of violence and aggression (including near misses) to their line manager at the earliest opportunity and ensure that the event is recorded on the Datix system. The line manager and/or a review team must then review the matter following the processes described in the Board’s Adverse Event Policy.

In line with Reporting of Injuries, RIDDOR 2013 the HSE must be informed of an adverse event that meets the criteria for reporting i.e. the injured party dies, suffers a major injury or is absent from work for more than seven days in a row. More information is available online via the following link http://www.hse.gov.uk/riddor/index.htm or the Safety and Risk Support Tool. http://intranet/departments/safetyandrisk/supporttool.html

All reports to the HSE under RIDDOR are co-ordinated by the Safety and Risk Manager. In practice this means that a face-to-face or telephone conversation takes place between the Safety and Risk Manager and the affected party to agree the detail of the report to the HSE. A copy of the RIDDOR report is provided for the affected party and uploaded to the Datix record by the Safety and Risk Manager.

High frequency low impact adverse events are considered to be a stressor and therefore can potentially impact on the health and well being of the people involved. Managers should prioritise the review and management of these adverse events.

Abusive, violent, disruptive or self-harming behaviour adverse events are recorded and categorised on the Datix system.

4.3 Preventing and Managing Aggression and Violence through Education and Training

There is no statutory requirement for all NHS Shetland staff to undertake training on the prevention and management of aggression and violence. However NHS Shetland has an obligation to provide training for staff in departments who are at risk of being victims to these behaviours. Managers are responsible for ensuring that employees, including temporary staff, receive the appropriate level of training as identified by local risk assessment and training needs analysis. Managers have a responsibility to have due regard to the requirement for refresher training for all employees whom they have management responsibility for.
Training will be relevant, purposeful, evidence based and provided by people with appropriate qualifications and expertise. Refresher training will be provided annually and regularly reviewed and evaluated.

Details of training are available from the Staff Development team and will be advertised within the quarterly Staff Bulletin. Current availability of training is based on Non Violent Crisis Intervention Training and Management of Actual and Potential Aggression foundation (MAPA) training.

4.4 Staff Support

NHS Shetland will ensure that all staff who become involved in adverse events involving violence or assault has access to appropriate support. Managers are responsible for ensuring that adverse events are reviewed as soon as possible after occurrence with all staff involved and that any relevant referrals for follow up support are completed. Staff may need time off to receive medical attention, legal advice or counselling support. Referral to Occupational Health is recommended for advice and support. Managers can refer staff to this service or staff can self refer.

4.5 Involving the Police and Prosecution

NHS Shetland is actively committed to protecting staff from violence and assault and will support criminal proceedings against those who carry out assault. All staff are encouraged to report violent events to the police and will be supported by the Organisation throughout the process. Furthermore, employees have the full support of NHS Shetland to request a police presence in circumstances where there is a belief that there is the potential for an act of violence to take place.

The Procurator Fiscal may decide to take legal action and line managers must make sure that staff have access to ongoing support throughout this process. The Employee Counselling Service offers a 24 hour helpline (Tel: 08003897851) and the Occupational Health service can offer workplace trauma support. Support may also be available to staff through Trade Union membership.

4.6 Withdrawal of Service or Treatment

The Scottish Government has made it clear the NHS Boards have the ability to withdraw treatment and ban patients in certain circumstances (Managing Health at Work Partnership Information Network Guidelines).

http://www.scotland.gov.uk/Publications/2003/02/16388/18311

When a patients aggressive, violent or threatening behaviour significantly impairs an employee’s ability to undertake his/her duties properly, or has become an immediate and significant threat to their safety, the safety of others or to property, NHS Shetland supports the right to withdraw their service or delay treatment until a safe option for treatment is developed.

Emergency treatment will always be offered if it is safe to do so and in these circumstances patients will be offered the opportunity to discuss their behaviour if appropriate. A full explanation of any safe alternative will be given to the patient. If the behaviour continues the person will be informed by the relevant manager that their behaviour is unacceptable and the expected standards to be observed explained to them. While each case will be considered individually, and the right to
implement conditional care exercised only as a final resort, it is imperative that staff should have recourse to ensure that the delivery of care to all is not compromised.

The patient's Consultant, relevant Head of Clinical Service and Medical Director will advise the Chief Executive of the decision to withhold treatment based on clinical assessment. The patient will receive a written explanation from the Chief Executive giving the reason for this. A copy will be sent to the patient's GP.

The withholding of treatment will be regularly reviewed by the Medical Director on behalf of the Chief Executive and applied for a maximum period of 12 months. This decision will be recorded in the patient’s nursing and medical notes.

Other relevant and appropriate NHS service providers and external agencies involved in the patient's care will be informed of this decision.

Each case will be considered on an individual basis.

Further consideration will be given to patients who are:

- Under 16 years of age.

Or in the opinion of a relevant clinician:

- Are suffering from a mental health disorder.
- Mentally infirm (as defined within the Adult Support and Protection Act, 2007).
- Require emergency or life saving treatment.
- Appear to lack capacity.

A patient may appeal against any decision to withhold treatment to the Chief Executive and this will be dealt with through the local complaints procedure.

http://www.shb.scot.nhs.uk/board/complaints.asp

4.7 Relatives and Visitors

Abuse of those covered by the policy from relatives and visitors is unacceptable and will not be tolerated.

If a relative/visitor is aggressive or violent, s/he will be offered an opportunity to explain his/her behaviour if safe to do so.

If the behaviour continues s/he will be informed, by the responsible line manager that his/her behaviour is unacceptable and the expected standards to be observed.

Where a relative or visitors aggressive or violent behaviour impairs an employee's ability to undertake his/her duties safely, or has become a threat to the safety of others and/or Board property, NHS Shetland has the right to ask that person to leave NHS premises if it is safe to do so. If the person refuses and continues to present a risk the police should be contacted.

4.8 Compensation

The Criminal Injuries Compensation Scheme provides a system of compensation for any victim of violent crime. Guidance on eligibility and advice on making a claim is available online via www.cica.gov.uk and assistance may be available from Trade Union Representatives.
If an employee (inclusive of temporary staff) loses earnings as a result an adverse event s/he should contact the Human Resources department for information and advice on making a claim to the Scottish Public Pensions Agency – NHS Scotland Injury benefits Scheme, whether or not s/he is a superannuation scheme member. Further information can be found online here: www.sppa.gov.uk/nhs/injury

If a staff member suffers loss or damage to personal property as a result of an assault, a claim for compensation can be made through their line manager in consultation with the Finance Department.

5.0 Monitoring and Reviewing

5.1 Director for Human Resources and Support Services will be accountable:

- To NHS Shetland for implementing the policy.
- For ensuring the Policy is reviewed every three years as required.
- For ensuring the arrangements for PMAV are reflected in the Boards Risk Management Strategy.
- For ensuring that risk assessments, safe systems of work and adverse event statistics are monitored and any system or service weaknesses are raised through the Staff Governance, Clinical Governance and/or Health and Safety Committees as appropriate.

5.2 Safety and Risk Support Team, Organisational and Staff Development and the PMAV trainer will be accountable for:

- Managing the three yearly policy review.
- Managing resources appropriately to ensure that appropriate training resource is available to meet the learning needs of staff.
- Monitoring all aspects of PMAV service and reporting to the Director of Human Resources and Support Services, highlighting any service issues.

5.3 Indicators of success will include:

- Awareness of employees, inclusive of temporary staff, of the policy and a demonstrable understanding evidenced through localised induction and completion of the checklist.
- Monitoring and feedback on the reporting of such adverse events using information recorded on the Datix system.
- Monitoring of Health and Safety Committee forum activity regarding prevention and management of violence and aggression.
- Analysis of participant evaluation of training courses.

5.4 Mechanisms for evaluation will include:

- Feedback obtained from local and national staff surveys of changes in organisational culture, regarding aggression and violence.
- Collecting of all reported adverse event statistics by the Safety and Risk Support Team.
- Analysis of participant evaluation of training courses.
6.0 Guidelines for PMAV

These guidelines provide practical advice in order to assess, PMAV in the workplace.

Many factors are involved in an adverse event involving violence and aggression. Whilst some staff may have a comprehensive understanding of how, why and when a violent situation will occur, adverse events will sometimes arise without warning or indication. It is therefore important that each member of staff assess the risk of violence to themselves and others as they undertake their normal duties.

Violent adverse events do not necessarily need to cause physical harm. The range covered includes:

- Cause major injury.
- Require medical assistance.
- Require first aid only.
- Involve a threat, even if no physical injury results.
- Involve verbal abuse.
- Involve non-verbal abuse, such as stalking.
- Involve other threatening behaviour.

6.1 Reasons for Aggression and Violence

Violence can occur for a number of reasons which may include:

- Effects of injury.
- Life threatening medical conditions e.g. hypoglycaemia, hypoxia or brain injury.
- Alcohol, drug and/or solvent misuse or withdrawal.
- Stress, frustration, feelings of fear.
- Mental health.
- Reaction to uniformed staff/authority.
- Environmental triggers e.g. too hot, too cold, too bright, too noisy.
- Unrealistic expectations of the service.
- Unsympathetic attitudes on the part of staff at a time when reassurance and sympathy are required.
- Communicating information effectively to patients, relatives and visitors is critical in lessening the risk of aggression and violence.
- Bias, discrimination or indifference on the part of staff to the patients, relatives or visitors.
- Reluctance by individuals to receive treatment in a health care environment or in their own homes. In most circumstances you do not have the right to examine or treat patients without their consent. It is only patients who are admitted under The Mental Health Act (Scotland) 2003 on Short term detention (up to 28 days) that may be treated without their consent and when the Responsible Medical Officer follows the safeguards outlined in part 16 of The Act. In some instances this can also occur under Emergency detention (3 days) where treatment is needed urgently or they are being treated under part 5 of the Adults with Incapacity (Scotland) Act.

http://www.mwcscot.org.uk/media/73317/a_guide_to_consent_to_treatment.pdf
6.2 Indicators of the Potential for Violence

If you are to protect yourself, it is important for you to recognise early warning signs of those staff, patients and members of the public who might be potentially violent. Sometimes a threat can be made quite openly e.g. threatening language and/or gestures, but other actions may be less obvious.

The individual may:

- Be tense and agitated displaying signs of anxiety.
- Reply to questions abruptly.
- Increase voice pitch and volume.
- Wring hands, make fists, punch their own hands or nearby objects.
- Increase their activity e.g. pacing, fidgeting.
- Exhibit unusual or inconsistent behaviours e.g. the noisy person who becomes withdrawn or quiet.
- Invite your personal space.
- Have a history of previous violence.
- Be under the influence of alcohol or drugs which might increase the likelihood of violent/aggressive behaviour.

This list is neither exclusive nor exhaustive.

6.3 Managing situations

If you are faced with a potentially violent situation, you should:

- Put your and colleagues safety first
- Stay calm, confident and objective; plan your retreat should you need it, position yourself between the door and the aggressor.
- Listen and then talk, answer rational questions with a rational, informative jargon free response, give the person your full attention.
- Be non judgemental and non critical.
- Keep a soft relaxed tone to your voice and only use the volume required to be heard.
- Consider your body language: stand a safe distance away from the person, stand sideways to reduce your size as a target and allow extra mobility should a retreat be necessary.
- Maintain eye contact without staring and use open and fluid hand movements.
- Show concern and understanding and acknowledge the feelings of the person you are communicating with.
- Let the person suggest solutions.
- Ask questions to clarify matters and gain control – assume nothing.
- Use distraction in some cases where the person may be confused.
- Say sorry when required, it can be incredibly powerful.

You should not:

- Get drawn into a heated debate but stay focused and consider withdrawing and summoning help.
- Over react to the patients emotions.
- Tell the person to “calm down”, “don’t be silly”, “don’t worry about it” as this may escalate the situation.
• Attempt to touch a person in this situation as this could trigger a more violent reaction and could be interpreted as an assault in law.
• Make promises you cannot keep or offer too many options.
• Put yourself at risk to prevent damage to property or equipment.

The possibility of having another member of staff, a colleague, doctor, the Police or other relevant specialist back up should be considered if:

- There is a known history of violence.
- Violence has been threatened by a patient or other individual.
- There are reasonable grounds for believing someone possesses an offensive weapon.

More comprehensive guidance will be available through staff training as detailed above.

6.4 Guidance on conducting a risk of violence assessment

Ward sisters, community nurses, team leaders and heads of departments are responsible for ensuring that they assess the risk of violence in their areas. For each significant hazard staff must either remove the hazard or decide upon appropriate control measures to put in place.

6.4.1 Identify the hazards:

- In records of adverse events in your area.
- Talk to your staff and their representatives.
- Identify potential assailants. You need to consider the full range of people staff may come into contact with. These may include patients, their relatives and friends, the confused patient recovering from anaesthesia, the family of a patient at home etc. Consider carefully risks from particular groups such as patients with learning difficulties.
- Consider particular activities, which may present a high risk of violence, such as refusing an appointment, administering medication, complicated paperwork, delivering unwelcome information.
- Staff required to attend outlying, remote locations may be exposed to greater risk due to the isolation and communication difficulties. Staff should carry a mobile phone to keep in touch and summon assistance if needed.
- Staff in the community and primary care setting should always inform colleagues of their whereabouts when visiting patients, especially when any degree of concern exists about the safety of the visit.
- Staff should take extra care during the hours of darkness, as there are often fewer people available locally to assist with aggressive situations.

6.4.2 Decide who could be harmed and how:

- Consider all staff who may visit your area, such as allied health professionals and facilities staff, not just those that are permanently employed.
- Remember to take account of the level of staff training and skills. This will affect their vulnerability to assault.
- Remember the potential effects on staff of repeated or severe verbal abuse or threats.
- Remember the potential effects on patients and visitors of witnessing abuse and threats.

### 6.4.3 Evaluate the risks and decide on appropriate control measures:

- Primarily consider the most serious risks and those that affect most people.
- Is there a way to change and improve:
  - The jobs people do?
  - The circumstances in which they work?
  - The way tasks are completed?
  - The layout of the workplace?
  - The information given to employees and the way it is communicated?
  - The systems of sharing information about patients?
  - The response to adverse events?
- Is training directed at the relevant employees?
- Are there support systems for employees, which are confidential and accessible?

### 6.4.4 Record the findings and implement them:

All risk assessments are recorded directly onto the Datix electronic risk management system. Any member of staff can document a risk using the appropriate link on the home page of the intranet.

Clicking on the link takes you directly to a Risk Assessment Form (RA1) which allows you to record:
- Risk summary.
- Description of the risk.
- Risk grade.
- Controls in place.
- Review date.

Additional fields are available to managers and Heads of Departments to manage their risks via their Datix LOGIN link, including:
- Potential impact of risk.
- Level of risk e.g. departmental/directorate/corporate.
- Initial, current and target risk grade.
- Closed date (for risks that are no longer applicable).

Once you have completed the risk assessment, you must act on the findings. This means putting the results of your risk assessment into practice – which is what contributes to a safer, healthier workplace, improved patient outcomes and, ultimately, the delivery of organisational objectives. Writing down the results of your risk assessment and sharing them with staff encourages you to do this.

### 6.5 Review and revise the Assessment

Risks must be reviewed regularly. If further actions have been required then the review will help to establish whether the action has been taken and if so how much progress has been made. The Datix Risk Assessment Form incorporates a Review
Date section. The Review Date is the date when you will next review the risk and control measures.

If no further actions are required, then the risk assessment should be reviewed after 12 months. Where moderate or minor risks are identified, then a 6 monthly review is normally sufficient. A significant, ongoing risk will require close monitoring and be reviewed at intervals of not more than three months.

A comprehensive guide to risk assessment in NHS Shetland is available here: http://www.shb.scot.nhs.uk/board/policies/RiskAssessmentProcedureAndRiskRegisterGuidance.pdf

6.6 Reducing the Risk

When developing and implementing control measures you need to consider the following:

- The workplace – physical aspects of the premises.
- Access controls.
- Working patterns and practices.
- Staffing levels and competence.
- Training: there is an accredited trainer based at Staff development who is available to provide local training and advice.
- Security – particularly in line with the lone working policy.

6.7 Adverse event reporting

All adverse events must be reported and investigated in accordance with the Adverse Event Policy (Identification, Reporting, Review and Learning) found here: http://9.200.150.6/documents/pphandbook/documents/AdverseEventsReportingAndInvestigation.pdf

In recording adverse events you should use your discretion to distinguish between verbal abuse and the type of offensive language some people may use as part of their everyday vocabulary.

It is also important that any types of disengagement/breakaway techniques used are also recorded.

No employee should fail to report an adverse event because they believe that violence is part of the job. Some areas may feel that a continuing level of violence is part of the job – such as learning disabilities, mental health or older people with Alzheimer’s or dementia. It is important that staff understand all forms of violence are unacceptable and are reported so all adverse events are captured.

6.8 Debriefing

Debriefing is an essential element of the management and prevention of violent and aggressive adverse events and the reporting manager has responsibility to ensure this takes place as soon as practically possible following any adverse event. Occupational Health can support this review process. It is not just for the victim of the event but ideally should include everyone who was involved (witnesses, other staff, possibly even the aggressor him/herself, if appropriate).
The purpose of debriefing is to establish what happened, what further action or support is required and what lessons should be learnt. It is important that the lessons learnt are communicated to all relevant staff, whether or not they were involved in the adverse event.

7.0 The Law and Assault

The purpose of this policy is to support staff taking appropriate action and outlines the Organisations responsibility to support staff to act reasonably within the context of the policy. In law, a person may restrain a patient/client who may be a danger to themselves or others, only with such force as is deemed necessary and reasonable in the circumstances. The minimum amount of force possible should be used. Staff carrying out any restraint must be appropriately trained.

"Reasonable means the amount of force which is sufficient to stop the attacker or to prevent you or others being injured". Unlawful restraint may result in criminal or civil liability.

In law there are two types of assault:

- Serious assault charges are usually brought where there is evidence of significant injury. In such cases the police will normally always prosecute. If you are assaulted there will be a requirement to provide a statement and, unless an assailant pleads guilty, give evidence at a court of law.
- Common assault is used to describe a situation where there is not normally physical evidence of injury. Police are not able to bring prosecution in such cases and the onus is on you to initiate legal action. In these circumstances you are advised to seek the advice of your line manager, Trade Union and / or take legal advice.

7.1 Retaliation and Defence

In law, any retaliation could be considered an assault. When defending yourself from a violent person you should consider that a person in a state of excitement, or who is struggling violently, will have a rapid heart rate and be breathing rapidly and shallowly. These changes in cardio-respiratory function reflect the person’s need for increased oxygen. It is therefore dangerous to impede respiration in any way, such as:

- Sitting on/restricting a persons chest.
- Putting an arm around the throat from behind.

Should you need to defend yourself then you should bear the following in mind:

- The threat posed must be immediate before you can claim that the actions you take are in self defence.
- There must be no means of escape. A court would be more reluctant to hold that your actions were in self defence if there was available to you a reasonable means of escape.
- Most importantly, the amount of force used in self defence has to be commensurate to the amount of violence presented.
The law only allows you to put up such a defence as to protect yourself. If you do have to physically defend yourself then the advantage of having a witness to substantiate your actions is helpful. However the Organisation recognises that this is not always possible during lone working situations. Most Trade Unions and Scotland’s Prosecution Service [http://www.copfs.gov.uk](http://www.copfs.gov.uk/) will provide legal assistance to those who are involved in a violent adverse event.

### 8.0 Restraint

#### 8.1 Mechanical restraint

Restraint is not included within the context of this policy and is included for staff to reference for information.

“Restraint is taking place when the planned or unplanned, conscious or unconscious actions of staff prevent a person doing what he or she wishes to do and as a result places limits on his or her freedom” (Mental Welfare Commission: Rights, Risks and Limits to Freedom, 2006).

In the UK, the use of any form of what is known as mechanical restraint (this covers the use of splints for example), such as:

- To prevent someone with a severe learning disability self injuring.
- The use of bed rails to prevent a confused elderly person climbing out of bed or
- The use of any form of tie such as bandage to restrain someone’s freedom of movement (for example, to restrain arms to prevent a patient pulling out a catheter).

may be illegal unless carried out in accordance with specific principles. Every reasonable attempt must be made to use alternatives prior to the use of mechanical restraint, which must be regarded as an absolute last resort.

If mechanical restraint is being considered, management advice should be obtained as a matter of urgency, prior to its use. A comprehensive risk assessment which records the circumstances in which mechanical restraint was used must be completed. This will highlight the potential harm which would arise if it was not used and detailing why it was considered necessary. The use of mechanical restraint must be continually reviewed with a view to discontinuing its use as soon as the risk assessment suggests appropriate. Staff must document their decisions and reasons explicitly in a care plan recording which restraint will be used, what form the restraint will take and how it will be reviewed. Any measures taken should impose the minimum restrictions on the patient’s autonomy and independence balanced with their safety.

This guidance should be considered in tandem with the NHS Shetland Policy on the Use of Restraint (Adults)

8.2 Medication and Chemical Sedation.
There are certain situations in which patients may benefit from anti-psychotic or sedative medication, such as in cases of extreme restlessness or agitation or if a patient is very frightened. Prescribing advice should be sought as appropriate. All staff prescribing or administering benzodiazepines or anti-psychotic drugs must be familiar with the properties of these drugs.

8.3 Chemical Restraint

Chemical restraint is the use of medicine purely to control or moderate an individual’s behaviour. This includes covert medication administration, such as concealing medicine in food or drinks and the administration of medication against someone’s will.

In the UK, the use of any form of what is known as chemical restraint (this covers the use of tranquillisers for example), to prevent someone with a severe learning disability self injuring; the use of tranquillisers to prevent a confused elderly person climbing out of bed or to prevent a potential aggressive outburst; or the use of any form of medication to restrain someone’s freedom of movement (for example, to sedate a person to prevent a patient pulling out a catheter) may be illegal unless carried out in accordance with specific principles. Every reasonable attempt must be made to use alternatives prior to the use of chemical restraint, which must be regarded as an absolute last resort.

If chemical restraint is being considered, management advice should be obtained as a matter of urgency, prior to its use. A comprehensive risk assessment which records: the circumstances in which chemical restraint was used; describes the potential harm which would arise if it was not used, and detailing why it was considered necessary, must be completed. The use of chemical restraint must be continually reviewed with a view to discontinuation of its use as soon as the risk assessment suggests appropriate. Staff must document their decisions and reasons explicitly in a care plan recording which medication will be used, what form the medication will be administered, how often and how it will be reviewed. Any measures taken should impose the minimum restrictions on the patient’s autonomy and independence balanced with their safety.

8.4 Rapid tranquillisation of a person suffering from a mental health disorder.

Rapid Tranquillisation as defined by National Institute for Health and Care Excellence (NICE) is: the use of medication to calm/lightly sedate the service user, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression in order to allow a thorough psychiatric assessment/evaluation to take place, and allowing comprehension and response to spoken communication throughout the intervention. It should be recognised that, although not the intention, rapid tranquillisation can lead to deep sedation/ anaesthesia.

Chemical sedation, in the form of rapid tranquillisation should only be used only as a short term measure and in conjunction with treatment for the cause of the psychomotor agitation, e.g. psychiatric illness. If used to restrain patients who are acutely disturbed, the aim should be to do one or more of the following to:
• Reduce physical and psychological strain.
• Reduce the risk of violence.
• Reduce the risk of injury to self and others.

If a patient is acutely disturbed a doctor must be called to assess the patient. Non-psychiatric causes for disturbed behaviour must be explored and excluded. Prior to using rapid tranquillisation there should be an assessment of risk. It should only be used when the risk of not using rapid tranquillisation is greater than the risk of the acute pharmacological treatment.

As with other forms of restraint (in care settings), other interventions such as increasing staffing levels, increasing levels of observation, should be considered before using chemical sedation. Any type of restraint should not be used to compensate for inadequate staffing.

The patient must be informed that he or she is to be given medication. Oral medication should be the first choice. If the patient is unable to give informed consent, then treatment under Common Law should be considered.

The minimum effective dose of medication should be used. The maximum British National Formulary doses (for older patients this should be half of the recommended dose) should only be used in exceptional circumstances.

Any existing treatment plans or Advance Statement that advises preferable medication to be used in the event of acute psychomotor agitation should be taken into consideration and recorded in the appropriate document.

Oral medication should be offered before parenteral treatment is administered.

8.5 Evaluation and review of use of restraint
The use of restraint should be evaluated in terms of effectiveness and alternatives considered wherever possible by the Mental Health Officer or Psychiatrist.

The use of restraint in an emergency situation (including the use of rapid tranquillisation) should be viewed as a Category I adverse event and recorded as such. The factors, which led up to the use of restraint and its appropriateness, should be discussed and reviewed by the multidisciplinary team.

8.6 Secluding patients
Secluding patients by placing them in a room or area from which they cannot escape is explicitly forbidden and its use will be regarded as misconduct.

All staff employed by NHS Shetland will be offered training in MAPA that includes de-escalation and disengagement techniques with regular refreshers offered as identified via personal development plans and clinical risk assessment of the work area.

It is not common practice to administer rapid tranquillisation out-with adult in-patient facilities. In NHS Shetland Rapid Tranquillisation should only be used as a last resort in emergency departments where the Mental Health Department have been contacted to provide assessment, and considered only once de-escalation and other strategies have failed to calm the service user. Where it has been deemed as necessary then, following assessment of the person’s mental state, a clinical
decision must be made on the appropriateness of the persons transfer and admission to Royal Cornhill Hospital in Aberdeen for further care and treatment. Any use of tranquillisation must be for the safety of the service user or others and must be a reasonable and proportionate response to the risk posed by the service user.

This guidance should be considered in tandem with the NHS Shetland Policy on the use of restraint. [http://www.shb.scot.nhs.uk/board/policies/RestraintPolicy.pdf](http://www.shb.scot.nhs.uk/board/policies/RestraintPolicy.pdf)

In accordance with NICE Clinical Practice Guidelines (CG25) [http://www.nice.org.uk/CG025quickrefguide](http://www.nice.org.uk/CG025quickrefguide) all staff directly involved in the Rapid Tranquillisation of a service user should be trained in Intermediate Life Support and all staff monitoring a rapidly tranquillised service user must be trained in Basic Life Support (Resuscitation Council UK). This level of training provision is supported by NHS Shetland's Resuscitation Policy. [http://www.shb.scot.nhs.uk/board/policies/ResusPolicy.pdf](http://www.shb.scot.nhs.uk/board/policies/ResusPolicy.pdf)

NHS Shetland also adheres to NHS Grampian Rapid Tranquillisation Guidelines that were written in partnership. [http://www.nhsgrampian.org/grampianfoi/files/NHSGRapTranq.pdf](http://www.nhsgrampian.org/grampianfoi/files/NHSGRapTranq.pdf)

### 9.0 References


### 9.1 Linked Policies and Procedures within NHS Shetland

- Lone Working Policy
- Eliminating Bullying and Harassment
- Adverse Event (Identification, Reporting, Review and Learning) Policy
- Policy on the Use of Restraint (Adults)
- Resuscitation Policy
- Risk Assessment Procedure and Risk Register Guidance
- Rapid Tranquillisation Grampian NHS as adopted by NHS Shetland
- Security Policy
- Violence and Aggression towards Primary Care Staff
9.2 Useful Links

Safe and Well at Work: Occupational Health and Safety Strategic Framework for NHS Scotland:  
- [http://www.scotland.gov.uk/Publications/2011/03/17125508/5](http://www.scotland.gov.uk/Publications/2011/03/17125508/5)


NHS Scotland Staff Governance Standard 4th Edition  
[http://www.scotland.gov.uk/Publications/2012/06/9560/5](http://www.scotland.gov.uk/Publications/2012/06/9560/5)

Violence and Aggression to staff in Health Services – guidance on assessment and management, Health and Safety Executive  
[http://www.hse.gov.uk/pubns/books/violence-health-services.htm](http://www.hse.gov.uk/pubns/books/violence-health-services.htm)

Working alone – health and safety guidance on the risks of lone working  
[http://www.hse.gov.uk/pubns/indg73.pdf](http://www.hse.gov.uk/pubns/indg73.pdf)

Scotland’s Prosecution Service  