Kent and Medway
NHS and Social Care Partnership Trust

Promoting Safe Services
Policy and Guidance

(Previously Management of Aggression and Violence Policy)

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DOCUMENT TRACKING SHEET

Promoting Safe Services Policy
(Previously Management of Aggression and Violence Policy)

Version	Status	Date	Issued to/approved by	Comments
2.1	Policy review	July 11	Senior Practitioner PSTS	
2.2	Draft	July 11	Senior Practitioner PSTS	
3.0	Approved			
3.1	Reformatted			
3.2	Amendments			
4.0	Approved		Governance & Risk Committee	
4.1	Policy Review	July 12	Chief Pharmacist	sections added on rapid tranquilisation
4.2	Review	Sept 12	Senior Practitioner PSTS	Section added on risk management
4.3	Review	Jan 13	Senior Practitioner PSTS & Forensic Consultant Psychiatrist	Risk assessment tool removed replaced with references to RiO Risk assessment
5.0	Approved	Feb 13	Patient Safety Group	Ratified
5.1	Amendments	Nov 13	VRS group	Discussion and comments amendments to monitoring form and inclusion of additional information about use of de-escalation rooms
5.2		Jan 14	Quality Committee	Discussion and comments made
5.3		Jan 14	Policy Group	agreed
6.0		Jan 14	Trust Board	Ratified
7.0		Nov 15	Trust wide Health Safety & Risk Group	Ratified
8.0	Amendments	September 2016	Trust Wide Health Safety & Risk Group	Two additional appendices ratified.
9.0	Approved	November 2016	Trust Wide Patient Safety and Mortality Group	Rapid Tranquilisation section updated. Ratified.
9.1	Amendments	Mar 17	D & T group	Section 17 updated to match section 15 and consultant approval required for olanzapine added
10.0	Approved	April 2017	Trust Wide Patient Safety and Mortality Group	Ratified
10.1	Approved.	Dec 2017	Positive and proactive group Senior Practitioner PMVA Policy Manager	Amendments: To clarify reporting on use of cuffs Separated Equality Impact Assessment from document. Amended 'Service line' to 'Care group' throughout document.

11.0	Approved	October 2018	Trust Wide Patient Safety and Mortality Review Group	Changes to rapid tranquilisation information ratified.
11.1	Policy review	Apr 19	Clinical lead PSS	Spilt the original policy
11.2		May 19	Clinical lead PSS	Update new definitions
12.0	Final	Jun 19	Trust Wide Patient Safety and Mortality Review Group	Ratified

REFERENCES

Care Quality Commission: Monitoring the Mental Health Act in2012/13
Criminal Justice and Immigration Act 2008 Part B (119-121) Causing a nuisance or disturbance on NHS premises. London:
Criminal Law Act 1967, Section 3.
Department of Health (2015) Mental Health Act 1983: Code of Practice.
Department of Health (2014) Positive and Proactive Care: reducing the need for restrictive interventions.
Department of Health (2012) Protecting people, Promoting health: A public health approach to violence prevention for England.
Department of Health (2004) Mental Health Policy Implementation Guide Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-Patient Settings. London
Direction to NHS Bodies on Measures to Deal with Violence against NHS Staff (2003) Directions. London: Crown Copyright.
Equality Act 2010
Equality and Human Rights Commission (2015) Preventing Deaths in Detention of Adults with Mental Health Conditions: An Inquiry by the Equality and Human Rights Commission
Health & Safety at Work Act 1974
Health and Safety Executive (2005) Work Related Violence. Human Rights Act 1998
Management of Health and Safety at Work (Amendment) Regulations (2006)
NHS Protect (2013) Meeting needs and reducing distress: Guidance on the prevention and management of clinically related challenging behaviour in NHS settings
NHS Protect (2012) Not Part of the Job. Part 1: A guide to reporting Assaults and violent incidents at work
NHS Security management Service (2010) Tackling violence against staff; Explanatory notes for reporting procedures introduced by Secretary of State Directions in November 2003 (updated June 2009)
National Institute for Clinical Excellence (2015) Violence and aggression: short-term management in mental health, health and community settings – NG10 https://www.nice.org.uk/guidance/NG10
National Institute for Clinical Excellence (2015) Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges – NG11 https://www.nice.org.uk/guidance/ng11
National Institute for Mental Health in England (2003) Inside-Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England
Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (2003) Independent Inquiry into the Death of David Bennett.
The Royal College of Psychiatrists (2006) The National Audit of Violence Final Report. London: The Royal College of Psychiatrists' Research Unit.
University of Manchester (2006) Avoidable Deaths Five Years Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

RELATED POLICIES/PROCEDURES/PROTOCOLS/FORMS/LEAFLETS

	Reference
Clinical Risk Assessment Policy	KMPT.CliG.009
Kent and Medway CPA Policy and Procedures	KMPT.CliG.001
Clinical Post Incident Review and Supporting Policy and Procedure	KMPT.CliG.159
Management of Incidents including the Management of SIs	KMPT CorG.017
Dignity at Work policy	KMPT.HR.001

Lone Working Policy	KMPT.CorG.024
Stress Policy	KMPT.HR.017
Segregation and Seclusion Policy	KMPT.CliG.065
Safeguarding Vulnerable adults Policy	KMPT.CliG.006
First Aid at Work and Resuscitation Policy	KMPT.CliG.010
Joint Working Agreement between Kent Police and Kent Health Bodies	KMPT.CliG.006
NHS Protect Guidance Meeting Needs and Reducing Distress	
Decontamination Procedure	KMPT.CliG.127
Safer Moving and Handling Policy	KMPT.CorG.008
Health and Safety Policy	KMPT.CorG.005
Concerns and Complaints Policy	KMPT.CorG.019

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
Apr 19	PMVA Training Manager/Clinical Lead	Throughout	Divided the original policy into it 3 separate documents. Renamed this policy Promoting Safe Services Policy.
May 19	Promoting safe service Clinical Lead	Throughout	Updated the definitions as stated by NHS England

CONTENTS

1 INTRODUCTION

1.1 The Kent and Medway NHS and Social Care Partnership Trust (KMPT) attaches the greatest importance to the personal safety and security of employees, patients, visitors, carers and other persons carrying out authorised tasks for and on the behalf of the Trust. The Trust accepts its legal and moral responsibility to eradicate or reduce risks to staff, patients, visitors, carers and other persons so far, as is reasonably practicable.

1.2 The NHS (SMS) a Professional Approach to Managing Security in the NHS was launched in December 2003 (NHS Protect 2003). This outlines the service's overall aims and objectives and sets out the NHS Security Management Service's approach to security management issues.

1.3 The Trust recognises the risk of violence towards its staff, patients, visitors and carers and aims to ensure, through the provisions of this policy, as safe and secure environment as is reasonably practicable. This policy should be read in conjunction with the Safeguarding Vulnerable Adults policy.

1.4 The Trust will accept vicarious liability provided that employees adhere to the Trust's policy and procedural guidelines. In addition, the Trust will reserve the right to exclude persistently violent patients, visitors and carers to support the prosecution of those acting violently or abusively towards its staff, equipment or premises.

1.5 This policy will cover all aspects of Promoting Safe Services (PSS):

1.6 The Trust will learn from Best Practice and is committed to reducing/eliminating prone/face down restraint.

2 PURPOSE

2.1 This document outlines the Trust approach to minimise the risks to staff that could potentially arise through violent or aggressive behaviour. It also summarises the actions that could and should be taken by staff if and when they find themselves in a potentially violent situation.

3 DEFINITION OF VIOLENCE

3.1 Non-physical assault – "The use of inappropriate words or behaviour causing distress and/or constituting harassment". (NHS Protect June 2012)

3.2 Physical assault – "The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort (NHS Protect June 2012)

3.3 The following list provides examples of behaviours that are deemed by the Trust to be unacceptable. Violators (staff, patients, visitors and carers) who exhibit extreme and or persistent inappropriate behaviours will face sanctions proportionate to their actions; this may include disciplinary procedures, withdrawal of treatment and prosecutions.

3.4 Staffs, patients, carers, visitors of the Trust have the right to work and be cared for in a safe and supportive environment. The Trust will not tolerate (See also Employment and Procedures Manual):

3.4.1 Verbally abusive and aggressive language including racial and sexual harassment

3.4.2 Verbal and non-verbal threats of violence

3.4.3 Disruptive behaviour that prevents staff from carrying out their duties, this can be active or passive e.g. withdrawing co-operation and communication

3.4.4 Emotional and or psychological intimidation

3.4.5 Destructive behaviour toward Trust property including fire setting, wilful damage and theft

3.4.6 Self-injurious behaviour

3.4.7 Misuse / abuse of alcohol, drugs and or other substances on site

3.4.8 Drug dealing on site

3.4.9 Stalking

3.4.10 Attempted / actual physical assault

3.4.11 Aggravated physical violence

3.4.12 Threats of violence involving a weapon and attempted / actual weapon assault

3.4.13 Offensive sexual gestures, inappropriate touching, attempted rape and rape

3.4.14 Any behaviour toward a member of staff that threatens or undermines their own personal safety and security is threatened

3.4.15 Bullying and Harassment

3.4.16 Detaining staff against their will.

4 EMPLOYER'S DUTIES

4.1 Employer's duties with respect to the management of work related incidents of violence and aggression are determined by National Health and Safety legislation, and by the common-law duty of care in the UK.

4.2 The Trust Board

4.2.1 The Trust is committed to providing an environment which minimises risk and promotes the health, safety and well being of all those who enter or use its premises whether as staff, patients, visitors and carers. It has overall responsibility to:

a) Ensure that appropriate training (PSS) is in place and effective throughout the Trust.
b) Work to ensure full compliance with all appropriate legislative and statutory requirements.
c) Ensure risk management becomes an integral part of the management processes and financial planning within the Trust.
d) Ensure that strategies, structures and processes are constantly reviewed and evaluated to ensure the continuing health, safety and well being of staff, patients, visitors and carers.

4.2.2 They have delegated responsibility for monitoring and review through the Integrated Audit and Risk Committee.

4.2.3 A memorandum of understanding has been developed with the Association of Chief Police Officers (ACPO). The Trust will provide information to Kent County Constabulary through the Local Security Management Specialist (LSMS) where appropriate.

4.3 Executive Director of Nursing and Governance

4.3.1 Takes the lead for delivering clinical governance and ensuring that PSS follows the Department of Health and Security Management's Services (SMS) Guideline's and acts as effective risk management tool for all staff.

4.3.2 Executive boards must approve the increased behavioural support planning and restrictive intervention reduction programmes to be taught to their staff.

4.4 Integrated Audit and Risk Committee

4.4.1 Have responsibility and the authority to act on behalf of the trust board.

4.4.2 Ensure that a risk training strategy is in place and an annual review is undertaken.

4.4.3 Receive reports from trust wide health and safety group.

4.4.4 Responsible for providing assurance to the trust board.

4.4.5 Report to the board twice yearly.

4.5 Trust Wide Health Safety Reporting Group

4.5.1 Ensure compliance with Health and Safety law, including (RIDDOR) 2010 specifically include those serious injuries sustained by staff as a result of violence.

4.5.2 Have responsibility and the authority to oversee and receive reports from The Violence, Restraint and Seclusion Monitoring group.

4.5.3 Ensure that there are suitable arrangements in place within directorates/care groups to meet their training in Promoting Safe Service (PSS) requirements and demonstrate compliance with CQC 5 Key Standards.

4.6 Promoting Safe Service Monitoring Group

4.6.1 Will undertake regular and systematic audit of all activities clinical and non-clinical to identify, and where possible eliminate or minimise risk.

4.6.2 This Group will have a senior representative from PSS, Corporate Nursing, Health and Safety, Care Groups and Safeguarding.

4.6.3 The Group will consider themes and trends and ensure these are taken to the Learning from Experience Group and picked up in supervision if needed in the Care Groups.

4.7 Complaints Manager

4.7.1 Ensures that the PSS Training Manager or Clinical Practice Lead is involved in reviewing complaints regarding the use of physical intervention skills, seclusion or any issues of conflict management.

4.7.2 Feeds back outcomes from complaints to ensure lessons can be learnt.

4.8 **Head of Learning and Development**

4.8.1 Ensure staff induction and training programmes take full account of all hazards and risks, clinical and non-clinical, likely to be encountered in the workplace and provide safe systems of work based upon evidence-based practice where available.

4.8.2 Reviews corporate, directorate and care group mandatory and statutory training requirements, and reports on compliance.

4.8.3 Provides sufficient courses to train all staff in PSS as stated in training matrix.

4.9 **Promoting Safe Services Manager and Clinical Practice lead.**

4.9.1 Ensures that training is fit for purpose and available to all staff.

4.9.2 Designs and delivers packages tailor-made for services or challenging individuals via team teaches.

4.9.3 Works with Risk Manager to review incidents regarding (aggression, violence, seclusions and SI s)

4.9.4 Monitors and audits physical intervention skills (Trust wide).

4.9.5 Develops safe systems of working and best practice.

4.9.6 Provides Clinical Support to wards and provides the link between clinical area's and training teams.

4.9.7 Assists in complaints process on issues of physical interventions.

4.9.8 Provides advice to Trust on lessons to be learnt from incidents.

4.9.9 Provides a monthly report to care groups and bi-monthly reports to the Trust wide Health and Safety Group.

4.9.10 Will follow up with Service Managers incomplete reporting forms to ensure complete learning is picked up.

5 EMPLOYEE'S DUTIES

5.1 All staff have a responsibility and are expected to attend relevant theoretical and practical training and development opportunities in order to gain the necessary competencies associated with the professional management of a violent or potentially violent incident in accordance with Trust policy and other locally determined procedures.

5.2 Those registered nurses who are involved in administration of rapid tranquilisation must undertake Immediate Life Support training yearly.

5.3 All other nursing staff who are trained in physical interventions must under take Basic Life Support training yearly.

5.4 All employees will identify potential / actual risks within their own work area and bring these to the attention of their designated manager at the earliest opportunity.

5.5 All staff must be aware of the systems and procedures in place for summoning assistance when required.

5.6 All employees will report all incidents / near misses of violence and aggression in accordance with Trust policy and procedures, to their Line Manager and complete the necessary documentation at the earliest opportunity, whether directly or indirectly involved in an untoward incident or as a witness to a violent or potentially violent incident, in accordance with the Trust's Incident/Accident/Near Miss Reporting Policy.

5.7 Ensure there is available Information for patients, visitors and carers with regard to the Trust's position on violence.

6 REDUCING THE RISK

6.1 The Trust is committed to providing an environment which minimises risk and promotes the health, safety and well being of all those who enter or use its premises whether as staff, patients, visitors or carers. To this end the Trust will:

6.1.1 Work to ensure full compliance with all appropriate legislative and statutory requirements.

6.1.2 Ensure a proactive Risk Assessment (Risk Assessment form on RiO) is carried out in relation to all PSS matters

6.1.3 Undertake regular and systematic audit of all activities clinical and non-clinical to identify, and where possible eliminate or minimise risk.

6.1.4 Enable and ensure all staff are competent and safe to practice and are aware of their personal responsibility for the management, reporting and recording of clinical and non-clinical risk.

6.1.5 Ensure support and information systems are in place to assist the implementation of all aspects of risk management.

6.1.6 Ensure that strategies, structures and processes are constantly reviewed and evaluated to ensure the continuing health, safety and well being of staff, patients, visitors and carers.

7 ENVIRONMENT AND SECURITY

7.1 Appropriate measures commensurate with the risk assessment will be taken to adapt the working environment to reduce and or manage identified risks of violence toward staff, patients, visitors, carers and others.

8 COMMUNICATION AND RECORD KEEPING

8.1 All staff must be aware of the systems and procedures in place for summoning assistance when required.

8.2 All incidents of aggression and violence must be reported via the Datix electronic system within 24 hours of occurrence.

8.2.0 All types of abuse verbal, racial, gender and body image.

8.2.1 Non-physical and Physical assaults

8.2.2 Use of Personal Safety

8.2.3 Use of Physical Interventions

8.2.4 Use of de-escalation

8.2.5 Use of Rapid tranquilisation

8.2.6 Use of Segregation (see Segregation / Seclusion Policy for documentation)

8.2.7 Use of Seclusion (see Segregation / Seclusion Policy for documentation)

8.3 It is the responsibility of all staff to report and record actual or potential incidents using the appropriate reporting documentation. Following incident investigations it is the responsibility of Managers to report to the individual(s) and or staff groups concerned their findings and recommendations to prevent further incidents from arising.

8.4 Information for patients, visitors and carers with regard to the Trust's position on violence is available

9 LONE WORKING

9.1 **Definition:**

9.1.1 Lone working is defined as - Staff who work by themselves in areas without direct supervision and away from Trust staff or other persons who would be able to provide immediate assistance if required. This includes staff working in the community as well as in isolated parts of any non-domestic building or premises used as a workplace by Trust staff.

9.1.2 All staff have a responsibility to ensure they comply with their local lone working protocol which should be created in line with the Trust Lone Working Policy, available from

http://i-connect.kmpt.nhs.uk/document-library/lone-working-policy/224

9.2 **Register of staff details**

9.2.1 Managers are responsible for maintaining an up-to-date register of the details of staff who work alone.

9.2.2 Staffs who work alone should provide limited personal information (9.2.4) to assist in any search. This information should be kept in a secure place at the team base and updated by staff following any change.

9.2.3 The risk assessment should identify the systems for recording staff details, including where these are stored and accessed in the event of staff being unaccounted for.

9.2.4 As a minimum, staff details should include:

a) Name	d) Next of kin name, address, contacts number.
b) Recent photograph	e) Emergency contact (if different to next of kin)
c) Mobile phone number	f) Car details (registration, make, model and colour

10 DE-ESCALATING A VIOLENT SITUATION

10.1 De-escalation primarily concerns the actions staff undertake to manage potentially untoward situations.

10.2 The aim of de-escalation is to defuse the situation and avoid the need for physical intervention. The purpose of de-escalation is to:

Alter the course of the aggression cycle	Re-direct the patient to a calmer state
Reduce their level of anxiety / arousal	Restore control to the health care environment
Avoid violent responses and the need for physical intervention	
Staff should not at any time during the interaction exceed their personal capabilities or professional responsibilities or place unrealistic expectations on the potential aggressor; this could cause the situation to rapidly deteriorate	

10.3 In approaching the situation staff will need to demonstrate through their verbal and non-verbal behaviours that they are:

Calm	Caring	Open and non-judgemental
Controlled	Non-threatening	

10.4 De-escalation should be carried out in the follow locations:

De-escalation Room	Quiet Room	Lounge/Sitting area
Bed Area (last option)	Dining area	Any low stimulus room

10.4.1 De-escalation in principle is only effective under certain circumstances where the level of risk is relatively low.

10.4.2 Where the motivational circumstances and the presenting behaviours of the potential attacker(s) indicate increased risk, then staff will need to seek immediate help and assistance as opposed to trying to engage the patient in de-escalation strategies.

10.4.3 Staff must at all times adhere to planned responses in order to ensure that potentially violent episodes are properly managed. Any ad hoc actions taken by staff must comply with local / Trust policy and procedures.

10.4.4 All incidents involving staff action should be reported and recorded on the PSTS section on the Datix electronic reporting system as soon, as is practically possible after the event, but no later than 24 hours.

10.5 The De-escalation Process

Staff must:

10.5.1 Be aware of personal space and keep a safe distance.

10.5.2 Remain calm and in control of their own level of arousal.

10.5.3 Adopt non-confrontational verbal and non-verbal behaviours – Keep own personal threat level low.

10.5.4 Remain open and non-judgemental – be cautious of demonstrating negative feelings through unguarded comments or facial expressions.

10.5.5 Assess the potential aggressor's verbal and non verbal behaviour.

10.5.6 Determine their grasp on reality, psychosis / substance abuse.

10.5.7 Assess the degree of dangerousness (potential harm) associated with their behaviour and their willingness / ability to co-operate.

10.5.8 Consider the impact staff presence is having upon the situation.

10.5.9 Conduct an environmental assessment, exit routes, door locking mechanisms, lighting, floor surface, potential barriers, proximity to unsafe areas i.e. tops of stairs, large glass areas, corners of a room, etc. Avoid all vulnerable areas do not compromise personal safety.

10.6 Adopt non-confrontational behaviours, seek and maintain non-threatening eye contact – observe and listen - give them your full attention.

10.6.1 Encourage them to talk and ask questions, ensure honest responses are given, do not make promises that you or others cannot deliver on, use non-provocative language avoiding jargon.

10.6.2 Throughout your interactions continually monitor and assess the patient's behaviour, how are they responding is their behaviour becoming less or more aggressive.

10.6.3 Clarify the problem, search for an acceptable solution; agree a course of action and act.

10.6.4 Report and record the incident in detail, document the antecedents and the behaviours exhibited by the potential aggressor and the de-escalation process you undertook and the outcome of your intervention.

11 RESTRICTIVE INTERVENTIONS

Restrictive interventions are defined as:

(1) 'Planned or reactive acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- *-take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken;*

and

- *end or reduce significantly the danger to the person or others;*

and

- *contain or limit the person's freedom'*

A - Physical restraint (sometimes referred to as manual restraint)

This revised dataset seeks to record incidents that meet
(1) the MHA code of practice (2015, DH) definition of physical restraint 'any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another.
and (2) meets all parts of the above definition of restrictive interventions
and (3) that take place in one of the following positions:

Position	Definition
Prone	A physical restraint in a chest down position, regardless of whether the person's face is down or to the side.
Supine	A physical restraint where the patient is held on their back.
Side	A physical restraint where the patient is held on their side

Standing	Where the patient is restrained in a standing position.
Seated	Where the patient is held in a seated position.
Kneeling	Where the patient is held in a kneeling position.
Restricted escort	Any restrictive hold where an individual is moved/ re-located from one area of a unit to another or between units regardless of level of hold.

11.1 The Trust recognises that staff who are likely to find themselves in aggressive or violent situations, where intervention might be necessary, must attend an appropriate course run by qualified instructors.

11.2 Patients (either detained or informal), visitors or others may behave in such a way as to disturb others around them and their behaviour may present a risk to themselves or others. These problems may occur anywhere and it is important to distinguish

11.2.1 The needs of the patient, visitors and others who pose an immediate threat to themselves or others around them and where Physical interventions are used must be to:

a) Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and

b) end or reduce significantly the danger to the patient or others. (Mental Health Act 1983 s.26.36)

11.3 The Trust seeks to highlight the legal and statutory requirements that Trust employees must observe when managing difficult patients or members of the public. This Policy should be read in conjunction with the policies guidance and references above.

11.4 The most important legal principle underpinning the valid use of Physical Interventions is that of `least restrictive alternative' (Mental Health Act 1983) or `least necessary use of force' (Criminal Law Act 1967) must be used.

11.5 The principles of understanding cultural sensitivity and awareness underpins the principles of this policy and procedures therein.

11.6 Non-resistive physical interventions, which do not involve the use of force, may the DoH suggests, include such measures as assisting a person walking.

11.7 A restrictive physical intervention is defined as involving the use of force to control a person's behaviour and can be employed using bodily contact, mechanical devices or changes to the persons environment (Mental Health Act 1983 Code of Practice s.26) (The idea is that there may be some kind of resistance exercised by the person to whom the force is applied.

11.8 All such interventions may constitute the offences of assault, assault and battery, or false imprisonment.

11.9 In more serious cases it may constitute the offences of inflicting grievous bodily harm (GBH), causing harm with intent, and where death occurs manslaughter.

11.10 A duty of care exists when duties and responsibilities are imposed upon professionals or paid carers. In general terms, this means taking reasonable care to avoid acts or omissions that are likely to cause harm to another person. Judgement about what is or is not a 'reasonable' course of action may be made with reference to the following:

11.10.1 The conduct of other practitioners with similar skills and responsibilities

11.10.2 An appropriate body of expert opinion

11.10.3 What is reasonable in the circumstances

11.10.4 The foreseeable risks associated with a course of action

11.10.5 KMPT is aiming to reduce the number of restrictive interventions (i.e. Restraint, Seclusion and Rapid Tranquilisation) alongside significant reductions in the use of prone restraint

a) Full account should be taken of the individual's age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment, which may confer additional risks to the individual's health, safety and well being in the face of exposure to physical restraint.

b) A member of staff should monitor the individual's airway and physical condition to minimise the potential of harm or injury. Observation, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/discolouration), should be conducted and recorded.

c) People should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen.

d) There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor. (Prone is any position that the person's chest is in contact with a solid surface). Only exception high level seclusion method as taught on PSS training.

e) If exceptionally a person is restrained unintentionally in the prone/face down position (i.e. they over power the team due body mass, strength or skills) staff should reposition into a safer alternative as soon as possible (i.e. immediate turn) if the environment allows.

f) Where unplanned or unintentional incidents of any restrictive practice occur there should always be recording and debrief to ensure learning and continuous safety improvements.

g) There maybe the odd occurrence where it maybe the patients preference due to some past trauma, if this is the case it must be documented in the notes, care plan and behaviour therapy put in place to deal with the past trauma and to move away from this preference.

h) When restraint is used on a pregnant woman, restraint in the prone (chest on floor)/supine (back on floor) position should be avoided if possible (as these positions can put the mother and unborn child at risk). There maybe times that the person may force themselves into one of the above positions. The restraining team should be mindful of the actual restraint position utilised that it follows the least restrictive holds for the shortest possible time and this

should be reflected in the Proactive use of holding pregnant women in the seated position – ideally on the safety pod/chair/bed is preferred option. This should always be of priority in the third trimester of pregnancy

i) Staff must not deliberately use techniques where a person is allowed to fall unsupported, other than where there is a need to escape from a life-threatening situation.

11.11 Whilst deployment of personal safety techniques generally occur in a one to one situation or with a member of staff rescuing some one else, physical intervention must be employed using a team approach.

11.12 A minimum of one team per site must be available (which must be noted in the designated nurse in-charge folder).

11.13 A physical intervention team consists of three members of staff a team leader and two support members.

12 MECHANICAL RESTRAINT (HAND/SOFT CUFFS)

12.1 Mechanical restraint is a form of restrictive intervention that refers to the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural. (Section 26.75, Mental Health Act Code of Practice 2015)

12.1.1 **Hand/Soft cuffs are only in use in Forensic services following Ministry of Justice Guidelines, and will only be applied to co-operative/compliant individuals. If the individual does not wish to co-operate other arrangements will be made for their movement to court/hospital (see separate policy).**

12.1.2 As mechanical restraint (hand/soft cuffs) is a form of restrictive practice. All relevant paperwork must be completed this includes (appendix b of the forensic services hand cuff procedure) and Datix.

Mental Health Act Code of Practice 1983

12.2 Section 41(3)(c)(i) of the Mental Health Act Code of Practice 1983 (2008) requires a responsible clinician to obtain consent from the Secretary of State before granting Section 17 leave to a restricted patient detained under section 37/41 and 47/49. No such patient may leave the hospital or unit named on the authority of detention without such consent.

12.2.1 Staff applying soft /handcuffs devices must have undergone an appropriate training:

- In their application of use.
- Maintenance of the equipment.
- All successful staff names will be kept on the learning and development training data base.

12.2.2 All training will be delivered internal by the recognised train the trainer who must be updated annually by a recognised and accredited tutor/company.

12.2.3 All staff attending their mandatory use of handcuffs training must firstly be in date with their PSS training prior to attendance. Use of soft/handcuffs must only be applied if staff have successfully completed that aspect of training.

12.2.4 Mechanical restraint which involves tying an individual (using tape or a part of the individual's garments) to some part of a building or its fixtures should never be used.

Human Rights Act (Article 2 Right to life)

12.3 Under article 2 and 3 the following needs to be taken into consideration if handcuffs/soft cuffs are to be authorised for use by the KMPT and applied by its staff.

- Article 2 provides for us the positive obligation for public authorities to promote the right to life giving high value to everyone's right to life.
- It also promotes the positive obligation to preserve life. This means that if there is a risk to life and something can be done to eliminate or reduce that risk to life then that absolutely should be done.

Article 3 Prohibition of Torture

12.4 **Torture:** Deliberate inhumane treatment causing very serious and cruel suffering.

Inhumane Treatment: Treatment that causes intense physical and mental suffering.

Degrading Treatment: treatment that arouses in the person a feeling of fear, anguish and inferiority capable of humiliating and debasing the person and possible breaking his/her physical or moral resistance.

- It could be considered that the application handcuffs/soft cuffs in certain situations could be considered degrading and inhumane for example a person detained under the mental health act that are being taken for medical or dental treatment outside of the secure establishment.
- We need to balance between Article 3 and 2 the intention of the restriction and the degradation/humiliation imposed by it i.e. the "positive benefit" taking into account prevailing foreseeable risk factors.
- In short undertaking a risk assessment to justify its use, which is backed up by clear policy and protocol?

12.4.1 Application of pain please refer to section 18 of this policy, Section 78-83 of the Department of Health Positive and Proactive Care.

12.5 **Article 5 – Liberty and Security of Person**

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law

2. Everyone who is arrested or detained shall be informed promptly, in a language which he understands, of the reasons for his detention and of any charge against

12.6 **Article 8 – The Right to Respect for Private and Family Life, Home and Correspondence**

This article is very broad and holds a wide range of implications. Public authorities may only interfere with someone's private life where they have legal authority to do so, the interference is necessary in a democratic society for one of the aims stated in the article and is proportionate to that aim. For example to maintain the safety of others.

Older Adults: (Mechanical Restraint) (see relevant policy)

12.7 Mechanical restraint also includes the following:

- Cot sides on beds. (The use of these needs to be risk assessed and should include the patient (if possible) and their next of kin in the decision making)
- Lap belts on wheel chairs. (These should only be used for the transportation of patient from A to B and not for any other reason).
- Lap belts on hoists free standing. (Must be used as per training and manufactures guidelines)
- Lap belts on bath hoists fixed ((Must be used as per training and manufactures guidelines or lowering in and out of the bath). Unless risk assessment states otherwise i.e. risk of sliding of seat.
- Arm Splints. (These are generally used to limit self-injurious frequent and intense behaviour of the patient)

13 CULTURAL ISSUES IN RELATION TO PHYSICAL INTERVENTIONS

13.1 Recognition of sensitivities based on Equality Protected Characteristics of age, disability, gender reassignment, sex, sexual orientation, marriage and civil partnership, religion and belief and race. In addition to recognition of sensitivities relating to socio-economic status, language, geography and occupation.

13.2 There have been numerous reports highlighting inadequate provision of mental health services for ethnic minority groups, including:

13.2.1 Suffolk and Cambridgeshire SHA (2003) Independent Report into the death of David Bennett. This report looked into the death of an African Caribbean during restraint and stated that there was 'institutionalised racism in the NHS'.

13.3 Guidance from the Dept. of Health in 2003 –Inside Outside – Improving Mental Health Services for Black and Ethnic Minority Communities states that ethnic minority groups are more likely to:

13.3.1 Be disproportionately represented in special hospitals, medium secure units and psychiatric in-patient units.

13.3.2 Experience far more detentions under the Mental Health Act 1983 and are forcibly restrained more often.

13.3.3 More likely to be prescribed anti-psychotic medication.

13.4 The Race Relations (Amendment) Act 2000 requires;

"All public authorities to actively promote race equality, including eliminating unlawful racial discrimination", therefore as much information should be gathered about the patient's cultural beliefs as possible, this information can be found within our own trust policies and from research but should primarily be sought from the patient and their family and carers.

13.5 It is important to communicate with patients and others to gain insight and understanding to their way of life.

14 SUMMARY

14.1 Preservation of life outweighs all other factors.

14.2 We must be prepared to justify our actions and our omissions.

14.3 If in doubt- find out by listening to patients and their carers.

15 THE USE OF MEDICATION IN THE MANAGEMENT OF VIOLENCE AND AGGRESSION

15.1 This policy has been updated in accordance with NICE guideline 10: Violence and aggression: short term management in mental health, health and community settings. Published May 2015.

15.2 Involving service users in decision-making

15.2.1 Involve service users in all decisions about their care and treatment, and develop care and risk management plans jointly with them. If a service user is unable or unwilling to participate, offer them the opportunity to review and revise the plans as soon as they are able or willing and, if they agree, involve their carer.

15.2.2 Check whether service users have made advance decisions or advance statements about the use of restrictive interventions, and whether a decision-maker has been appointed for them, as soon as possible (for example, during admission to an inpatient psychiatric unit) and take this information into account when making decisions about care.

15.2.3 If a service user has not made any advance decisions or statements about the use of restrictive interventions, encourage them to do so as soon as possible (for example, during admission to an inpatient psychiatric unit). Ensure that service users understand the main side-effect profiles of the medications recommended in this guideline for rapid tranquillisation so that they can make an informed choice.

15.3 Using oral PRN (pro re nata) medication

PRN in this policy refers to the use of oral medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression. It does not refer to PRN medication used on its own for rapid tranquillisation during an episode of violence or aggression (this is described in section 15.3).

15.3.1 If a patient is admitted outside of normal working hours the clerking doctor may prescribe oral lorazepam or promethazine PRN ONLY IF CLINICALLY INDICATED until the patient can be reviewed by a multi-disciplinary team (15.2.2)

15.3.2 A multi-disciplinary team that includes a psychiatrist should develop and document an individualised pharmacological strategy for using routine and PRN medication to calm, relax, tranquillise or sedate service users who are at risk of violence and aggression as soon as possible after admission to an inpatient psychiatric unit.

15.3.3 If a specialist pharmacist was not present in the multi-disciplinary team meeting then their agreement with the strategy or further discussion should take place as soon as possible.

N.B 15.2.1 – 15.2.3 Are a variation on NICE NG10 to allow for the safety of staff and clients admitted outside of normal working hours.

15.3.4 The multi-disciplinary team should review the pharmacological strategy and the use of oral PRN medication at least once a week and more frequently if events are escalating and restrictive interventions are being planned or used. The review should be recorded and include:

a) Clarification of target symptoms
b) The likely timescale for response to medication
c) The total daily dose of medication, prescribed and administered, including regular and PRN medication that is being used for tranquilisation / sedation
d) The number of and reason for any missed doses of regular medication
e) Therapeutic response
f) The emergence of unwanted effects.

15.3.5 When prescribing oral PRN medication as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression:

a) Do not prescribe PRN medication routinely or automatically on admission unless this is outside of working hours and clinically indicated. Such a prescription must be reviewed ASAP by a multi-disciplinary team
b) Tailor PRN medication to individual need and include discussion with the service user if possible
c) Ensure there is clarity about the rationale and circumstances in which PRN medication may be used and that these are included in the care plan
d) Ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the BNF when combined with the person's standard dose or their dose for rapid tranquillisation
e) Only exceed BNF maximum daily dose (including PRN dose, the regular dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented, and carried out under the direction of a senior doctor
f) Ensure the interval between PRN doses is specified

15.3.6 The multidisciplinary team should review PRN medication at least once a week and, if PRN medication is to be continued, the rationale for its continuation should be included in the review. If PRN medication has not been used since the last review, consider stopping it.

15.4 **Rapid Tranquillisation (See relevant policy)**

15.5 Alternative treatment options

15.5.1 These recommendations do not preclude the use of alternative treatment options. However, the use of alternative treatments should be tailored to the individual in line with the recommendations for rapid tranquillisation and the rationale for using a medication that is not recommended above must be clearly documented in the patient's notes, with agreement from a multi-disciplinary team, prior to a prescription being written.

15.6 Rapid tranquillisation during seclusion

15.6.1 If rapid tranquillisation is needed while a service user is secluded, undertake with caution, following the above recommendations and

a) Be aware of and prepared to address any complications associated with rapid tranquillisation
b) Ensure the service user is observed within eyesight by a trained staff member
c) Undertake a risk assessment and consider ending the seclusion when rapid tranquillisation has taken effect.

15.7 Immediate Post incident Support

15.7.1 Following an incident involving the use of rapid tranquillisation, once the risks of harm have been contained, it is good practice for an immediate post-incident review should take place where practical, including a doctor and a nurse, to identify factors that can be addressed to reduce the likelihood of a further incident and amend risk and care plans accordingly.

15.7.2 Ensure that the service user involved has the opportunity to discuss the incident in a supportive environment with a member of staff or advocate. If the service user takes up the offer, this should be recorded in the clinical record.

15.8 Formal Post incident review

Where possible and practical, it is good practice for a formal external post-incident review to take place within 72 hours after an incident involving rapid tranquillisation. The group undertaking the review should ensure that the review:

15.8.1 Is led by a service user and includes staff from outside the ward where the incident took place, all of whom are trained to undertake investigations that aim to help staff learn and improve rather than assign blame

15.8.2 Uses information recorded in the immediate post-incident debrief and the service user's notes related to the incident

15.8.3 Includes interviews with staff, the service user involved and any witnesses

15.8.4 Evaluates the physical and emotional impact on everyone involved, helps service users and staff to identify what led to the incident and what could have been done differently

15.8.5 Determines whether alternatives to rapid tranquillisation were discussed

15.8.6 Recommends change to philosophy, policies, care environment, treatment approaches, education and training, if appropriate

15.8.7 The group undertaking the review should provide a report to the ward where the incident took place.

16 THE USE OF PAIN IN MANAGEMENT OF ACTUAL VIOLENCE

16.1 Pain based techniques serve no therapeutic value and must only be used in extreme circumstances to ensure safety of self/others (NICE 2005).

16.2 Staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purpose of an immediate rescue in a life-threatening situation.

16.3 The patient's freedom should be contained or limited for no longer than is necessary. Unless there are cogent reasons for doing so, staff must not cause deliberate pain to a patient in an attempt to force compliance with their instructions (for example, to mitigate an immediate risk to life).

16.4 The P.S.S. (Promoting Safe Services) team will, throughout training and practice, provide clear guidance to students of exceptional circumstances where the use of pain may be acceptable and circumstances where it is unacceptable.

17 MONITORING OF PHYSICAL INTERVENTION/ RAPID TRANQUILISATION

17.1 Following any physical intervention or rapid tranquilisation the monitoring forms MUST be completed via Datix electronic reporting system. Failure to report can leave the staff and or patients, visitors and carers at risk.

17.2 **Staff and Patient Support (See relevant policy)**

17.2.1 Following an incident of violence appropriate after-care will be provided for affected staff and patients, visitors and carers through the immediate line management who will involve other personnel as appropriate.

17.2.2 It is important to consider informing next of kin, family member or carer of staff or patient who have been involved in the incident before any press involvement.

17.2.3 Staff should work with the Patient to review and amend their Positive Behaviour Support Care Plans

17.3 **Immediate Support**

17.3.1 Ensure all staff and patients are safe. Arrange physical care is given as required. Ensure all staff and patients have the opportunity to talk through their experiences. Provision should be given for further and ongoing support.

17.3.2 Arrange for Incident Debriefing to take place (48-72 hours after incident)

17.4 **Follow Up**

17.4.1 Appropriate support must be offered to all those who have been directly or indirectly affected by the incident.

17.4.2 Access to support is available for staff see staff handbook

17.4.3 It may be necessary to access other professionals to provide on going support to patients visitors and carers visitors and carers including the Safeguarding team

17.5 **Additional Action to be taken following an Incident**

17.5.1 To notify the Police that a violent incident/ crime has occurred.

a) For a level 4 or 5 (SI reportable) i.e. broken bones, skin and/or blood) call 999
b) For level 3 or below report through the 101.

17.5.2 The Local Security Manager Specialists (LSMS) should be informed of the incident by the member of staff affected by the incident, the ward manager or nurse in charge.

17.5.3 That the incident is reported through the Datix system.

17.5.4 Ensure witness statements are taken within 48 hours.

17.5.5 The nurse in charge at the time must make and document an assessment:

a) Of the patient's capacity at the time of the incident.
b) Complete a Police Capacity Assessment Form.
c) A current and updated risk assessment for the police.
d) He or she should then arrange for assessment of the patient by a consultant within 24-48 hours.

17.5.6 An Advocate may need to be appointed to act on behalf of the assaulted victim (to act on their behalf and to keep them informed of proceedings)

17.5.7 The situation should be discussed with the wider multi-disciplinary team in relation to safeguarding and DoLS any appropriate assessments made, please refer to the Safeguarding Vulnerable adult's policy.

17.6 **Remember:**

17.6.1 Other staff and patients, carers and visitors may experience a reaction to the incident. They may require support and guidance in addition to training to help them manage future situations effectively. Involving all staff in any review of departmental risk assessments and safety procedures soon after the incident and periodically thereafter will help to allay any anxieties staff groups may feel in relation to particular incidents.

17.6.2 The Trust will support police prosecution of individuals committing any acts of violence against staff and patients, visitors and carers.

17.6.3 The Trust will support private prosecution of individuals where appropriate and subject to favourable legal advice.

17.6.4 The member of staff and/or patient assaulted must make a statement to the police if they wish a prosecution to be pursued with any chance of success.

17.6.5 Additional support and advice can be obtained through the Trust's Legal Department.

17.7 **Client observation (as soon as possible following interventions**)

17.7.1 One staff member should lead throughout the use of manual restraint. This person should ensure that other staff members are:

- able to protect and support the service user's head and neck, if needed
- able to check that the service user's airways and breathing are not compromised
- able to monitor vital signs
- that the person is supported throughout the process

17.6.1.1 Monitor the service user's physical health and psychological health for as long as clinically necessary after using manual restraint.

17.7.2 If Rapid Tranquillisation has been used monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. Monitor every 15 minutes if the BNF maximum dose has been exceeded or the service user:

a) Appears to be asleep or sedated
b) Has taken illicit drugs or alcohol
c) Has a pre-existing physical health problem
d) Has experienced any harm as a result of any restrictive intervention

(This needs to be documented via MEWS if any issues with readings follow MEWS guidelines.)

18 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

18.1 The Trust provides compulsory training in accordance with National and Local policy and guidelines (See Trust Learning and Development Training Prospectus for details of courses).

18.2 Set out below is the training needs analysis for all staff groups identifying which members of staff require training and the level they require.

The aim of the training is to:
Ensure all staff are aware of their duties/roles and responsibilities to enable them to implement the policy.

PACKAGE	WHO AIMED AT	CONTENT'S	DURATION/VENUE	UPDATE'S
A Inpatient Services	Forensic/learning Disabilities Younger/ Older Adults/ Rehab Units-on Trust Sites	Theory Personal Safety Physical Interventions	5 DAYS (Gym)	Yearly 3 Days
B Inpatient Services	(Stand alone)Older Adult Wards:- Frank Lloyd Unit	Theory Personal Safety Physical Interventions	2 DAYS (Gym)	Yearly 2 Days
B Patient Contact	Community Teams Doctor's Domestic/Porter's/Kitchen Physiologist's Occupational Therapists Ward Clerk/Receptionists Any person on an inpatient site (according to Risk Assessment) Rehab Units- off site*	Theory Personal; Safety	1 Day (Gym/Team Teach)	Yearly ½ Day
C Non-Patient Contact	All Other Staff	Theory	e-Learning or ½ Day (Class room or Team Teach)	Every 3 years

*** Rehabilitation Services based on hospital sites will complete physical interventions.**

19 STAKEHOLDER, CARER AND USER INVOLVEMENT

19.1 **Key Individuals:**

Promoting Safer Therapeutic Services Training Manager/ Senior Practitioner

19.2 **Groups:**

a) Promoting Safe Services Team	b) Promoting Safe Services Group
c) Trust Wide Health and Safety Group	d) Risk Management Domain Group
e) KMPT and CFSMS information Sharing Group	f) Local Faith Groups
g) Violence, Restraint, Seclusion Monitoring Group.	

19.3 **Disciplines:**

a) All staff through consultation with representatives	b) Via Clinical Governance Group

19.4 **Carers/Users and Associated groups:**

a) Via consultation and monitoring group	b) Via Clinical Governance Group

Stakeholders will be informed of any changes via consultation, monitoring Group and Health and Safety Group.

20 EQUALITY IMPACT ASSESSMENT

20.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes. The Equality Impact Assessment for this document can be found on the Equality and Diversity pages on the trust intranet.

21 HUMAN RIGHTS

21.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breech the human rights of any individual the trust comes into contact with.

22 KEY PERFORMANCE INDICATORS

22.1 Reduce the number of aggressive and violent incidences to staff, carers, services users and visitors.

22.2 Reduce staff sickness caused by assault or injury.

22.3 To ensure all staff are trained in how to deal with aggressive and violent incidents.

22.4 That the Trust has a clear understanding of its role and responsibilities.

22.5 That staff have a clear understanding of their role and responsibilities.

22.6 That all Trust staff will have a clear understanding of support as it relates to staff, carers, services users and visitors.

22.7 To reduce the use of prone restraint to those situations where it is the patients own choice of position due to past trauma or situations where the patient over powers the team accurate and complete recording of all incidents

23 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring	Action to be taken in event of non compliance
Effectiveness of the policy and ability of staff to apply it in practice.	Observation of trends and review of incidents - data to service managers every 4 weeks to enable them to produce reports every 8 weeks to VRS group	Promoting Safe Services monitoring Group	Bi-monthly meetings and reporting to Trustwide H&S group H&S group to report to IARC quarterly. Board to sign off annually.	Minutes and reports from VRS group, Trust wide H&S group, IARC and board	A lead member of the clinical team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders through the PSS training team. Audits will be undertaken by the PSS Manager and identify if any patients were subject to DOLS or any safeguarding alerts have been raised.
Processes and duties for undertaking prevention & management of violence and aggression risk assessments are adhered to.	Review of PSS incidents via Datix	PSS Manager and PSS Senior Instructors	1. Bi-monthly 2. Bimonthly 3. Monthly	1. Reports to Promoting Safe Services monitoring group 2. Reports to Trust wide H&S group 3. Monthly reports to care groups.. 4. Annual reports to commissioners made publically available.	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the clinical team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders through the PSS training team.
Risk assessments are shared to protect staff and patients from violence and aggression	Review of PSS monitoring forms	PSS Manager and Clinical Practice Lead	Monthly	Reports to care groups	A lead member of the clinical team will work with the PSS training team to share learning with relevant stakeholders.

Appropriate Staff attend PSS training and Rapid Tranquilisation	Training stats	Learning & Development team PSS Manager	8 weekly	Training reports to care groups	Line managers will ensure that staff attend next available training course.
Processes and duties on prescribing guidelines for rapid tranquilisation and documenting observations carried out after rapid tranquilisation are adhered to	Review of PSS monitoring forms	Senior Pharmacist	Annual	1. Report to Promoting Safe Services monitoring group	Required changes to practice will be identified and reported to the Promoting Safe Services group. A lead member of the clinical team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders

24 EXCEPTIONS

24.1 Forensic Services and those areas where specialist mattresses are used can restrain on a bed or mattress. All other areas must restrain on the floor to minimise the potential risks.

APPENDIX A ABBREVIATIONS AND DEFINITIONS

Abbreviation	Meaning
ACPO	Association of Chief Police Officers.
AED	Automatic External Defibrillator
BNF	British National Formulary
CFSMS	Counter Fraud Security Management Services.
CQC	Care Quality Commission
DoH	Department of Health
HSWA	Health and Safety at Work Act
KMPT	Kent and Medway Partnership Trust
LSMS	Local Security Management Specialist
MHSWR	Management of Health and Safety at Work Regulations.
NIMHE	National Institute for Mental Health in England
NMS	Neuroleptic Malignant Syndrome
PSS	Promoting Safe Services
RIDDOR	Reporting of Injuries, Disease and Dangerous Occurrences Regulations.
RT	Rapid Tranquillisation
SMS	Security Management Services.
SPC	Summary of Product Characteristics
VAS	Violence, Restraint, Seclusion Monitoring Group
PBS	Positive behaviour Support

APPENDIX B THE USE OF PHYSICAL INTERVENTIONS TO MEET THE NEEDS OF PATIENTS PERSONAL HYGIENE NEEDS

WARD OR UNIT NAME:	
NAME OF PATIENT:	
STATUS:	
CAPACITYASSESSMENT DATE:	

In order to meet the personal hygiene needs of the above named patient, and to ensure the safety of both the individual and the staff. It will at times be necessary for up to three members of the nursing team to intervene using the following technique(s)

Guidance		**Hold 1(Elbow/Wrist)**		**Hold 2 (Figure Four)**	
Hold 3 (Thumb to Thumb		**Arm Wrap**		**Seated**	

At all times, the patients dignity and privacy will be respected, and any treatment will be given in the patients best interest as stated in the Capacity Act 2007 (Section 6) as dated above.

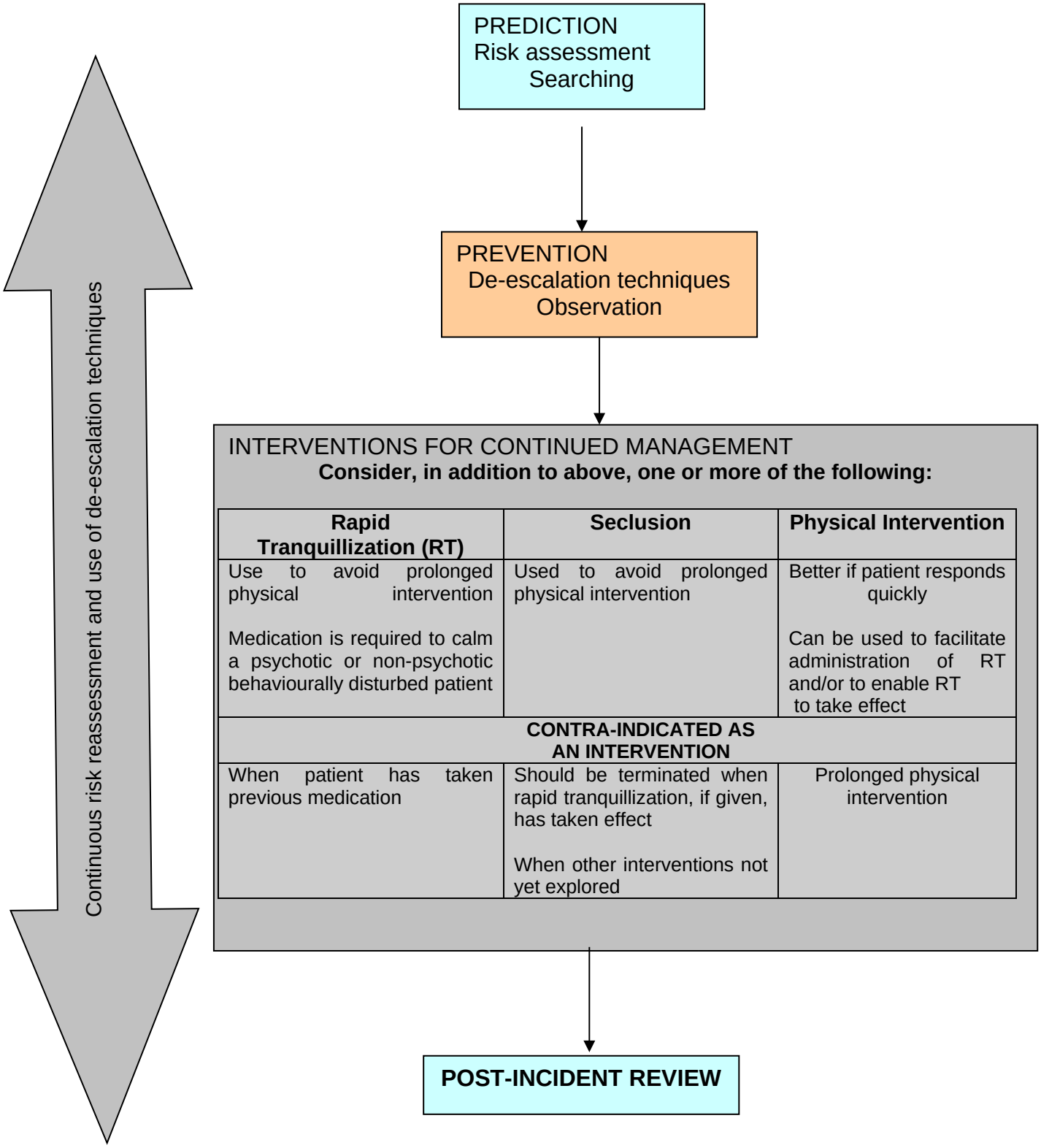
Such action will only be deployed as a last resort following the failure of other interventions such as gentle persuasion and the promotion of self independence.

Full details of the approach to be used and the number of nursing staff required to carry out the intervention is not only listed above but will be incorporated into the patient's care-plan. Also an entry will be made in the daily nursing notes documenting the level of intervention required.

CONSULTANT'S SIGNATURE:	
WARD MANAGER'S SIGNATURE:	
NEXT of KIN'S SIGNATURE:	

N.B Use of any hold above hold 1, requires completion of prevention and Management of aggression and violence risk assessment form

APPENDIX C OVERVIEW OF THE SHORT-TERM MANAGEMENT OF DISTURBED / VIOLENT BEHAVIOUR



APPENDIX D DE-ESCALATION/CALMING ROOM PROTOCOL

1. INTRODUCTION

1.1 De-escalation will provide the patient with an opportunity to calm themselves either with or without staff assistance, however staff should continue observe and be available if required.

1.2 De-escalation rooms will provide a low stimulus environment in which staff and patient can interact away from other patients.

1.3 Use of de-escalation rooms will, under normal circumstances, be by mutual agreement between the patient and the staff and should not be confused or used within the seclusion process.

2. ENVIRONMENTAL RECOMMENDATIONS

2.1 The de-escalation space should be planned as a single purpose area; it may be close to or connected to the seclusion suite.

Spaces used for de-escalation should be:

- Minimally furnished with either robust furniture that cannot be lifted and thrown, or lightweight furniture (for example foam) that would not cause injury or damage if thrown
- Soothing in decor with muted and restful colours
- Quiet, without a telephone or television

-Extracted from the Department of Health Environmental Recommendations for De-escalation areas.

3. SCOPE

3.1 This protocol is to be implemented on wards within Kent and Medway NHS social care partnership Trust - that have access to a de-escalation room.

4. INDIVIDUAL PROFESSIONAL RESPONSIBILITIES AND DUTIES

4.1 The Chief Executive holds overall accountability for the implementation and adherence to this protocol.

4.2 Service managers and ward managers are responsible for ensuring that staff on the wards are aware of this protocol.

4.3 The Promoting of Safer Therapeutic Services Training team will include de-escalation in their training programmes, elements of theory are also included in Trust e-learning however the best way for staff to learn who to de-escalate a situation is by observing good practice and practicing under the supervision of someone more experienced. It is therefore the responsibility of managers and mentors to cover this through clinical supervision and role modelling and for individuals to be receptive to feedback on their handling of situations.

5. INTERVENTION

5.1 All patients, whether detained or informal, may make use of de-escalation facilities

5.2 The following list is not exhaustive and the multi disciplinary team should use their discretion when suggesting using the de-escalation room;

- Severe over stimulation
- High risk of self harm/ suicide
- Sexually disinhibited behaviour
- High risk to others of violence/ aggression
- Specific threats to particular patients or members of MDT
- Initial assessment when admitted to the ward
- Behaviour likely to be detrimental to the well being to others e.g. persistent bullying, racism, stealing, etc.
- Extreme vulnerability

5.3 a nurse should remain with the patient at all times unless to do so would increase the risks to patient or staff member.

5.4 Patients should never be locked in a de-escalation room as this would constitute de-facto detention or false imprisonment, unless under extreme circumstances, such as if there is a weapon involved, in which case it would be justified.

5.5 On occasions the de-escalation room may be used for physical restraint, if this happens a PSTS form should be completed.

6. RECORDING OF DE-ESCALATION

When de-escalation is used the care plan, risk assessment and progress note must be updated to reflect this and should state what interactions were effective and what were not to engage the individual and what plans have been put into place to get the person back into the main ward environment.