Royal Devon University Healthcare NHS Foundation Trust

Title
Patients Excluded from Care

Reference Number: RDF2348-24
Date of Response: 07/03/24

Further to your Freedom of Information Act request, please find the Trust's response(s) below:

Please be aware that the Royal Devon University Healthcare NHS Foundation Trust (Royal Devon) has existed since 1st April 2022 following the integration of the Northern Devon Healthcare NHS Trust (known as Northern Services) and the Royal Devon and Exeter NHS Foundation Trust (known as Eastern Services).

Please can we request the following information under FOI.

1. *How many patients were excluded from care (any patients who have been banned from receiving care from the Trust for any reason e.g., aggression, vexatious complaints etc.) at your Trust in the calendar years 2010,2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023.*
   Answer: The Trust has not implemented any bans on patients from receiving medical care. On occasion a person may be banned from site as a visitor, however those sanctions do not ban them from receiving care.

2. *How many of the above patients received a planned review of their status?*
   Answer: Not applicable.

3. *How many excluded patients were subject of an Equality Impact Assessment?*
   Answer: Not applicable.

4. *Where do you record patients excluded status?*
   Answer: Not applicable.

5. *Do you have a policy for the exclusion of patients? Please supply a copy of that policy.*
   Answer: Please see the response to question 1. The Royal Devon Northern Services Violence and Aggression Policy and the Eastern Services Violence Prevention Reduction Policy are attached for your reference (see appendices covering sanction management).

Document Control

Title	**Violence & Aggression Policy**		
Author [redacted]		**Author's job title** Health and Safety Manager and Local Security Management Specialist	
Directorate		**Department** Compliance Team	
Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
2.2	Apr 2015	Revision	Three year revision:
3.0	Sep 15	Final	Approved at CSEC and Published on Bob
4.0	Dec 17	Final	Roles & Responsibilities amended. Training information updated. Reference to NHS Protect removed. Reference to NICE guideline NG10 added. 24/7 Security officer arrangements at NDDH added. Occupational Health responsibilities added. For approval at Health and Safety Committee. Issued Jan 2018.
4.1	July 2021	Revision	Policy harmonised and aligned to mirror RD&E policy, presented to July 2021 H&S Group meeting.
5.0	Sept 2021	Final	Final version, minor amends following consultation & feedback. Approved at H&S Group meeting 09.09.21

Main Contact
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Health and Safety Manager and Local Security Management Specialist
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Lead Director
Director of Nursing Quality and Workforce

Superseded Documents
NDHT Managing Violence & Aggression policy (v4.0 Dec 2017)

Issue Date	**Review Date**	**Review Cycle**
Sept 2021	Sept 2024	Three years

Consulted with the following stakeholders:

- Clinical Matron Unscheduled Care
- Community Nurse Team Manager
- Consultant Emergency Medicine
- Deputy Director of Nursing and Head of Professional Practice
- Divisional Nurse Planned Care
- Divisional Nurse Unscheduled Care
- Emergency Preparedness, Resilience & Response Officer
- Head of Clinical Site Services
- Head of Therapy Services, Trust Falls Lead
- Health and Safety Group Members
- Health and Social Care Cluster Manager

- Modern Matron
- Outpatients Service Manager
- Occupational Health Department
- Quality Improvement Facilitator (Patient Safety)
- Rapid Intervention, Urgent Care Nursing & Care Home Team Manager
- Safeguarding Adult Lead
- Safeguarding Children's Lead
- Security Management Director

Approval and Review Process

- Health and Safety Group

Local Archive Reference

[redacted]

Policy categories for Trust's internal website (Bob)	**Tags for Trust's internal website (Bob)**
Security, Health and Safety	Violent, harassment, assault, violence, aggression, violence and aggression, violence & aggression, v&a, v & a, physical assault, non-physical assault, non-physical assault, abuse, intimidation

CONTENTS

1. Introduction

1.1 This policy is concerned with violence, aggressive and challenging behaviour, both physical and verbal, towards employees of the Northern Devon Healthcare NHS Trust (NDHT) from patients, relatives, visitors or other members of the public. Working in an atmosphere of continuing threat is profoundly damaging to the confidence and morale of staff. There are also costs to the Trust in terms of reduced efficiency, sickness or absence.

1.2 The Trust recognises that as an employer, it has a duty of care towards its staff and that reasonable steps should be taken to ensure their health and safety at all times.
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1.3 The Trust does not tolerate intentional violence and aggression towards its staff. This will be publicised in public notices displayed in Trust premises (**Appendix B: Violence and Aggression Poster**).

1.4 The Trust recognises enforcing zero tolerance towards individuals for acts of violence and aggression is not achievable due to the occasions when there will be violent and abusive incidents when the person exhibiting challenging behaviour is unable to control their actions due to medical factors.

1.5 This policy will provide guidance to the Trust to pro-actively manage intentional violent and aggressive behaviour and challenging behaviour due to medical factors on the most effective interventions required to minimise risk to staff, patients and visitors.

1.6 The Trust reserves the right to implement a range of sanctions against persons using intentional violence and aggression including the right to exclude any person who in the considered opinion of the Trust threatens the safety and or security of the Trust employees, patients, visitors or property. For further information and guidance refer to **Section 12 Sanctions Management** and **Appendix G**.

1.7 The Trust also acknowledges the need for staff to be skilled in the de-escalation of aggressive and violent behaviour. Additionally identified staff should be trained in a range of restrictive practices refer to **Section 13: Training.**

2. Purpose

2.1 This policy will provide guidance and advice for all employees of the Trust and persons providing services on the management of intentional violence and aggression and challenging behaviour due to medical factors.

2.2 It is important that staff feel safe in their working environment. Violent behaviour not only affects staff personally but it also has a negative impact on the standard of services and the delivery of patient care. In terms of tackling violence against staff, this policy provides information and guidance on a range of measures introduced to make the NHS a safer place to work

3. Regulatory Framework

3.1 The provision of a safe working environment is embedded in the Care Quality Commission's Fundamental Standards (CQC, 2015) Regulation 13: Safeguarding service users from abuse and improper treatment and Regulation 15: Premises and

equipment.

3.2 The NHS Standard Contract should have regard to the violence prevention and reduction standard, and are required to review their status against it and provide board assurance that they have been met it twice a year.

3.3 Commissioners are also expected to undertake compliance assessments as part of their regular contract reviews, twice a year as a minimum or quarterly if significant concerns are identified and raised.

4. Definitions

4.1 Physical Assault

Physical assault is defined as: "the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort."

(Secretary of State Directions, Department of Health. 2003).

4.2 Non Physical Assault

Non Physical assault is defined as: "the use of inappropriate words or behaviour causing distress and/or constituting harassment."

(Secretary of State Directions, Department of Health. 2003).

Examples of physical and non-physical assault including harassment, unacceptable behaviour both verbal & written together with guidance on abusive phone calls can be found at **Appendix C – Examples Physical and Non-Physical Assault including abusive telephone calls.**

4.3 Clinically Related Challenging Behaviour

Clinically related challenging behaviour is often a manifestation of a patient's distress and an attempt by the person to communicate their unmet needs. For further advice and guidance see **Appendix D – Clinically Related Challenging Behaviour**.

4.4 Perpetrator

A person responsible for committing an offence and or crime i.e. physical assault.

4.5 Victim

A person who is adversely affected by an action as a consequence of the perpetrators actions

4.6 Restrictive Practices

Restrictive practices refer to the implementation of any practice or practices that restrict an individual's movement, liberty and/or freedom to act independently without coercion or consequence. For further information see Restraint & Restrictive Practices Policy

5. Responsibilities

5.1. Role of the Chief Executive

The Chief Executive has overall responsibility for ensuring a safe and secure environment. The Chief Executive has delegated this responsibility to the Chief People Officer.

5.2. Role of Chief People Officer as the Executive Violence & Reduction Lead & Security Management Director (SMD)

The Chief People Officer is the Trusts nominated Executive Violence & Reduction lead & SMD. The Chief People Officer is responsible for the following:

- Security of hospital premises as far as is reasonably practicable with regard to the nature of our services and functions.
- To support and promote the Violence Prevention and Reduction Policy

5.3. Role of the Local Security Management Specialist

The Local Security Management Specialist is responsible for:

- Promote a pro-security culture throughout the Trust
- Provide advice and guidance to managers in conducting physical security assessments and risk assessments relating to violence and aggression.
- Analysis of the Trust's Incident Reporting system to identify trends and take appropriate action to minimise any reoccurrence.
- Provide support to victims of violence and aggression whilst signposting staff and managers affected by incidents to the Trusts Supporting Staff Involved in an Incident, Complaint or Claim Policy.
- Provide advice and guidance to the Security Management Director as required including investigations, sanctions and redress against perpetrators.
- Ensure full co-operation with the Police and / or other agencies in investigations and subsequent actions i.e. sanctions and redress.
- Attend Health & Safety Group meetings and other relevant groups (e.g. Restraint & Restrictive Practices Working Group) to discuss violence and aggression and other security incidents trust wide.
- To ensure compliance with NHS Provider Contract Security Standards.
- The Trusts LSMS is the named Violence Prevention & Reduction Lead.

5.4. Role of Fire & Security Advisor

The Trust Fire & Security Advisor will work with the Local Security Management Specialist to:

- Support the implementation of this policy.

- Implement measures (relevant to role and job description) as is reasonably practicable concerning the management of fixed building and asset security arrangements, also where actions are required to mitigate identified violence and aggression risks.

5.5. Role of Health and Safety Manager

The role of Health and Safety Manager has been merged with the role of Local Security Management Specialist and as such is a dual / combined role. Health and Safety responsibilities (in addition to LSMS responsibilities listed under section 4.6) are outlined in the Health and Safety Policy.

5.6. Role of Senior Managers and Line Managers

Senior managers and line managers will:

- Ensure staff work in an environment that is as safe as possible which includes community visits to a patient's home.
- Complete Violence and Aggression risk assessments and reduce the risks identified.
- Ensure support is offered to staff following violent or distressing incidents in accordance with the Supporting Staff Involved in an Incident, Complaint or Claim Policy.
- Ensure that safety measures are reviewed following an incident.
- Ensure staff are appropriately trained in local procedures and incident reporting requirements.
- Ensure all front line staff complete conflict resolution training.
- Ensure patient facing staff complete Customer Care training.
- Ensure all staff are risk assessed where appropriate for the requirement and attendance at Dementia, Breakaway and Physical Intervention Training.
- Challenge harassment including racial harassment and offer all appropriate protection and support to the victim. In cases where staff members are victims, this may include referral to the counselling service.
- Where incidents of violent, aggressive or challenging behaviour occur, the line manager must conduct a full debriefing of all staff involved. Actions to be completed can be found at Appendix 6: Violence and Aggression Action Card.
- The Line Manager of the staff involved in the incident should ensure it is reported on the Trust incident reporting system, to enable central monitoring of incidents and responses. This may also support equality monitoring.

5.7. Role of Employees

Employees will:

- Employees should ensure the health, safety and welfare of themselves and other persons by being vigilant in respect of themselves and others.
- Employees should ensure that they act in accordance with the training they have received (See Section 10 for relevant training).

- Staff are required to report incidents of violent, aggression or challenging behaviour using the Trust incident reporting system on the Trust intranet, in line with the Incident Reporting, Analysing, Investigating and Learning Policy and Procedures.

5.8. Role of Sodexo

Security officers are employed under contract by the Trusts partnered hotel services provider. Sodexo are responsible for the day to day line management of the security officers who work 24/7 at the NDDH site [redacted] The nominated line manager is the Portering Manager, Sodexo.

The Security contract is monitored by the Facilities Manager.

Operational support concerning the proactive and reactive management of violence & aggression and theft is undertaken by the Trust Health and Safety Manager and Local Security Management Specialist.

Operational support concerning proactive management of fixed buildings and asset security arrangements is undertaken by the Trust Fire and Security Officer.

Sodexo Security Officers will:

- Provide 24–hour assistance to patients, visitors and staff whilst maintaining appropriate order and preventing public disorder at North Devon District Hospital
- Support and assists in the protection of patients, staff, volunteers, contractors and visitors against acts of violence, aggression and abuse.
- Assist with violent, aggressive and challenging behaviour patients at ward level and carries out regular patrols of the Trust car parks and support car parking staff when required.
- Support senior manager (e.g. clinical site, nurse in charge of shift, service manager, matron) in the instigation of Police response to any suspicious incidents or offences that warrant Police attendance.

6. Violence and Aggression Risk Management

6.1. Risk Management Process

Prevention of violence at work must start with a full assessment of the risks. The risk assessment should be carried out by appropriately trained staff gathering information from a number of sources at both organisational and employee level, help and assistance can be obtained from the Local Security Management Specialist.

The risk assessment process should be:

- For the identification of violence and aggression hazards;
- For evaluating violence and aggression risks;
- To agree action plans; and
- To implement monitor and review measures to reduce risk.

The risk assessor must ensure they have completed a suitable and sufficient risk assessment for all the activities being undertaken and must produce control measures that reduce the risk to the lowest level that is reasonably practicable.

The Trust's approved General Risk Assessment Form must be used for general risk assessments.

Additional advice and guidance can be found at Appendix F – Managing Risk and Assessing Behaviours.

See Appendix A for the patient specific challenging behaviour risk assessment tool.

6.2. Risk Assessments for Locations and Terms

Where a risk of violence and aggression has been identified a risk assessment should be undertaken in accordance with the Risk Management Policy for each ward, unit, department or team. The assessment should identify areas where a more detailed risk assessment is required and should include an examination of the physical layout and security measures of the area assessed.

It is recognised that there are some specific circumstances and situations where the risk in the Trust may be higher. These include:

- Where the employee is a lone worker.
- Where staff are dealing with relatives and carers who may be anxious, angry.
- Where patients that have medical conditions that may well give rise to challenging behaviour.
- Where staff are making home visits.
- When patients are being seen alone or with single chaperone.
- When the number and locality of staff that may be able to respond to situation does not provide adequate support.
- Where environmental factors which may give rise to violence and aggressive behaviour such as levels of lighting, noise, distractions, number of people present, location of furniture, clear lines of sight, potential weapons, colour schemes.

6.3. Risk Assessments of Individual Service Users

Individual service users may be subject to a risk assessment for Violence and Aggression. This assessment, where appropriate, will support existing patient care plans for a patient presenting with challenging behaviour. Where it is identified that an individual service user may present a risk to staff or others, the appropriate health care professional must ensure that:

- Completion of a Challenging Behaviour risk assessment (see Appendix A) with relevant action / care plans is completed with support from their respective teams and specialist advisers, where appropriate.
- The assessment and actions are documented in the patient's healthcare record and if appropriate on Trust information systems in accordance with Trust policy.
- All appropriate staff and services are informed of any actions that need to be taken.

- A process is put in place to ensure that where there are shift changes; information is passed on via the handover process.
- Where care is delivered by staff outside of their immediate team, e.g. out of hours weekends, the information is shared in a timely and effective manner.
- A review of the risk assessment and control measures is undertaken if a further incident occurs or at the set review date.

6.4. Markers on Patient Records

Following certain violence and aggression incidents where circumstances warrant placing an alert against a patient's healthcare record, the warning marker will be placed once approved following procedures outlined in the Violence and Aggression Warning Marker Standard Operating Procedure.

6.5. Risk Assessments for Community, Home Visits and Lone Workers

Staff undertaking community and home visits may be particularly vulnerable. Local teams and managers are expected to ensure that systems are in place that meet their staff requirements and comply with Trust policy.

Where the risk of violence to staff is assessed as significant, or liable to arise because of the work activity, and where that risk cannot be avoided e.g. by providing the service in another suitable location such as a Medical Centre, appropriate risk control measures must be taken to reduce the risk of violence & aggression to the absolute minimum so far as reasonably practicable.

The Trust has a Lone Working Policy which details how lone workers can protect themselves to minimise the risk and make their working environment safer. This policy is accessible on the Trust's intranet. Managers who have identified Lone Workers within their departments / wards must complete a Lone Worker Risk Assessment. This is particularly important for high risk staff undertaking community or home visits.

If the risk is related to an individual service user, the process described in 6.3 must be implemented.

Based upon national guidance, best practice and following an overarching assessment, lone worker safety devices have been identified as an appropriate additional layer of protection to complement existing control measures to manage the risk of violence and aggression in patient homes and other community settings.

Devices have been issued to certain community teams where lone working activities carry risk factors that warrant their use.

Community staff must use lone working safety devices and / or other forms of technology issued to them, subject to risk assessment (e.g. work mobile phones, tablets).

Handovers must be completed in accordance with applicable policies and procedures such as the Community Nursing Safe Effective Handover Tool.

6.6. Risk Assessments for Work Environment and Building Design

The Local Security Management Specialist will work in collaboration with the Trust Fire and Security Advisor and Departmental Managers, as well as design and estate facilities teams, to ensure work environments are as safe and secure as possible to reduce the risk of violence and aggression.

7. Incident Reporting

All incidents of physical and non-physical violence and aggression including unacceptable behaviour should be reported in accordance with the Trust's Incident Reporting, Analysing, Investigating and Learning Policy and Procedures The immediate supervisor and/or line manager must also be informed at the first available opportunity.

The Local Security Management Specialist will monitor violence and aggression reported incidents.

The Compliance Team will investigate all reported incidents of intentional Violence and Aggression and monitor incidents involving challenging behaviour due to medical factors.

8. Security at NDDH

Where staff are unable to manage risks of violence and aggression, Sodexo Security can be contacted to provide support [redacted](emergency) or through Switchboard [redacted](non-emergency).

When called to assist clinical staff caring for a patient, should talk down and de-escalation fail and the proportionate use of restraint as a last report is necessary and lawful, it must be clinically led in accordance with the Trusts Restraint & Restrictive Practices Policy.

9. Contacting the Police

Trust Wide inclusive of all sites and locations occupied or visited by staff where Police assistance is considered necessary in the event of an emergency that cannot be dealt with by Trust and / or contracted staff (e.g. Security Officer), staff must be satisfied that at least one of the following criteria has been met:

- There is an identifiable and immediate risk to life or property
- The person at risk is suffering or is at risk of suffering immediate and significant harm
- It is reasonably believed that a crime has been committed or is about to be committed and / or
- Attendance of a Police Officer is necessary to prevent a breach of the peace.

Where the criteria has been met and in emergency situations: Dial [redacted] followed by 999.

In non-emergency situations for example reporting a theft or criminal damage discovered after the event to obtain a crime reference number and to log the incident, the Police can be contacted via 101 or via the Devon & Cornwall Police Online crime reporting form.

Concerning Police involvement regarding any incident of physical or non-physical violence and aggression (e.g. physical assault, hate crime, threats made). Prior to Police

involvement and upon investigation with clinical advice and input, it may be established that the assault was not intentional.

Contributory factors to non-intentional assaults or the like include:

- Medical factors; the patient not fully aware of their actions due to illness or treatment;
- Mental ill health or severe learning disability; or
- Adverse reactions to medication administered.

The view of the person assaulted should also be sought in each incident.

The manager allocated to the incident (via DATIX) is responsible for the ensuring an investigation is conducted in a manner proportionate to the incident with advice support and assistance provided where required by specialist advisors such as the Local Security Management Specialist as is necessary.

10. Communication

Where patients are identified as being violent or potentially violent, it will be necessary to share information about such patients in accordance with the employer's duty to protect the health and safety of staff and to protect the staff of other organisations in accordance with Data Protection and Caldicott requirements and the Crime and Disorder Act 1998.

Employees of the Trust must communicate to their colleagues if there is a likelihood of a patient displaying violent or aggressive behaviour. This information must be recorded clearly in the patient care plan and referral documentation.

The sharing of and disclosure of information to other organisations may occur for the purposes of community safety and security provided requirements are satisfied as outlined in the Violence and Aggression Warning Marker Standard Operating Procedure.

11. Support for Staff

The Trust acknowledges that its staff may be affected physically and emotionally following a violent or other security incident. For further advice and guidance please refer to the Supporting Staff Involved in and Incident, Complaint or Claim Policy and the Stress and Mental Wellbeing Policy

12. Sanctions Management

A wide range of sanctions can be taken for intentional physical and non-physical assaults dependent on the severity of the incident. These measures may include:

- Verbal Warning
- Warning Letter
- Acceptable Behavioural Agreement
- Exclusion from premises
- Secure Controlled Access
- Civil Proceedings and / or Crime Prevention Orders

- Criminal Prosecution

Full guidance on application and authorisation of sanction management refer to Appendix G: Sanctions Management.

13. Training

Conflict Resolution Training

The Trust requires that all front line staff (those dealing directly with the public) receive the National Syllabus in Conflict Resolution Training. This training is intended to help prevent situations escalating and to diffuse potentially abusive and violent incidents. This training includes the causes of violence, the recognition of warning signs and de-escalation techniques.

Higher Risk Groups

Staff in higher risk groups may require a more in-depth level of training in defusing situations where aggression is being displayed or in responding to physical violence. This training may include the following:

- Dementia Training
- Breakaway Training
- Physical Intervention Training

Physical intervention training is applicable to staff in patient facing situations and the training course is still applicable to staff in patient facing situations working at the NDDH site (in addition to the presence of 24/7 security staff).

Training requirements will be determined by risk assessment conducted by the service manager and staff. The Health & Safety Manager and the Local Security Management Specialist will support risk assessment and identification of available training.

Training matrix and booking

Training can be booked via Learn+.

Staff can use Learn+ to access bookings for learning events and complete e-Learning. Staff have access to a personalised compliance dashboard to view mandatory training requirements and search for learning opportunities.

14. Monitoring Compliance with and the Effectiveness of the Policy

14.1. Standards/ Key Performance Indicators

The Trust undertakes to evaluate the effectiveness of this policy and the associated guidelines, the key performance indicators comprise:

- Number of incidents being reported
- Number of significant event reports

- Number of serious investigations
- NHS Staff survey results (Violence & Aggression section)
- The uptake of training programmes

14.2. Process for Monitoring Compliance and Effectiveness

Monitoring compliance of this policy against all minimum requirements in Clause 24 of the NHS Standard Provider Contract will be the responsibility of the Local Security Management Specialist. This will be monitored on a continuous basis using the Trust's Incident reporting system. It will provide baseline information on the number, nature and location of incidents of violence and aggressive behaviour within the Trust.

Where non-compliance is identified, support and advice will be provided to improve practice.

Responsibility

The Local Security Management Specialist will be responsible for monitoring and reporting violence and aggression incidents to the Health & Safety Committee.

15. References

- National Institute for Health and Care Excellence (NICE) (2015): Violence and aggression: short-term management in mental health, health and community settings (NICE Guidance NG10). [online]. Available at: https://www.nice.org.uk/guidance/ng10
- The Nursing and Midwifery Council (NMC) (2010). Code of professional conduct. London: CMC. [online]. Available at; http://www.nmc-uk.org/Documents/Guidance/NMC-Guidance-on-professional- conduct-for-nursing-and-midwifery-students.pdf
- Health & Safety Executive [HSE] (n.d.) Work-related violence (HSE Guidance). HSE. [online]. Available at: http://www.hse.gov.uk/violence/
- The Equality Act 2010. London: Stationery Office. [online]. Available at: http://www.legislation.gov.uk/ukpga/2010/15/contents
- National Association for Healthcare Security. [online]. Available at: http://www.nahs.org.uk
- Health and Safety at Work Act 1974. [online]. Available at: http://www.hse.gov.uk/legislation/hswa.htm
- The Protection from Harassment Act 1997 [online]. Available at: http://www.legislation.gov.uk/ukpga/1997/40/contents
- The Public Order Act 1986 [online]. Available at: http://www.legislation.gov.uk/ukpga/1986/64
- Human Rights Act 1988 [online]. Available at: http://www.legislation.gov.uk/ukpga/1998/42/contents
- Mental Health Act 2007 [online]. Available at:

http://www.legislation.gov.uk/ukpga/2007/12/contents

- Mental Capacity Act 2005 [online]. Available at: http://www.legislation.gov.uk/ukpga/2005/9/contents
- The Mental Health Act 1983 Code of Practice [online]. Available at: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
- Criminal Law Act 1967 [online]. Available at: http://www.legislation.gov.uk/ukpga/1967/58
- Criminal Justice and Immigration Act 2008http://www.legislation.gov.uk/ukpga/2008/4/contents

16. Associated Documentation

- Challenging Behaviour Strategy
- Deprivation of Liberty Safeguards (DoLS) Policy
- Health and Safety Policy
- Incident Reporting, Analysing, Investigating and Learning Policy and Procedures
- The Use of Ligature Cutters Standard Operating Procedure
- Lone Worker Policy
- Mental Capacity Policy
- North Devon Healthcare NHS Trust Code of Conduct leaflet
- Observation of Patients Policy
- Patient Safety Briefing and bedside Handover SOP
- Police Welfare Checks Standard Operating Procedure
- Restraint and Restrictive Practice Policy
- Risk Management Policy
- Safeguarding Adults Policy
- Safeguarding Children Policy
- Search of Persons & Property Standard Operating Procedure
- Secure Environment Policy
- Violence and Aggression Warning Markers Standard Operating Procedure

Appendix A: Challenging Behaviour - Patient Risk Assessment

Challenging Behaviour - Patient Risk Assessment

Section A - Patient details:

Patient Name: …… DOB: / / Patient No ……

Address……..

Postcode: ……... Date of Assessment: / / Time: ……

Unit …… Ward/ Dept. ……

Section B – Risk indicators: (answer all statements below)

Is the patient displaying physical signs? **Yes** □ **No** □
(E.g. tense and agitated, sweating profusely, voice/ pitch change, dilation of pupils, physical signs of aggression etc.)

Is the patient a risk to staff or others? **Yes** □ **No** □
(E.g. aggression, violence)

Has there been a previous episode of violence/ aggression? **Yes** □ **No** □
(E.g. patient lashing out, verbal threat etc. this admission or previous admissions)

Is the patient presenting challenging behaviour? **Yes** □ **No** □
(E.g. inappropriate demands, poor service response etc.).

Is the patient a risk to themselves? **Yes** □ **No** □
(E.g. suicide, self-harm etc.).

Section C - Initial Management Plan to manage risks identified:

(See Appendix E and / or Restraint & Restrictive Policy for further guidance – Challenging Behaviour)

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Section D - Action Stages Available: (this section must be completed)

1. Is the Initial Management Plan above suitable to manage risks?

   □ Yes, no further action at this stage

   □ No, go to question 2

2. Has the Patient Management Plan been amended and the risk managed?

   □ Yes, detailed below and no further action at this stage

   □ Further action required, go to question 3

3. Has a consultation/ discussion taken place with Team Leader/ Nurse in Charge/ Head of Department and outstanding actions agreed to manage risk?

   □ Yes, detailed below and no further action at this stage

   □ Further action required, go to question 4

4. Team Leader/ Nurse in Charge/ Head of Department must organise a meeting with senior members of staff - Patient Management Team/ Manager on Call/ Medical staff/ Modern Matron/ Senior Nurse/ Local Security Management Specialist

   □ Actions agreed and detailed below

Further Actions taken to manage risk following action stages 2, 3 and/ or 4

Action must include next review time no later than 24 hours

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……
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……

Section E – Person completing risk assessment:

Completed by: …… Signed: ……

Designation:…… Date……

CHECK LIST

Risk Assessments of Individual Service Users

Individual service users may be subject to a risk assessment for Violence and Aggression.

Where it is identified that an individual service user may present a risk to staff or others, the appropriate health care professional must ensure that:

- A Violence and Aggression risk assessment with relevant action plans is completed with support from their respective teams and specialist advisers such as the Local Security Management Specialist, where appropriate.
- The assessment and actions are documented in the patient's healthcare record and if appropriate on Trust information systems in accordance with Trust policy.
- All appropriate staff and services are informed of any actions that need to be taken.
- A process is put in place to ensure that where there are shift changes; information is passed on via the handover process.
- Where care is delivered by staff outside of their immediate team, e.g. out of hours weekends, the information is shared in a timely and effective manner.
- A review of the risk assessment and control measures is undertaken if a further incident occurs or at the set review date.

If this risk assessment was completed following an incident, please ensure the incident is reported on the Trusts incident reporting system (DATIX) in accordance with the Incident Reporting and Management Policy

Appendix B: Violence & Aggression Will Not Be Tolerated - Poster

NHS
Northern Devon Healthcare
NHS Trust

We want NDHT to be safe and secure for all our patients, visitors and staff.

Intentional violence, aggression and threatening or abusive behaviour will **not** be tolerated**.**

We may decide to withhold treatment or services from patients or visitors who are violent or abusive towards our staff.

Patients or visitors who are violent or abusive may be removed from our premises or grounds and could face Prosecution.

POLICING IN PARTNERSHIP

Appendix C: Examples of Physical & Non-physical Assault Including Abusive Telephone Calls

Examples of physical and non-physical assault including abusive telephone calls:

1. **Physical assault;** Examples could include:

- Intentional physical contact on a person that has resulted in bodily harm and injury such as a bite, scratch, bruise, reddening of the skin etc.
- An intentional, unlawful threat to cause bodily harm or injury.
- A circumstance which creates in the other person a well-founded fear of imminent peril or danger.
- Battery – the wilful or intentional touching of a person against that person's will by another person.
- Offensive touching.
- Sexual Assault – sexual contact against a person's consent or will.
- Unwanted physical contact by another.
- Spitting

2. **Non-physical assault;** Examples could include:

- Offensive language, verbal abuse and swearing which prevents staff from doing their job or makes them feel unsafe.
- Loud and intrusive conversation.
- Unwanted or abusive remarks.
- Negative, malicious or stereotyping comments.
- Invasion of personal space.
- Brandishing of objects or weapons.
- Offensive gestures.
- Threats or risk of serious injury to a member of staff, fellow patients or visitors.
- Bullying, victimisation or intimidation.
- Stalking.
- Alcohol and drug fuelled abuse.
- Unreasonable behaviour and non-cooperation such as repeated disregard of hospital visiting hours.
- Any of the above which is linked to destruction of or damage to property.

In short, unacceptable / inappropriate behaviour can be defined as any incident where a staff member feels harassed, abused, threatened, bullied (not by a colleague), insulted or assaulted in circumstances relating to their work or whilst they are at work.

Note: staff-on-staff bullying does not fall under the remit of security management. Any such issues will be managed by line managers and /or Human Resources.

3. **Abusive Telephone Calls**

If you experience the type of behaviour previously described in the form of a phone call, you should:

- Inform the caller that you do not wish to be spoken to in the manner being used If

the caller persists:

- Reiterate that you do not wish to be spoken to in the manner being used and that you

will terminate the call should they persist

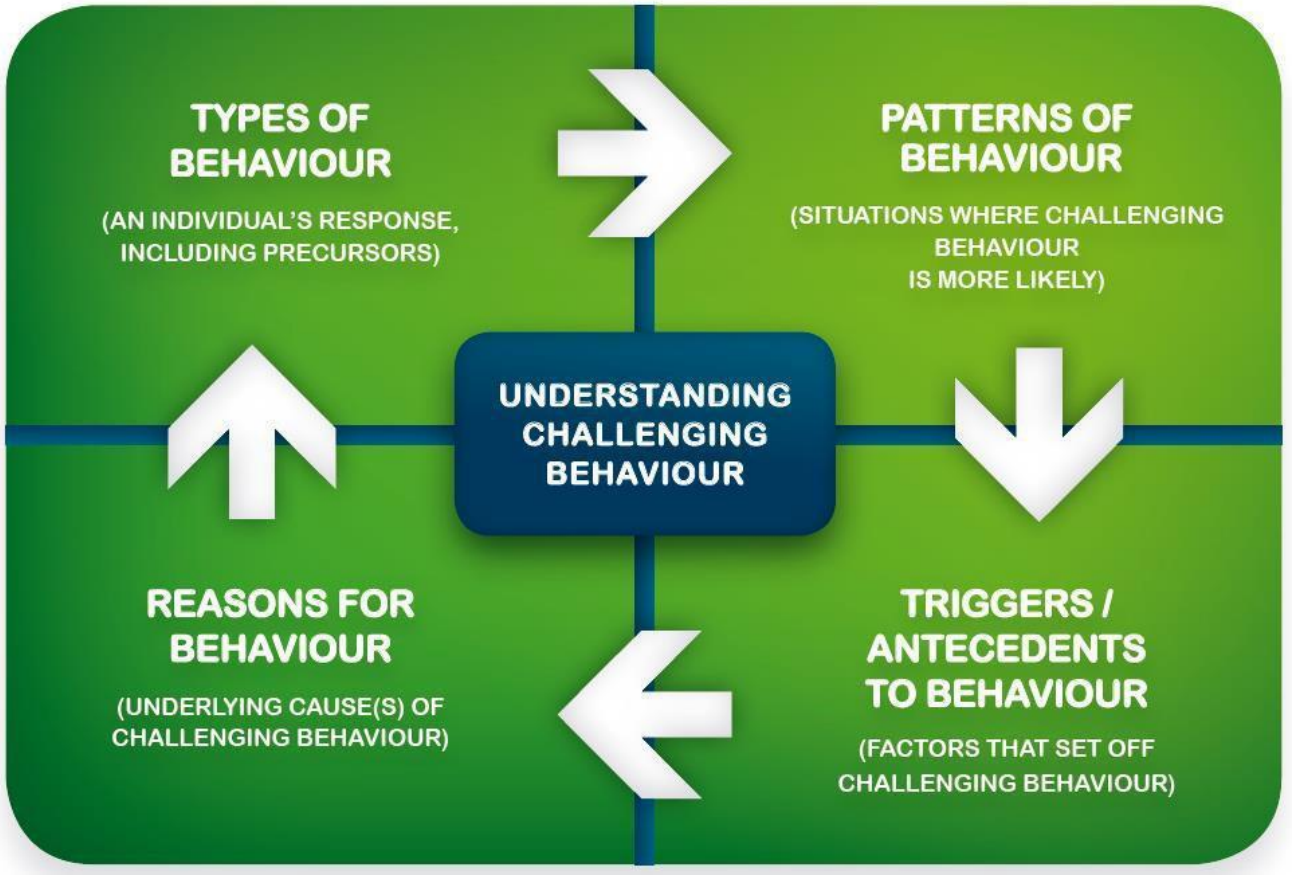
If the caller persists:

- Inform the caller that you will not be spoken to in that manner and that you are terminating the call
- Then put the phone down and report the incident to a Senior Manager and via the Trust's Incident Reporting system

Should the caller continue to ring and display this inappropriate behaviour you must refer on to a senior member of staff with all the relevant details. If the caller is still persistent and displays this inappropriate behaviour this becomes a point of law under "The Protection from Harassment Act 1997" and must be reported to the Local Security Management Specialist and / or Police as appropriate.

It is important to note that examples of physical and non-physical assault can be either displayed in person or by telephone, letter or e-mail, or any other form of communication such as graffiti on Trust property and buildings.

Appendix D: Clinically Related Challenging Behaviour



1. COMMON CHARACTERISTICS

1.1 Individuals who manifest challenging behaviour often have some degree of cognitive impairment, either chronic (e.g. dementia or a learning disability) or acute (e.g. delirium, head or brain injury, drug or alcohol intoxication). It may also be seen in other mental health conditions such as psychosis or personality disorder.

1.2 Care is needed that the behaviour is not as a result of an underlying illness or injury which needs urgent attention.

2. TYPES OF BEHAVIOUR

2.1 Challenging behaviour may describe many kinds of deliberate or non-deliberate non-verbal, verbal or physical behaviour. Some of these behaviours (e.g. staring, crying and shouting) may represent legitimate expressions of distress.

2.2 It can include behaviours which may be less risky, such as apathy, lethargy, fatigue, hyperactivity, hypo activity, being non-compliant or withdrawn, if staff need to intervene because the behaviour poses a safety risk to staff, patients and service users or others, e.g. an individual trying to get out of bed when they cannot stand and may fall.

2.3 There is no continuum of behaviour and where someone is sufficiently distressed or alarmed; their behaviour may instantly result in a physical action.

3. PATTERNS OF CHALLENGING BEHAVIOUR

3.1 Identifying patterns to predict when challenging behaviour is more likely to occur can assist when planning, preventing and preparing for it. Challenging behaviour tends to occur in response to:

- Unmet care needs (e.g. toilet, pain, thirst, hunger)
- Care tasks, including intimate procedures
- Administering medication (especially where the patient has to wait for pain relief)
- Pre-operative period (waiting, nil-by-mouth, clinical interventions and procedures)
- Post-operative period
- Gender issues (preferences for male or female carer)
- Pressure on staff time (i.e. staff not being on the 'shop floor')
- Lack of engagement by staff
- Times when staff are otherwise engaged (mealtimes, medication, handovers etc.)
- Areas where there are less experienced staff (e.g. less aware of psychological issues)
- 'Sundowning' (i.e. behaviours are more prevalent during afternoon and evenings, due to factors such as tiredness and changes in levels of light, or sensory deprivation)
- Night time disturbance
- Over-stimulating or under-stimulating environments
- Heightened activity (e.g. mealtimes)
- Lack of meaningful activity
- Relatives leaving
- Cultural, religious or spiritual needs
- Individuals feeling that staff are not hearing or listening to what they are saying
- Staff hostility
- Inconsistent rule setting
- Provocation by other individuals, distress in other individuals.

4. TYPES OF BEHAVIOUR

Non-verbal	Verbal	Physical
• Agitation • Wandering, pacing, following • Intimidating facial expressions, staring • Intimidating body posture • Cornering, invading personal space • Interference with equipment or property • Being withdrawn, extreme passivity, refusal to move	• Shouting • Swearing • Crying • Screaming • Repetitive statements or questions • Personal comments or questions • Racist, sexist, offensive speech • Bizarre, psychotic content, not based on known reality	• Scratching • Grabbing, hair pulling • Biting • Hitting, slapping, punching • Pinching • Spitting • Kicking • Pushing, shoving, knocking into someone • Striking or throwing objects • Inappropriate touching (self or others) • Urinating, smearing • Undressing • Self-harm • Absconding • Removal of lines, masks, catheters, dressings, incontinence pads • Non-compliance, resistive behaviour (e.g. refusing medication, blood tests)

5. TRIGGERS AND ANTECEDENTS

5.1 Triggers and antecedents are factors which occur prior to an individual's challenging behaviour. These factors may include the care environment or setting, individuals or interventions, activities or objects, thoughts or feelings, pain or discomfort.

5.2 For example a person may become overwhelmed, when a high number of healthcare professionals undertake a care intervention in close proximity to them.

5.3 Observing, identifying and documenting triggers and antecedents is the first part of a proactive strategy for minimising an individual's stress or distress. This is because, once identified, many of these situations can be avoided or changed.

6. PRECURSORS

6.1 Challenging behaviours can occur without warning and staff need to be aware of, recognise and identify precursors. Precursors are behaviours and are different to triggers, which are factors that can lead to challenging behaviour.

6.2 Precursors can often be very subtle and leave staff feeling 'uncomfortable', or they may signpost the onset of challenging behaviour.

6.3 Common recognisable cues include:

- Tense and angry facial expressions
- Increased and prolonged restlessness, pacing, body tension
- Increased breathing, muscle twitching and dilated pupils
- Increased volume of speech and swearing
- Refusal to communicate, withdrawal, irritability
- Prolonged eye contact
- Confusion of thought processes, poor Concentration
- Delusions or hallucinations
- Verbal threats or gestures
- Verbalising an intention that suggests distress, e.g. 'I want to go…'
- Replicating behaviour which preceded earlier disturbed or challenging episodes
- Reporting anger or violent feelings
- Generally, anything that seems out of character, e.g. excessive crying or laughing hysterically.

7. REASONS FOR CHALLENGING BEHAVIOUR

7.1 There is always a cause of clinically related challenging behaviour, even if it is not evident at the time. An overall approach that looks to prevent distress by identifying, categorising and understanding its reasons should reduce the likelihood of these potentially 'unforeseen' events occurring. The main categories are:

- Physical factors
- Cognitive factors
- Psychological and emotional factors
- Environmental or social factors

8. Reasons for challenging behaviour – Summary

This table is not exhaustive and is only examples of what may cause challenging behaviour.

Physical	Cognitive	Psychological/ Emotional	Environmental/social
• Hypoxia • Hyperglycaemia • Hypoglycaemia • Electrolyte abnormality • Dehydration • Constipation • Infection • Pain • Visual or hearing impairment • Sleep deprivation • Medication (effects) • Illicit drugs or alcohol • Drug or alcohol withdrawal • Pre or postoperative • Hunger, thirst • Incontinence, urgent toilet needs • Earache • Epilepsy	• Communication problems (expression and understanding) • Memory loss • Difficulty with language or dialect • Reduced spatial awareness • Learning disabilities • Disorientation • Poor executive function (reasoning, planning, foresight) • Loss of insight • Autism	• Fear • Anxiety • Anger • Depression • Social isolation • Mania • Fixed beliefs or current thinking • Separation anxiety • Loss of self-worth	• Noise • Lights • Temperature • Overcrowding, or busy environment • Inappropriate signage • Lack of information • Long waiting times • Cultural factors • Lack of continuity of staffing, or care • Loss of routine • Unfamiliar surroundings • Pace of surroundings • Lack of meaningful activity • Over-stimulation • Under-stimulation • Imposed boundaries or routine • Stopping a habit/behaviour (e.g. smoking)

9. Physical factors

9.1 The physical causes which may lead to challenging behaviour include features of an individual's condition that pre-dispose him or her to distress (such as sensory impairments e.g. a loss of sight, hearing) unpleasant symptoms, pain and discomfort. They can all cause irritability and agitation or trigger distress.

9.2 Patho-physiological changes that cause delirium can be a significant factor and it is worth mentioning them specifically. Delirium is a short term confused state, or worsening of pre-existing confusion, due to a physical cause. It comes on suddenly (days to hours), fluctuates with time and is characterised by cognitive impairment and inattentiveness (distractibility) or drowsiness. Delusions, hallucinations and emotional changes (fear, anger) are common and symptoms are often worse at night. Delirium usually resolves with treatment of the underlying cause, but it may persist and rarely does not always recover. Suspicion of delirium requires assessment by a suitably skilled doctor. Supporting information can be found in the Alcohol Withdrawal Guidelines.

9.3 Poor sleep is common in illness and in hospital, and leaves people fatigued and irritable. Hunger, thirst and urinary symptoms are associated with strong urges in an individual and may manifest as challenging behaviours if they cannot be communicated.

10. Cognitive factors

10.1 Cognitive factors include the inability to remember new information, explanations or instructions, the loss of inhibitions, poor judgment and planning and importantly communication problems.

10.2 They often result in an inability to articulate needs or a difficulty in understanding and interpreting the communication of those around them (both verbal and non-verbal) and can all lead to distress or difficult behaviours.

10.3 Staff needs to translate the reasons for challenging behaviour into unmet needs before identifying strategies to meet these needs.

10.4 Staff and carers can sometimes lack an understanding of communication impairment and overestimate a person's ability to understand information and make choices.

11. Psychological or emotional factors

11.1 Individuals suffering from delusions, especially paranoid, can feel they are being threatened and this can lead to defensive and challenging responses on their part. People with personality disorders may have difficulty foreseeing the consequences on others of their actions and may become acutely distressed. Fear is powerful in provoking difficult or aggressive behaviours. Anger can arise at a time of threat, as part of bereavement, or if needs are not being met.

12. Environmental or social factors

12.1 Factors relating to an individual's surroundings (e.g. excessive noise) can be provocative particularly if they are prolonged or persistent and may also interfere with the individual's rest and sleep. People with cognitive impairment often find care surroundings overwhelming and over-stimulating and may not keep up with the speed or volume of information or activity they are exposed to.

12.2 A lack of stimulation and activity, engaging in meaningless activity or over-activity can lead to frustration in individuals. This may be exacerbated by a lack of communication and dialogue between staff and patients or service users, poor care planning and a lack of coordination of activities between multi-disciplinary teams (MDTs).

12.3 Finally, a lack of understanding of an individual's culture and related behaviour can lead to frustration and agitation on their part. This can lead to a lack of trust, misinterpretation of their behaviour and miscommunication. Cultural sensitivity is important in dealing with this kind of challenging behaviour.

Appendix E: Violence & Aggression Action Card

VIOLENCE/AGGRESSION ACTION CARD
A PATIENT WHO EXHIBITS AGGRESSIVE OR VIOLENT BEHAVIOUR (PHYSICALLY OR VERBALLY)
FOR USE BY: Senior Staff **LIASE WITH: Site Management/Matron/Senior staff**

E NSURE 'ALL' RELE V ANT ACTIONS ARE DOCUME NTED!

CORE RESPONSIBILITIES:

Are staff OK? Is the patient ok?

Does the member of staff /patient require medical?

Does security/police need to be contacted? [redacted]

Does the member of staff need a break period from the bay/cohort bay?

Consider if the staff involved can continue working and if so, do they need to work elsewhere?

If restraint or rapid tranquilisation used, record details in patient notes and increase observations refer to Trust Policy on Rapid Tranquilisation.

Debrief with the rest of the team

Refer to Trust Policy on Violence and Aggression

Complete Incident Report on DATIX

Inform senior staff e.g. Matron or Manager of incident

ASSESS AND CONSIDER POTENTIALLY REVERSIBLE CONDITION, PAIN, INFECTION, ETC.

Identify any clinical explanation for aggressive behaviour (i.e. head injuries, infection, medication, delirium or dementia etc.)

Medication review by the medical team

Review/Create Challenging Behaviour Patient Risk Assessment to identify a plan of appropriate measures of control (Appendix A)

If patient remains unsettled, consider calling the security team on [redacted] to also alert to possible reoccurrences and possible requirement for Police attendance

M AT RO N'S RE S PO NSIB I L IT IES:

Follow up with staff involved as soon as possible after the incident

Consider referral to Occupational Health or Counselling Service

Hold team debrief

Refer to Trust Policy on Violence and Aggression

Make other staff aware through safety brief

Consider enhanced observations

WHEN AN INCIDENT OF VIOLENT OR ANTI-SOCIAL BEHAVIOUR OCCURS OUTSIDE TRUST BUILDINGS THE PERSON AT THE SCENE MUST CONSIDER/ADOPT THE FOLLOWING ACTION:

Request Security team via [redacted] if the nature of the assault more serious, request the police via 999

Always ensure others within the immediate area such as patients, staff, relatives are protected and where/when possible moved to a safe environment

Provide a detailed brief to the site manager as soon as possible, also to the security team upon their arrival

Support the security team if needed/requested until conclusion met

Appendix F: Managing Risk & Assessing Behaviours

1. RISK FACTORS

2. Risk factors increase the likelihood of challenging behaviour and require quick management decisions. Risk factors may include a person's previous history and current clinical presentations. Historical and current factors may operate independently or interact together, and they may combine with environmental and situational triggers to heighten the risk of challenging behaviour.

3. The following factors point to an increased risk of challenging behaviour:

Person	Environment	Situational
Historical factors History of aggressive/violent behaviour History of intent to harm others History of mental condition(s)/self-harm/suicide attempts Cognitive impairment Previously detained under a section of the Mental Health Act Forensic, criminal related history, e.g. prisoners in hospital etc. History of abuse or trauma History of substance and alcohol abuse or withdrawal History of disruption to service delivery and resources, e.g. damage to property, equipment, disruption to staffing levels etc. **Current presentation** Specific diagnoses, physical, cognitive, (especially communication) and psychological/emotional factors.	Environmental factors, e.g. new environments, busy, active, crowded treatment areas Other agitated or distressed patients or service users Lack of meaningful activities.	Activities being undertaken, e.g. washing, dressing, giving medications etc. Services being provided and the client group Staff member, e.g. inconsistent staff attitudes, awareness and approach Staffing, e.g. staffing levels, skill levels and training Certain times of day Patient, e.g. mix/tensions, patient on patient incidents Restrictions, denial or confrontation, e.g. a person wanting to leave, cigarette requests.

4. PREVENTING THE RISK OF CHALLENGING BEHAVIOUR

4.1 Preventing the risk of challenging behaviour relies on meeting personalised care needs: *'Care where the patient is an equal partner with the healthcare professional and where both parties work together to make an assessment, identify options for the delivery of the most appropriate care. The care provided is holistic and the 'whole person' sits at the centre of the care package, which may be delivered by a range of health and social care professionals.'* (NHS Education for Scotland, 2010)

4.2 This approach is based on positive staff attitudes, high levels of tolerance, compassion and empathy. Dignity is important and requires that the individual is kept comfortable, valued, respected, is in control, and that they have choices in their treatment and care.

Empathic understanding means seeing problems from the perspective of the patient or service user.

It requires strong leadership, skilled staff confident in their own abilities and adequate resources. It requires training, practice and often role-modelling by people who know how to do it and can share their expertise.

In acute health settings, staff are often instilled with the belief that they need to work quickly in order to be effective. However, the approach presented here relies on staff being able to talk to the patient or service user and understand their psychological, emotional and physical care needs.

Personalised care means staff building positive relationships with the person being cared for, their family and carers. The rewards equally apply to those delivering the care as well as the person being cared for, as staff tend to feel empowered and supported by this approach.

Staff should understand that the way they interact is vital in helping the patient communicate the reasons for their distress and their unmet needs. They also need to be aware (and this should be reiterated through training) of how their interaction with the patient can positively or negatively reinforce challenging behaviours and of the need to communicate with them in a sensitive way.

A collaborative approach is the most effective way of preventing a person's challenging behaviour, which involves all staff having a unified understanding of an individual's behaviours, antecedents, triggers, reinforces and consequences and what everyone needs to do to prevent the behaviours. This understanding requires developing a personal profile and wherever possible observing and analysing what is happening and designing effective interventions – a functional assessment can assist where possible

5. MANAGEMENT TOOLS AND TECHNIQUES

Aggressive behaviour can nearly always be explained by the "fight or flight" reaction to a situation that is deemed "dangerous" by the victim. In such situations, the following points need to be remembered (however where a diagnosis of delirium has been made, refer also to the Clinical Guidelines for the Diagnosis and Management of Delirium):

- Reduce noise and stimulation
- Allow patients to "wander" safely
- Do not physically restrain patients unless they are a real danger to themselves or others. If absolutely necessary, use the minimal force possible.
- Remember that a uniform may not inspire confidence and may have the reverse effect
- Provide 1:1 care. Use friends or relatives if they are happy to come in; usually relatives are more than happy to be involved in the care, but additional staff may be needed, particularly over the first 24 hours
- Ensure adequate hydration, nutrition and comfort
- Do not be offended if the patient takes a dislike to you. Do not argue with the patient. Find someone that has a good rapport to do the bulk of the care; but make sure that they are supported and have regular breaks during an acute confusion period, as this is very

energy demanding.

- Use of bed rails. This may increase the patient's feeling of being trapped or held against their will. It often results in injury to the patient by either entrapment in the bed rails or climbing over the bed rails and falling from a greater height. A Risk Assessment from the Slips, Trips & Falls Policy (Inpatients) may be required. If necessary nurse the patient on a Hi-Lo Bed on the floor, or put the bed to its lowest height and place Crash Mats around the bed.
- Use a calm but firm approach so that the patient feels there is someone in control of the situation. Keep the voice calm and reassuring; do not shout or speak
- unnecessarily loudly. Keep commands/information short and concise; the patient
- will not be able to deal with too much information at once.
- Maintain consistency of approach by the whole team by through good handovers.
- Avoid the use of sedatives if at all possible. If this is the only safe way of managing the patient it should be used as a last resort and expert advice should be sought regarding appropriate drugs and dosage.

6. Keeping patients and visitors informed

The provision of information to patients, their relatives and friends and ensuring that patients' concerns and complaints are dealt with quickly and fairly is extremely important and can prevent the risk of violence. This is particularly the case in situations of acute distress and/or long waiting periods and is more relevant to areas such as the Emergency Department and Outpatients.

7. Keeping staff informed

Staff involved with patient care should ensure information is communicated to relevant staff, e.g. at handover, particularly when the following applies:

- New members of staff are involved
- New patients are admitted
- There has been a change in the patient's medical/physical state, medication, behaviour or mood, etc.
- Known violent patients/clients are being transferred from one department to another
- Where domiciliary visits are made to patients with a known or suspected history of aggressive or violent behaviour. Further details are available in the separate
- Lone Working Policy

8. Environment

It is important that the workplace environment and surroundings are subject to Risk Assessments in line with the Trust Risk Assessment Policy & Procedure. Where a risk assessment is to be made regarding violence & aggression a Matron or Senior Nurse will carry out the assessment. Further advice and guidance can be obtained from the Local Security Management Specialist.

The patient's environment can have a significant impact on their behaviour, specialty areas, mobility, etc. Items available to them within their environment may also become a hazard to others and/or a means to facilitate self-harm.

As part of the CBMP consideration should be given to:

- Bed location – can the patient be managed in a bay or is a side room more appropriate,

will their behaviour impact on the care and/or recovery of other patients including demands on nursing time

- Potential weapons – remove any non-essential items that may be used to strike and/or be thrown including patients personal property, consider using plastic cutlery
- and non-ceramic crockery, ensure that "hot drinks" are not hot enough to
- scald or injure
- If appropriate, remove sharps bins from the immediate vicinity of the patient, be aware of items on your person such as scissors
- Ensure the patient's visitors do not compromise safety by passing unsuitable items or substances during visits. Consider checking patient's property and local environment following visits.
- Giving each patient a defined personal space
- Providing distraction activities where appropriate
- Encouraging play areas and activities for younger patients with disturbed behaviour
- Providing activities and wandering space for patients with dementia
- Monitoring the mix of patients
- Removing aggressive patients to a single room or cubicle to protect both the health and safety of other patients and that of the aggressor himself/herself
- For patients with dementia and delirium there is also an argument for cohorting patients to reduce the risk of incidents of falls and aggression
- Request check of personal belongings for offensive weapon(s) and potential incendiary devices (matches, cigarette lighters).

9. Personal Safety of Staff

As well as managing the care of the patient concerned, the personal safety of all disciplines and groups of staff must be ensured as far as is reasonably practicable. Although patient care is the primary focus this must not be at the expense or risk of personal injury where the task being attempted is not of an essential and/or life preserving nature.

- Routine, non- essential tasks - bed making, room cleaning, patient hygiene etc. should not be undertaken or attempted when the patient is showing challenging behaviour (unless there is a risk to skin breakdown leading to pain and further aggression)
- Ensure that all staff that may have reason to have contact with the patient – doctors, nurses, (including departments such as x-ray, fracture clinic, cardiology),
- housekeepers, porters, chaplain – are aware of the potential or actual risk/s in
- dealing with the patient
- To avoid a one on one confrontation situation consider setting a minimum 2:1 staff to patient ratio at all times and document this in the patient care plan
- Report all challenging behaviour incidents involving the patient by completing a Trust incident report on Datix and ensure the CBMP is regularly updated and that
- new and/or revised information is communicated to all relevant staff
- Line managers should be aware that caring for challenging behaviour patients can be demanding and stressful and staff caring for challenging patients may require additional management support.
- In more serious or traumatic cases line managers should ensure staff are debriefed and if necessary counselling should be offered to staff. Refer to Action Card at Appendix 6.

10. Care planning

Risk assessment and management should inform the care plan as to whether specific interventions are required to manage challenging behaviour. The risk assessment

documentation should sit alongside the care plan and should be cross-referenced and updated accordingly if new risks emerge.

11. De-escalation

If prevention has failed, is failing or has never had a chance to work, staff need to be skilled in de-escalation. This is based around highly developed communication skills, fostering good relationships, empathy, calming, non-confrontation, minimising threat, negotiation, compromise, agreeing to any reasonable requests, distraction, activities and changes of staffing which are all key here.

12. Doing nothing/ watch and wait

Doing nothing and 'watch and wait' are important strategies in high risk situations where it is safe to apply them, although they require staff confidence as they may seem counter-intuitive. Challenging behaviour around the time of transition (e.g. hospital or care home admission, or ward or bed moves) often settles down within 2 or 3 days without intervention other than trying to keep the individual, staff and other people safe and offering comfort and reassurance. The latter meets psychological and emotional needs and improves the individual's experience of care.

13. Leave and return

'Leave and return' is a strategy when someone is resisting care. Staff need to employ good judgment here. If a patient or service user absolutely needs medical intervention or another essential intervention (e.g. a soiled incontinence pad needs changing), brief physical interventions may be necessary. But in the majority of cases things can wait (washing or shaving, for example). Constant informal risk assessment is needed, along with adequate supervision, opportunities to discuss and debrief dilemmas and staff being trusted to use their judgment.

14. Better understanding and tolerance

Some challenging behaviours may be difficult, or unnecessary, to stop (e.g. wandering or persistent 'vocalisation'). It is important for staff to be able to understand these behaviours, tolerate them (where they are not offensive), accommodate them within the confines of the care environment, keep the patient or service user and others safe and sometimes mitigate effects. For example, someone who is persistently shouting may have to be isolated to reduce stimulation and keep the environment tolerable for others, as well as to avoid provoking others or 'setting them off'.

15. Observation

Observation that goes beyond normal therapeutic engagement and assists in building relationships with patients or service users should be considered for the immediate and long term prevention and management of challenging behaviour. It must not be intrusive, should respect dignity and privacy and must be conducted safely. Organisations should have an action plan for checking availability of internal staff for observation (e.g. staff bank, temporary staff, central response team, movement of staff from other areas). An observation policy should clarify observation levels according to risk and what is expected of staff (a prior knowledge of the person's history is desirable) and how to initiate or discontinue higher level support.

16. Physical intervention and rapid tranquillisation

It is important for staff to be able to recognise situations where physical intervention and/or rapid tranquillisation (refer to Clinical Guidelines for Rapid Tranquilisation of Adults and / or Pharmacological Management of Disturbed Young People including Rapid Tranquilisation are required. Clinical staff need to be confident about when these short term intervention strategies are required, e.g. immediate control of a dangerous situation and when they are not required, i.e. where de- escalation, non-pharmacological means, or use of more routine medication (e.g. pain relief) should be attempted first.

During care planning, 'advance directives' (decisions) may be considered by asking a person to indicate what forms of treatment they would or would not prefer, should they lack capacity to refuse or consent in the future. This includes any treatment preferences that they may have in the event that they become challenging. Where a person has memory/understanding issues a formal capacity assessment is necessary and a plan made in their best interest following the process set out in the MCA Code of Practice taking into account views of relatives and those close to the patient.

Appendix G: Sanctions Management

1. A staged approach will be generally undertaken to manage any sanctions in respect of **intentional** violence and aggression. In such cases a 'Verbal Warning' would precede any 'Written Warning' and this would precede any 'Acceptable Behavioural Contract' or 'Exclusion'. There is no requirement to escalate the response in any particular order should the situation warrant immediate action.

2. Verbal Warning

Where a patient, relative or visitor is violent or abusive, the member of staff or senior member of staff should explain to the patient what is and is not acceptable behaviour and he/she should outline what the possible consequences of any further repetition of unacceptable behaviour could be. An experienced member of staff and / or security should always witness this explanation. Identification of any triggers for the behaviour may be useful in future prevention.

The main aim of the Verbal Warning process is twofold:

- To ascertain the reason of the behaviour displayed as a means of preventing further incidents or reducing the risk of them reoccurring; and
- To ensure that the patient, relative or visitor is aware of the consequences of further unacceptable behaviour.
- In the case of a patient, it may be appropriate to issue a Code of Conduct leaflet which contains information useful to prevent further escalation in
- their behaviour.
- The incident and local actions taken must be reported and investigated in accordance with the Trust incident reporting procedures. The fact that a Verbal Warning has been given should be recorded in the patient's notes.

NB: A Verbal Warning should be delivered no more than twice.

2.1 Written Warning

If having issued one or more verbal warnings, further incidents are reported, the local manager should consider if appropriate to issue a warning letter. Template letter is at **Appendix 8.1**

Any warning letters must be attached to the relevant electronic incident report.

The presence of a mental disorder should not preclude appropriate action from being taken, and it is important to note that the incident must still be recorded in accordance with directions.

2.2 Application

Applications detailing the reason for a 'Warning Letter' should be made directly to the Trust Local Security Management Specialist. The evidence will be reviewed by the Local Security Management Specialist.

2.3 Authorising & Serving

Where it is felt that there is sufficient evidence the case will be referred to the Divisional

Director for the Operations Support Division for authorisation. The serving of the 'Warning Letter' will be recorded delivery or by the Local Security Management Specialist.
The 'Warning Letter' will be attached to the appropriate incident report and the Security Management Specialist will monitor and review all 'Warning Letters' issued.

2.4 Acceptable Behavioural Contract

An Acceptable Behavioural Contract is an option that can be considered for patients, relatives or visitors, to address unacceptable behaviour where verbal warnings or a warning letter have failed, or as an immediate intervention depending on the circumstances.

An Acceptable Behavioural Contract is a written agreement between the parties aimed at addressing and preventing the recurrence of unacceptable behaviour and can be used as an early intervention process to stop unacceptable behaviour from escalating into serious behaviour both on Trust premises and in the community environment.

Where for example it is decided that an Exclusion is not justified but unacceptable or inappropriate behaviour has been identified of a patient or visitor the Trust retains the right to request that the person(s) agree to conduct themselves in a manner which is none threatening or abusive and which is not detrimental to the treatment of themselves or any other patient or safety of any Trust employee or NHS property.

The person(s) will be required to sign an Acceptable Behavioural Contract which will detail the manner of acceptable behaviour required for the continued treatment of themselves or another - see **Appendix 8.2**

2.5 Application

Applications detailing the reason for an Acceptable Behavioural Contract should be made directly to the Trust Local Security Management Specialist. The evidence will be reviewed by the Local Security Management Specialist.

2.6 Authorisation & Serving

Where it is felt that there is sufficient evidence the case will be referred to the Divisional Director for the Operations Support Division for authorisation. The serving of the Acceptable Behavioural Contract will be by recorded delivery or carried out by the Police or Police Community Support Officer in conjunction with the Local Security Management Specialist.

The Security Management Group will monitor all Acceptable Behavioural Contracts in force and the circumstances quarterly. Acceptable Behavioural Contracts will be reviewed every 12 months. Where an Acceptable Behavioural Contract has been signed by a patient a copy will be held on the patient's notes. A record of the Acceptable Behavioural Contract will be retained by the Local Security Management Specialist for a period of three years.

Where a person has an Acceptable Behavioural Contract in force but fails to comply with the conditions the person should be reported to the Local Security Management Specialist for consideration of Exclusion in line with this policy.

3. Exclusion

3.1 The Trust reserves the right to exclude any person or persons, who, in the considered opinion

of the Trust, threatens the safety and or security of the Trust's employees, patients, visitors or property by:

- Having been Convicted or Cautioned for a Criminal Offence, which has been committed on Trust premises or grounds, or
- In the case of a juvenile, is the subject of a Formal Warning or Final Reprimand

3.2 Where the above criteria is not met but a person or persons:

- Causes Trust employees, patients or visitors to fear for their safety, or
- Prevents Trust employees or their agents delivering healthcare, or
- In the professional opinion of the Trust Security Management Specialist or Acute Security Manager and / or in the opinion of a Trust Senior Manager is a threat to the safety and/or security of the Trust's employees, patients, visitors or property, an emergency exclusion order may be issued by the Trust Security Management Specialist or Acute Security Manager and/or a Trust Senior Manager.

3.3 It is not the intention of the Trust to prevent any excluded person from attending the site where they are:

- In need of emergency treatment or care, or
- Fulfilling a pre-arranged hospital appointment.

3.4 It is recognised that there must be sufficient justification for exclusion.

- The Trust must be able to clearly show the process by which any decision was made and in what way the named person is a perceived threat.
- The Trust must be able to show details where any decision has been reviewed such as altering any period of exclusion, and by whom.
- The Trust should determine whether the exclusion covers the whole of the Trust or selected sites or areas.
- The Trust must be able to show that the named person has been advised of any relevant decisions and by whom.

3.5 However, where an excluded person requires or wishes to visit Trust property for one or more of the reasons below then that person must seek permission to do so by writing to the Divisional Director for the Operations Support Division:

- Visiting a relative who is an in-patient within the Trust.
- In order to take part in bona fide lawful business on Trust property.
- They must include full details of the reason for them visiting the site, the time and duration of any visits and include a contact home address and telephone number, and give the Trust not less than 48 hours' notice to respond (not including weekends or Bank Holidays). This will allow time for the Trust to advise the excluded person of any decision.

3.6 The Divisional Director for the Operations Support Division, in consultation with the Chair of the Security Management Group will decide whether permission will be given to enter Trust property.

3.7 Any decision to refuse access to the excluded person will be made on the following criteria:

- The circumstances do not fall within guidelines laid out in section 2.4.
- It is believed the excluded person still constitutes a significant risk to persons or property.

3.8 Where permission is granted the excluded person can be advised verbally (a written record will be made for the file) or by letter if appropriate. They will be instructed to collect from the relevant site main reception and keep in their possession to show if requested by any representative of the Trust, a letter from the Divisional Director for the Operations Support Division giving permission to enter the site within laid down parameters.

3.9 It is recognised that it may be impossible for an excluded person to give sufficient notice in extreme circumstances such as when a relative is suddenly taken seriously ill and the named person attends at that time. In such cases the named person will advise staff immediately upon their arrival at the site that they are excluded, but circumstances had prevented them from complying with the requirements to give a minimum 48 hours' notice as laid out in section 2.5.

3.10 In such circumstances staff dealing with the named person will ensure the Divisional Director for the Operations Support Division is advised that an excluded person is visiting the site and the circumstances of that visit.

3.11 If further visits are likely the Divisional Director for the Operations Support Division in consultation with the Chair of the Security Management Group and Police, will determine what action is required. The excluded person will be contacted and advised of any decision and previously laid down procedures will be followed.

4. EXCLUSION PERIOD

4.1 Exclusion periods can be made for any period of time but are likely to be for periods of one to five years. After each 12-month period a risk assessment will be made by the Divisional Director for the Operations Support Division in consultation with the Chair of the Security Management Group and Police, to determine whether exclusion is still relevant and a record of that process and decision will be made.

4.2 Any decision to subsequently alter the length of any period of exclusion will be ratified at the next Security Management Group meeting.

4.3 The excluded person will be notified in writing of the result of that annual risk assessment.

4.4 An emergency exclusion order will usually be issued for a period of 14 days, or until ratified or overturned by the Chair of the Security Management Group and Divisional Director for the Operations Support Division if sooner, but will not exceed 31 days.

5. PROCEDURE

5.1 The Trust may consider information from any person or agency, advising that a named person maybe someone whom they believe should be the subject of exclusion notice.

5.2 Detailed records must be obtained and kept by the Divisional Director for the Operations Support Division. The Trust must be in a position to confirm all its actions, when they were made and by whom. These records must include (where available and applicable):

- Circumstances of the incident under discussion to include details of the provider of the information.
- Full name, address, date of birth and physical description of the named person (photograph if available).
- Highlight any specific warnings e.g. violence to staff or carries weapons, etc.
- A summary of any deliberations by the Trust.
- Any corroborative information or documentation that can be obtained and its source.
- All details of any correspondence between the Trust and the named person or other persons connected.
- Details of any further incidents involving the named person and any action instigated by the Trust.
- Details of any legal procedures.
- Any other relevant information.
- Records to be kept for a minimum of three years after exclusion period ends.

5.3 Where an emergency exclusion order has been issued by the Trust Local Security Management Specialist and/or a Trust Senior Manager it must be ratified or overturned by the Chair of the Security Management Group and the Divisional Director for the Operations Support Division (or their deputies) at the earliest opportunity. A written record of the decision must be made and tabled at the next Security Management Group meeting.

5.4 Where a person is to be excluded then the Divisional Director for the Operations Support Division will ensure a written notice of the Exclusion is delivered by hand to their last known address. Details of when and by whom the letter was delivered are to be attached to the file. The Exclusion notice will include:

- Confirmation that the Trust has decided formally to exclude them from Trust property (listing all the Trust addresses or selected areas or properties as appropriate).
- The reason for the period of Exclusion.
- Duration of the Exclusion.
- Any exemptions to the Exclusion (listed in sections 2. and 2.5)
- The procedure for an appeal.
- The consequences of breaching the terms of the Exclusion notice.
- How to contact the Divisional Director for the Operations Support Division.
- The Trust reference number if applicable.

5.5 If any person breaches their Exclusion notice then an injunction may be sought from the Court.

6. APPEAL

6.1 A named person has the right of appeal against an Exclusion notice by writing to the designated contact within the Trust who will be:

Patient Experience Manager Patient Advice and Liaison Service,

[redacted]

Raising a concern on line form

6.2 The appellant has the right to be accompanied by a friend or colleague not acting in a legal capacity and will be advised of this at the appropriate time by the Divisional Director for the Operations Support Division

6.3 The appeal panel will consist of two Trust Board Directors (one Executive and one Non-Executive Director). The decision of the panel will be final and binding and the named person will be informed in writing of their decision by the Divisional Director for the Operations Support Division.

Appendix G: Warning Letter

Northern Devon Healthcare NHS Trust

< insert address>

Dear <insert name>

Warning letter – unacceptable behaviour

The Northern Devon Healthcare NHS Trust has evidence which suggests on the <insert date> you <insert name> used/threatened unlawful violence/acted in an anti-social manner to a member of NHS staff/whilst on NHS premises **(delete as applicable)**.

Behaviour such as this is unacceptable and will not be tolerated. This Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse.

Such behaviour also deprives the Trust of valuable staff time and resources and may result in other patients having their treatment delayed or postponed. Just as the NHS has a responsibility to you, so you have a responsibility to use its resources and treat NHS staff in an appropriate way

Should there be any repetition of this type of behaviour; consideration will be given to taking action against you.

Such action may include the following:

- Excluding you from premises
- Seeking an Acceptable Behaviour Agreement
- Reporting to the police where your behaviour constitutes a criminal offence and fully supporting any prosecution they may pursue.
- Consideration of a private criminal prosecution

If you do not agree with the details contained in this letter about your alleged behaviour or feel that this action is unwarranted, please contact in writing < insert details of local complaints procedure> who will review the decision in light of your account of the incident(s).

A copy of this letter will be retained for 12 months and where appropriate kept with your Medical Records.

Yours sincerely,

Local Security Management Specialist

Appendix G: Acceptable Behaviour Contract

Northern Devon Healthcare NHS Trust

Date

Acceptable Behaviour Contract between, Northern Devon Healthcare NHS Trust, Devon & Cornwall Police and *(Insert name here)*

I am writing to you as the Local Security Management Specialist (LSMS) for Northern Devon Healthcare NHS Trust. The LSMS has responsibility in all aspects of security operational matters relating to the deterrence, prevention, detection, investigation and management of security in Northern Devon Healthcare NHS Trust.

One of my roles is to protect NHS staff from abusive and violent behaviour and NHS resources from misuse and it is in connection with this that we are writing to you. I have received (number) reports in which it is alleged that on (date) whilst attending ****** , you [details of incident or offence] causing [details of impact] .

Behaviour such as this is unacceptable and will not be tolerated. Northern Devon Healthcare NHS Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse, property loss or damage. Such behaviour also deprives Northern Devon Healthcare NHS Trust of valuable resources, causes other patients unacceptable distress and directly affects their quality of care and treatment whilst a patient on Northern Devon Healthcare NHS premises.

It is my view that your actions in the above incident could be considered as constituting criminal offences, in particular -
[Details of offence]

The NHS has a responsibility to provide a service, those using the service have a responsibility to use its resources and treat its staff in an appropriate way.

When attending NHS premises in the future you must comply with the following conditions:

- You will treat all people and property with respect that you come into contact with whilst on NHS Property.
- You will not use abusive, insulting or threatening words or behaviour to any member of Trust over the phone or in person.
- You will not use or threaten violence towards Northern Devon Healthcare NHS Trust staff, patients or visitors.
- You will pursue any complaint using the NHS procedure for doing so.

If you fail to act in accordance with these conditions and continue to demonstrate unacceptable behaviour, consideration will be given to taking action against you.
Such action will include the following:

- Reporting to the police where your behaviour constitutes a criminal offence and fully supporting any prosecution they may pursue.

- Seeking a court order to restrict your behaviour.

- Excluding you from the Trust for anything other than emergency medical care.

If any legal action is necessary any costs incurred will be sought from you and these may be considerable.

Enclosed are two copies of this letter for your attention. I would be grateful if you could sign the attached agreement at the declaration and return one of these in the envelope provided.

This agreement (should you sign it) will be reviewed in 12 months' time. If your behaviour causes no further concern and no further incidents have been reported to us it will be withdrawn.

If you do not agree with the conditions set out in this letter, or have any other representations to make in relation to this matter these should be submitted in writing to;

Local Security Management Specialist
North Devon District Hospital
EX31 4JB

Yours sincerely

Local Security Management Specialist

Northern Devon Healthcare NHS Trust

Appendix G: ACCEPTABLE BEHAVIOUR CONTRACT AGREEMENT

This agreement is between:

Northern Devon Healthcare NHS Trust & Devon and Cornwall Constabulary and (*Insert Name*)

Date of Birth:

I agree to the following in respect of my future behaviour -

- I will treat all people and property with respect that I come into contact with whilst on NHS Property.
- I will not use violence, or foul or abusive language or threatening behaviour towards any person while on NHS premises.
- I will not threaten violence or use foul or abusive language towards any NHS staff while on the telephone.
- I will follow the NHS procedure when making a complaint.

Declaration

I accept the conditions set out above and agree to abide by them accordingly.

Signed:

Dated:

Northern Devon Healthcare NHS Trust

Signed: Print name:

Position: Local Security Management Specialist Dated

For noting – NDHT acceptable behaviour contracts may be arranged at ward level and signed by divisional directors of nursing – recommend for NDHT post holder who could sign letter is extended to cover options such as senior nursing management, clinical site management, or matron

Appendix H: Equality Impact Assessment Tool

Name of document	Policy on the Management of Violence, Aggression & Challenging Behaviour
Division/Directorate and service area	Compliance Team
Name, job title and contact details of person completing the assessment	[redacted] Local Security Management Specialist, [redacted]
Date completed:	September 2021

The purpose of this tool is

- **Identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

To outline responsibilities and best practice in the management of violence and aggression.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☒ Staff ☒ Patients ☒ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)***Please insert an "x" in the appropriate box*** *(x)*

Protected characteristic	Relevant	Not relevant
Age	☒	☐
Disability	☒	☐
Sex - *including: Transgender, and Pregnancy/Maternity*	☐	☒
Race	☒	☐

Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

Please specify any groups you think may be affected in any significant way:

None identified

5. Do you think the document meets our human rights obligations? ☒Yes

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

***Fairness** – how have you made sure it treat everyone justly?*
Respect – how have you made sure it respects everyone as a person?
Equality – how does it give everyone an equal chance to get whatever it is offering?
Dignity – have you made sure it treats everyone with dignity?
Autonomy – Does it enable people to make decisions for themselves?

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

Please give a brief summary- identifying:

Race

Racial harassment is known to undermine confidence of ethnic minority staff. The policy directly recognises and addresses racially based violence and aggression from patients to staff. The issue is clearly recognised and managers are made responsible for challenging racist attitudes. The policy makes managers responsible for challenging harassment, clearly defines racial hate crime as being within its scope and recognises that race of the carer can be a trigger of violent or aggressive behaviour from patients.

Age

Elderly patients can be especially violent and aggressive, due to delirium or confusion. The policy directly recognises and addresses this issue and refers to published guidelines. Practical advice is made available on best practice in managing violence and aggression from confused, elderly patients. A detailed appendix is provided, outlining the causes of violence and aggression in some confused and delirious patients and how best to manage this

Disability

Disability (in the person requiring restraint) is directly mentioned as a factor which would lead to restraint being applied with extra caution.

7. If you have noted any 'missed opportunities', or perhaps noted that

there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

"Protected characteristic":	None
Issue:	

How is this going to be monitored/ addressed in the future:	N/A
Group that will be responsible for ensuring this carried out:	Health & Safety Group

Royal Devon and Exeter NHS Foundation Trust

Violence Prevention and Reduction Policy

Post holder responsible for Procedural Document	[redacted] Security Management Specialist
Author of Policy	[redacted] Security Management Specialist
Division/ Department responsible for Procedural Document	Estates and Facilities Management/Security Dept
Contact details	[redacted]
Date of original document	July 2004
Impact Assessment performed	**Yes**/ No
Ratifying body and date ratified	Health and Safety Group 3 September 2021
Review date	March 2026 (every 4½ years)
Expiry date	September 2026
Date document becomes live	26 October 2021

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience		Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute services	
CQC Fundamental Standards - Regulation: **13, 15, 18**		Infection Control	
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: Final	
Version	Date	Author	Reason
1.0	July 2004	Security Management Specialist (SMS)	New Policy
2.0	Dec 2007	SMS	Reviewed, minor amendments
3.0	Oct 2009	SMS	Reviewed, minor amendments
4.0	Jan 2011	SMS	Minor amendments
4.1	March 2013	SMS	Minor amendments, not published
5.0	March 2014	SMS	Minor amendments
6.0	Sep 2015	SMS	Inclusion of guidance on Restrictive Interventions and Physical Restraint
7.0	October 2017	SMS	• Removed references to NHS Protect which has been decommissioned • Section 6: Risk Assessment • Section 7: Reporting Crime & violence and aggression incidents. • Section 8: Support for staff • Section 9: Sanctions Management (linked to Security Policy) • Appendix 2: Definitions Physical & Non Physical Assault (including abusive telephone call procedure)
7.1	September 2018	Security Management Specialist	• Section1: Removal of Trust reference to 'Zero Tolerance' towards violence and aggression. • Section 9: Inclusion of 'Sanctions Management' • Appendix 8: Sanctions Management • Section 10: Training section updated
8.0	April 2021	Security Management Specialist	Removal of restrictive practices guidance Amendments to align with NDHT policy Amendments to align with NHS

			England Violence Prevention and Reduction Standards Name change of policy title

Associated Trust Policies/ Procedural documents:	Security Policy Harassment & Bullying at Work Policy Risk Assessment Standard Operating Procedure Lone Working Policy Equality & Diversity Policy Stress Management: Prevention, Recognition and Support Policy Supporting staff involved in an Adverse Event Procedure Incident Reporting, Analysing, Investigating and Learning Policy Slips, Trips & Falls Policy (Inpatients) Clinical Guidelines for the Diagnosis and Management of Delirium Clinical Guidelines for Rapid Tranquilisation of Adults Pharmacological Management of disturbed Young People including Rapid Tranquilisation
Key Words	Violence, Aggression, Challenging, Behaviour
In consultation with and date: Head of Facilities Management – 21 June 2021, Divisional Directors - 21 June 2021 Assistant Directors of Nursing, Senior Nurses - 21 June 2021 Governance Managers - 21 June 2021 Site Management - 21 June 2021 Equality and Diversity Manager – 21 June 2021 Security Management Group (Chair) – 28 July 2021 Quality Assurance – 6 August 2021 FM SGG – 24 August 2021 Health and Safety Group 3 September 2021	
Contact for Review:	Security Management Specialist
Executive Lead Signature: Chief Nursing Officer	[redacted]

CONTENTS

KEY POINTS OF THIS POLICY:

This policy is concerned with violence, aggressive and challenging behaviour, both physical and verbal, towards employees of the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) from patients, relatives, visitors or other members of the public. Working in an atmosphere of continuing threat is profoundly damaging to the confidence and morale of staff. There are also costs to the Trust in terms of reduced efficiency, sickness or absence.

The Trust recognises that as an employer, it has a duty of care towards its staff and that reasonable steps should be taken to ensure their health and safety at all times.

The Trust does not tolerate intentional violence and aggression towards its staff. This will be publicised in public notices displayed in Trust premises (**Appendix 1: Violence and Aggression Poster).**

This policy will provide guidance and advice for all employees of the Trust and persons providing services on the management of intentional violence and aggression and challenging behaviour due to medical factors.

It is important that staff feel safe in their working environment. Violent behaviour not only affects staff personally but it also has a negative impact on the standard of services and the delivery of patient care. In terms of tackling violence against staff, this policy provides information and guidance on a range of measures introduced to make the NHS a safer place to work.

1 INTRODUCTION

1.1 This policy is concerned with violence, aggressive and challenging behaviour, both physical and verbal, towards employees of the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) from patients, relatives, visitors or other members of the public. Working in an atmosphere of continuing threat is profoundly damaging to the confidence and morale of staff. There are also costs to the Trust in terms of reduced efficiency, sickness or absence.

1.2 The Trust recognises that as an employer, it has a duty of care towards its staff and that reasonable steps should be taken to ensure their health and safety at all times.

1.3 The Trust does not tolerate intentional violence and aggression towards its staff. This will be publicised in public notices displayed in Trust premises (**Appendix 1: Violence and Aggression Poster).**

1.4 The Trust recognises enforcing zero tolerance towards individuals for acts of violence and aggression is not achievable due to the occasions when there will be violent and abusive incidents when the person exhibiting challenging behaviour is unable to control their actions due to medical factors.

1.5 This policy will provide guidance to the Trust to pro-actively manage intentional violent and aggressive behaviour and challenging behaviour due to medical factors on the most effective interventions required to minimise risk to staff, patients and visitors.

1.6 The Trust reserves the right to implement a range of sanctions against persons using intentional violence and aggression including the right to exclude any person who in the considered opinion of the Trust threatens the safety and or security of the Trust employees, patients, visitors or property. For further information and guidance refer to **Section 9 Sanctions Management**.

1.7 The Trust also acknowledges the need for staff to be skilled in the de-escalation of aggressive and violent behaviour. Additionally identified staff should be trained in a range of restrictive practices refer to **Section 10: Training**.

2. PURPOSE

2.1 This policy will provide guidance and advice for all employees of the Trust and persons providing services on the management of intentional violence and aggression and challenging behaviour due to medical factors.

2.2 It is important that staff feel safe in their working environment. Violent behaviour not only affects staff personally but it also has a negative impact on the standard of services and the delivery of patient care. In terms of tackling violence against staff, this policy provides information and guidance on a range of measures introduced to make the NHS a safer place to work.

3. LEGISLATION

3.1 Underpinning Legislation

Employers (including NHS employers) have a general duty of care to protect staff from threats and violence at work. Five pieces of health and safety legislation cover violence at work:

- Health and Safety at Work Act 1974 (HASAWA)

- Management of Health and Safety at Work Regulations 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013(RIDDOR)
- Safety Representatives and Safety Committees Regulations 1977
- Health and Safety (Consultation with Employees) Regulations 1996.

3.2 Associated Legislation

- The Corporate Manslaughter and Corporate Homicide Act 2007
- Protection from Harassment Act 1997 – Legislation.gov.uk
- Assaults on Emergency Workers (Offences) Act 2018
- Equality Act 2010 - Legislation.gov.uk
- Offences against the person legislation
- Section 39 Criminal Justice Act 1988

3.3 Regulatory Framework

The provision of a safe working environment is embedded in the Care Quality Commission's Fundamental Standards (CQC, 2015) Regulation 13: Safeguarding service users from abuse and improper treatment and Regulation 15: Premises and equipment.

The NHS Standard Contract should have regard to the violence prevention and reduction standard, and are required to review their status against it and provide board assurance that they have been met it twice a year.

Commissioners are also expected to undertake compliance assessments as part of their regular contract reviews, twice a year as a minimum or quarterly if significant concerns are identified and raised.

4. DEFINITIONS

4.1 **Physical Assault** is defined as: "the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort."

(Secretary of State Directions, Department of Health 2003)

4.2 **Non Physical Assault** is defined as "the intentional use of inappropriate words or behaviour causing distress and/or constituting harassment."

(Secretary of State Directions, Department of Health 2003)

Examples of Physical and Non-Physical Assault including harassment, unacceptable behaviour both verbal and written together with guidance on abusive phone calls can be found at **Appendix 2 – Examples Physical and Non-Physical Assault including abusive telephone calls.**

4.3 **Clinically related challenging behaviour** is often a manifestation of a patient's distress and an attempt by the person to communicate their unmet needs. For further advice and guidance see **Appendix 3** – **Clinically Related Challenging Behaviour**.

4.4 **Perpetrator:** A person responsible for committing an offence and or crime i.e. physical assault

4.5 **Victim:** A person who is adversely affected by an action as a consequence of the

perpetrators actions

4.6 **Restrictive Practices -** Restrictive practices refer to the implementation of any practice or practices that restrict an individual's movement, liberty and/or freedom to act independently without coercion or consequence. For further advice and guidance see **Restrictive Practices Policy (currently under review).**

5. DUTIES AND RESPONSIBILITIES OF STAFF

5.1 **Role of the Chief Executive** has overall responsibility for ensuring a safe and secure environment. The Chief Executive has delegated this responsibility to the Chief People Officer.

5.2 Role of the **Executive Violence and Reduction Lead** and **Security Management Director (SMD)** is the Trust's designated Lead Executive responsible for the following:

- Security of hospital premises as far as is reasonably practicable with regard to the nature of our services and functions.
- To support and promote the Violence Prevention and Reduction Policy

The SMD has delegated the position of Chair of the Security Management Group to the Head of Facilities Management.

5.3 Role of the **Head of Facilities Management** delegated by the SMD is to Chair the Security Management Group where security issues are discussed and strategies monitored for effectiveness.

5.4 **Role of the Local Security Management Specialist** is the following:

- Promote a pro-security culture throughout the Trust
- Provide advice and guidance to managers in conducting physical security assessments and risk assessments relating to violence and aggression.
- Analysis of the Trust's Incident Reporting system to identify trends and take appropriate action to minimise any reoccurrence.
- Provide support to victims of violence and aggression whilst signposting staff and managers affected by incidents to the Trusts Supporting Staff Involved in an Incident, Complaint or Claim Policy.
- Provide advice and guidance to the Security Management Director as required including investigations, sanctions and redress against perpetrators.
- Ensure full co-operation with the Police and / or other agencies in investigations and subsequent actions i.e. sanctions and redress.
- Attend Security Management Group meetings to discuss violence and aggression and other security incidents trust wide.
- To ensure compliance with NHS Provider Contract Security Standards

5.5 **Role of Security Manager and Violence Reduction Lead**

5.5.1 Operational responsibility for the Security Operations Officers and delivery of security across the Heavitree and Wonford sites to minimise violence and aggression towards staff, patients and visitors.

5.5.2 To liaise with the Training Manager (Workforce Planning & Development) to ensure Conflict Resolution and relevant Physical Intervention training is delivered through a risk based approach Accountable for the design, maintenance, documentation and improvement of the organisational violence prevention and reduction systems and

processes.

5.6 **Role of Security Operations Officers**

- Provide 24–hour assistance to patients, visitors and staff whilst maintaining appropriate order and preventing public disorder on Heavitree and Wonford Sites.
- Support and assists in the protection of patients, staff, volunteers, contractors and visitors against acts of violence, aggression and abuse.
- Assist with violent, aggressive and challenging behaviour patients at ward level and carries out regular patrols of the Trust car parks and supports car parking
- staff when required.
- Instigate Police response to any suspicious incidents or offences

5.7 **Role of Senior & Line Managers**

5.7.1 Senior managers and line managers will:

- Ensure staff work in an environment that is as safe as possible which includes community visits to a patient's home.
- Complete Violence and Aggression risk assessments and reduce the risks identified.
- Ensure support is offered to staff following violent or distressing incidents in accordance with the Supporting Staff Involved in an Incident, Complaint or Claim Policy.
- Ensure that safety measures are reviewed following an incident.
- Ensure staff are appropriately trained in local procedures and incident reporting requirements.
- Ensure all front line staff attend conflict resolution training.
- Ensure all staff attend Customer Care training where appropriate.
- Ensure all staff are risk assessed where appropriate for the requirement and attendance at Dementia, Breakaway and Physical Intervention Training.

5.7.2 Where a risk of violence and aggression is identified appropriate control measures to be implemented and escalated accordingly.

5.7.3 A medical and/or psychiatric opinion should be professionally obtained at the earliest possible stage where appropriate.

5.7.4 As part of the risk assessment process, identify the training needs of their staff in regard to violence and aggression and control and restraint.

5.7.5 Challenge harassment including racial harassment and offer all appropriate protection and support to the victim. In cases where staff members are victims, this may include referral to the counselling service.

5.7.6 Where incidents of violent, aggressive or challenging behaviour occur, the line manager must conduct a full debriefing of all staff involved. Actions to be completed can be found at **Appendix 4: Violence and Aggression Action Card**.

5.7.7 The Line Manager of the staff involved in the incident should ensure it is reported on the Trust incident reporting system, to enable central monitoring of incidents and responses. This may also support equality monitoring.

5.8 **All Staff**

5.8.1 Employees should ensure the health, safety and welfare of themselves and other persons by being vigilant in respect of themselves and others.

5.8.2 Employees should ensure that they act in accordance with the training they have received (See Section 10 for relevant training).

5.8.3 Staff are required to report incidents of violent, aggression or challenging behaviour using the Trust incident reporting system on the Trust intranet, in line with the Trust Reporting, Investigating and Learning Policy & Procedure.

5.9 The **Security Management Group** meetings are held quarterly and the responsibility of the group include:

- Strategic planning and operational security issues.
- Reviewing current practice and making recommendations for improvement, in particular the need for crime reduction and the maintenance of a safe environment. Ensuring that both costs and risks are included in any security review process and forwarding information and results, as appropriate, to the Health and Safety Group.
- Ensuring systems are in place to monitor violence and aggression incidents.
- Producing a quarterly report to the Health and Safety Group to review progress.
- To liaise with the Learning and Development Service over the development of staff training programmes required to support safe practice and risk reduction.
- To maintain working partnership with the Police and the organisation.

6. VIOLENCE AND AGGRESSION RISK MANAGEMENT

6.1 Risk Management Process

The general risk of violence and aggression must be included in annual Health and Safety Audit Risk Assessments undertaken.

6.1.1 Prevention of violence at work must start with a full assessment of the risks. The risk assessment should be carried out by appropriately trained staff gathering information from a number of sources at both organisational and employee level, help and assistance can be obtained from the Local Security Management Specialist.

6.1.2 The risk assessment process should be:

- For the identification of violence and aggression hazards;
- For evaluating violence and aggression risks;
- To agree action plans; and
- To implement monitor and review measures to reduce risk.

6.1.3 The risk assessor must ensure they have completed a suitable and sufficient risk assessment for all the activities being undertaken and must produce control measures that reduce the risk to the lowest level that is reasonably practicable. The Trust's approved General Risk Assessment Form must be used. Additional advice and guidance can be found at **Appendix 5 – Managing Risk and Assessing Behaviours**.

6.2 Risk Assessments for Locations and Teams

6.2.1 Where a risk of violence and aggression has been identified a risk assessment should be undertaken using the General Risk Assessment Form in each ward, unit, department or team. The assessment should identify areas where a more detailed risk assessment is

required and should include an examination of the physical layout and security measures of the area assessed.

6.2.2 It is recognised that there are some specific circumstances and situations where the risk in the Trust may be higher. These include:

- Where the employee is a lone worker.
- Where staff are dealing with relatives and carers who may be anxious, angry.
- Where patients that have medical conditions that may well give rise to challenging behaviour.
- Where staff are making home visits.
- When patients are being seen alone or with single chaperone.
- When the number and locality of staff that may be able to respond to situation does not provide adequate support.
- Where environmental factors which may give rise to violence and aggressive behaviour such as levels of lighting, noise, distractions, number of people present, location of furniture, clear lines of sight, potential weapons, colour schemes.

6.2.3 The risk assessment and supporting action plan will be recorded on the divisional risk register and performance monitored via the Trust risk management process.

6.3 Risk Assessments of Individual Service Users

6.3.1 Individual service users may be subject to a risk assessment for Violence and Aggression. This assessment, where appropriate, will support existing patient care plans for a patient presenting with challenging behaviour. Where it is identified that an individual service user may present a risk to staff or others, the appropriate health care professional must ensure that:

- Completion of a Challenging Behaviour Management Plan risk assessment and communication tool (**see Appendix 5 Section 3 Managing Risk and Aggressive Behaviour**) with relevant action / care plans is completed with support from their respective teams and specialist advisers, where appropriate.
- The assessment and actions are documented in the patient's healthcare record and if appropriate on Trust information systems in accordance with Trust policy.
- All appropriate staff and services are informed of any actions that need to be taken.
- A process is put in place to ensure that where there are shift changes; information is passed on via the handover process.
- Where care is delivered by staff outside of their immediate team, e.g. out of hours weekends, the information is shared in a timely and effective manner.
- A review of the risk assessment and control measures is undertaken if a further incident occurs or at the set review date.

6.4 Risk Assessments for Community, Home Visits and Lone Workers

6.4.1 Staff undertaking community and home visits may be particularly vulnerable. Local teams and managers are expected to ensure that systems are in place that meet their staff requirements and comply with Trust policy.

6.4.2 Where the risk of violence to staff is assessed as significant, or liable to arise because of the work activity, and where that risk cannot be avoided e.g. by providing the service in

another suitable location such as a Medical Centre, appropriate risk control measures must be taken to reduce the risk of violence & aggression to the absolute minimum so far as reasonably practicable.

6.4.3 The Trust has a Lone Working Policy which details how lone workers can protect themselves to minimise the risk and make their working environment safer. This policy is accessible on the Trust's intranet. Managers who have identified Lone Workers within their departments / wards must complete a Lone Worker Risk Assessment. This is particularly important for high risk staff undertaking community or home visits.

6.4.4 The risk assessment and supporting action plan will be recorded on the corporate risk register and performance monitored via the Trust's risk management process.

6.4.5 If the risk is related to an individual service user, the process described in 6.3 must be implemented.

6.5 Risk Assessments for Work Environment and Building Design

6.5.1 The Local Security Management Specialist will work in collaboration with Departmental Managers, as well as design and estate facilities teams, to ensure work environments are as safe and secure as possible to reduce the risk of violence and aggression.

7. REPORTING OF CRIME AND VIOLENCE & AGGRESSION INCIDENTS

7.1 Contacting Security Team (Acute)

For security assistance on the acute site – Telephone [redacted] (routine) or dial [redacted] (urgent). The Security Team is available 24hrs a day 7 days a week.

For security advice and information follow the link to the Security site on the Trust intranet.

7.2 Contacting the Police

- Dial [redacted] followed by 999 if immediate action is required – life is threatened, persons are injured or threatened and need help, and offenders at or nearby the scene.
- Dial [redacted] followed by 101 to report a crime or incident where an immediate response is not required
- Non-urgent crime can also be reported through the on-line service https://services.devon-cornwall.police.uk/crimereporting/
- Or by emailing 101@devonandcornwall.pnn.police.uk

7.3 Incident reporting

All Violence and Aggression incidents should be reported in accordance with the Trust's Incident Reporting, Analysing, Investigating and Learning Policy and Procedure. The immediate supervisor and / or line manager must also be informed at the first available opportunity. The Local Security Management Specialist will monitor all violence and aggression reported incidents.

7.1.1 The Security Management team will investigate all reported incidents of intentional Violence and Aggression and monitor incidents involving challenging behaviour due to medical factors.

8. SUPPORT FOR STAFF

8.1 The Trust acknowledges that its staff may be affected physically and emotionally following a violent or other security incident. For further advice and guidance please refer to the

Supporting Staff Involved in an Adverse Event Procedure and the Stress Management: Prevention, Recognition and Support Policy.

9. SANCTIONS MANAGEMENT

9.1 Available Sanctions

A wide range of sanctions can be taken for **intentional** physical and non-physical assaults dependent on the severity of the incident. These measures may include:

- Verbal Warning
- Warning Letter
- Acceptable Behavioural Contract
- Exclusion from premises
- Secure Controlled Access
- Civil Proceedings and / or Crime Prevention Orders
- Criminal Prosecution

9.1 Full guidance on application and authorisation of sanction management refer to **Appendix 6: Sanctions Management.**

10. TRAINING

10.1 Conflict Resolution Training

The Trust requires that all front line staff (those dealing directly with the public) receive the Conflict Resolution Training via E-Learning during their first year in the Trust. This training is intended to help prevent situations escalating and to diffuse potentially abusive and violent incidents. This training includes the causes of violence, the recognition of warning signs and de-escalation techniques.

10.2 Higher Risk Groups

Staff in higher risk groups may require a more in-depth level of training in defusing situations where aggression is being displayed or in responding to physical violence. This training may include but not exclusively the following:

- Dementia Awareness Workshops
- Breakaway training
- Breakaway and Safe Handling combined training

10.2.1 The Break-away and Safe Handling combined training is a one day course, led by two specialist trainers. It is highly participative, using discussion of real life incidents and giving the chance to practice the skills necessary to defuse and manage incidents of aggressive communication, challenging behaviour, and physical violence.

NOTE: Physical Intervention training is under review and currently only the combined Breakaway and Safe Handling training is available to identified high risk staff within the acute environment.

10.2.2 Training requirements will be determined by risk assessment conducted by the service manager and staff. The Operational Security Manager / Physical Intervention Trainer and / or the Local Security Management Specialist will support the risk assessment and identification of available training.

10.2.3 If an employee has any health issues e.g. physical limitations or conditions like epilepsy that

may impact on their ability to undertake restrictive activities, the manager is to seek advice from Occupational Health to determine their fitness for these activities. There is a question in the annual Health Risk/ Hazards and Health Surveillance at Work Questionnaire where staffs who undertake restrictive practices can inform managers if they have any concerns about their ability to undertake restrictive practices.

10.2.4 Staff will have the training they require added to their individual skills matrix on Electronic Staff Record (ESR).

10.2.5 Both Conflict Resolution Training and Breakaway and Safe Handling Training are renewable every 3 years.

10.2.6 All training will be recorded on the Electronic Staff Record (ESR).

11. ARCHIVING ARRANGEMENTS

The original of this policy, will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

12. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

12.1 In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

What areas need to be monitored?	How will this be evidenced?	Where will this be reported and by whom?
All Services / Departments in which incidents of Violence and Aggression occur.	Review incidents reported through the Trust incident reporting system.	LSMS Quarterly Report to Security Management Group.
Violence and aggression statistics for all Divisions recorded inclusive of Non-Physical and Physical Assaults	Report through the Trust Incident Reporting System	LSMS Quarterly to H&S Committee
Compliance with violence prevention and reduction standard which supports a safe and secure working environment	Compliance with NHS Provider annual contract.	LSMS annually to H&S Committee
Suitable and sufficient training is provided by the Trust	Training reports	Violence and Prevention & Reduction Lead report to the Security Management Group.

13. REFERENCES

National Institute for Health and Care Excellence (NICE) (2015): *Violence and aggression: short-term management in mental health, health and community settings (NICE Guidance NG10)*. [online]. Available at: https://www.nice.org.uk/guidance/ng10

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Human Rights Act 1988 [online]. Available at: http://www.legislation.gov.uk/ukpga/1998/42/contents

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Criminal Justice and Immigration Act 2008http://www.legislation.gov.uk/ukpga/2008/4/contents

APPENDIX 1: VIOLENCE AND AGGRESSION WILL NOT BE TOLERATED - POSTER

Royal Devon and Exeter NHS
NHS Foundation Trust

We want the RD&E to be safe and secure for all our patients, visitors and staff.

Intentional violence, aggression and threatening or abusive behaviour will **not** be tolerated**.**

We may decide to withhold treatment or services from patients or visitors who are violent or abusive towards our staff.

Patients or visitors who are violent or abusive may be removed from our premises or grounds and could face Prosecution.

POLICING IN PARTNERSHIP

APPENDIX 2: EXAMPLES OF PHYSICAL AND NON-PHYSICAL ASSAULT INCLUDING ABUSIVE TELEPHONE CALLS

Examples of physical and non-physical assault including abusive telephone calls:

1. Physical assault; Examples could include:

- Intentional physical contact on a person that has resulted in bodily harm and injury such as a bite, scratch, bruise, reddening of the skin etc.
- An intentional, unlawful threat to cause bodily harm or injury.
- A circumstance which creates in the other person a well-founded fear of imminent peril or danger.
- Battery – the wilful or intentional touching of a person against that person's will by another person.
- Offensive touching.
- Sexual Assault – sexual contact against a person's consent or will.
- Unwanted physical contact by another.
- Spitting

2. Non-physical assault; Examples could include:

- Offensive language, verbal abuse and swearing which prevents staff from doing their job or makes them feel unsafe.
- Loud and intrusive conversation.
- Unwanted or abusive remarks.
- Negative, malicious or stereotyping comments.
- Invasion of personal space.
- Brandishing of objects or weapons.
- Offensive gestures.
- Threats or risk of serious injury to a member of staff, fellow patients or visitors.
- Bullying, victimisation or intimidation.
- Stalking.
- Alcohol and drug fuelled abuse.
- Unreasonable behaviour and non-cooperation such as repeated disregard of hospital visiting hours.
- Any of the above which is linked to destruction of or damage to property.

In short, unacceptable / inappropriate behaviour can be defined as any incident where a staff member feels harassed, abused, threatened, bullied (not by a colleague), insulted or assaulted in circumstances relating to their work or whilst they are at work.

Note: staff-on-staff bullying does not fall under the remit of security management. Any such issues will be managed by line managers and /or Human Resources.

3. Abusive Telephone Calls

If you experience the type of behaviour previously described in the form of a phone call, you should:

Inform the caller that you do not wish to be spoken to in the manner being used If the

caller persists:

Reiterate that you do not wish to be spoken to in the manner being used and that you will

terminate the call should they persist

If the caller persists:

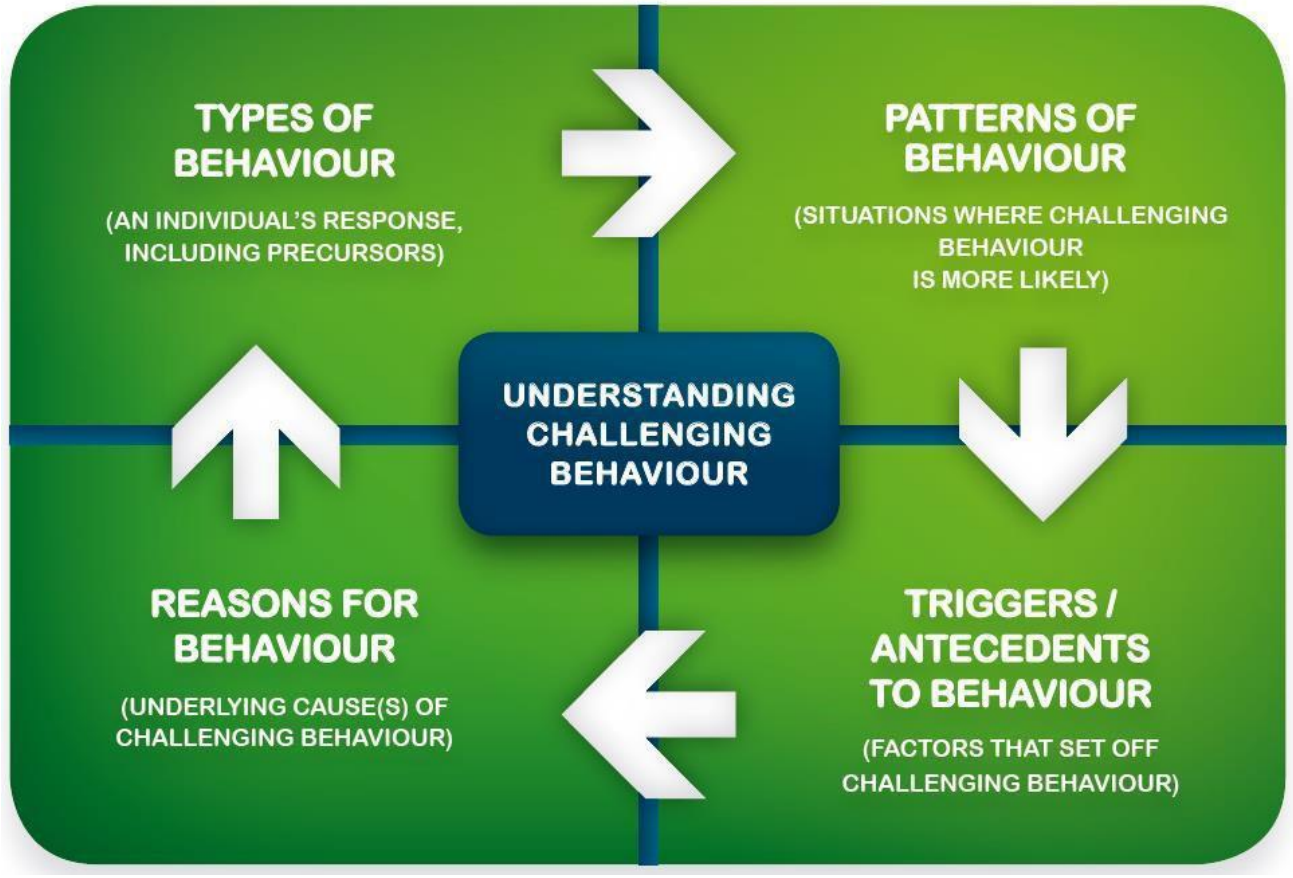
Inform the caller that you will not be spoken to in that manner and that you are terminating the call

- Then put the phone down and report the incident to a Senior Manager and via the Trust's Incident Reporting system

Should the caller continue to ring and display this inappropriate behaviour you must refer on to a senior member of staff with all the relevant details. If the caller is still persistent and displays this inappropriate behaviour this becomes a point of law under "The Protection from Harassment Act 1997" and must be reported to the Local Security Management Specialist and / or Police as appropriate.

It is important to note that examples of physical and non-physical assault can be either displayed in person or by telephone, letter or e-mail, or any other form of communication such as graffiti on Trust property and buildings.

APPENDIX 3: CLINICALLY RELATED CHALLENGING BEHAVIOUR



1. COMMON CHARACTERISTICS

1.1 Individuals who manifest challenging behaviour often have some degree of cognitive impairment, either chronic (e.g. dementia or a learning disability) or acute (e.g. delirium, head or brain injury, drug or alcohol intoxication). It may also be seen in other mental health conditions such as psychosis or personality disorder.

1.2 Care is needed that the behaviour is not as a result of an underlying illness or injury which needs urgent attention.

2 TYPES OF BEHAVIOUR

2.1 Challenging behaviour may describe many kinds of deliberate or non-deliberate non-verbal, verbal or physical behaviour. Some of these behaviours (e.g. staring, crying and shouting) may represent legitimate expressions of distress.

2.2 It can include behaviours which may be less risky, such as apathy, lethargy, fatigue, hyperactivity, hypo activity, being non-compliant or withdrawn, if staff need to intervene because the behaviour poses a safety risk to staff, patients and service users or others, e.g. an individual trying to get out of bed when they cannot stand and may fall.

2.3 There is no continuum of behaviour and where someone is sufficiently distressed or alarmed; their behaviour may instantly result in a physical action.

3. PATTERNS OF CHALLENGING BEHAVIOUR

3.1 Identifying patterns to predict when challenging behaviour is more likely to occur can assist when planning, preventing and preparing for it. Challenging behaviour tends to occur in response to:

- Unmet care needs (e.g. toilet, pain, thirst, hunger)
- Care tasks, including intimate procedures
- Administering medication (especially where the patient has to wait for pain relief)
- Pre-operative period (waiting, nil-by-mouth, clinical interventions and procedures)
- Post-operative period
- Gender issues (preferences for male or female carer)
- Pressure on staff time (i.e. staff not being on the 'shop floor')
- Lack of engagement by staff
- Times when staff are otherwise engaged (mealtimes, medication, handovers etc.)
- Areas where there are less experienced staff (e.g. less aware of psychological issues)
- 'Sundowning' (i.e. behaviours are more prevalent during afternoon and evenings, due to factors such as tiredness and changes in levels of light, or sensory deprivation)
- Night time disturbance
- Over-stimulating or under-stimulating environments
- Heightened activity (e.g. mealtimes)
- Lack of meaningful activity
- Relatives leaving
- Cultural, religious or spiritual needs
- Individuals feeling that staff are not hearing or listening to what they are saying
- Staff hostility
- Inconsistent rule setting
- Provocation by other individuals, distress in other individuals.

4. TYPES OF BEHAVIOUR

Non-verbal	Verbal	Physical
• Agitation • Wandering, pacing, following • Intimidating facial expressions, staring • Intimidating body posture • Cornering, invading personal space • Interference with equipment or property • Being withdrawn, extreme passivity, refusal to move	• Shouting • Swearing • Crying • Screaming • Repetitive statements or questions • Personal comments or questions • Racist, sexist, offensive speech • Bizarre, psychotic content, not based on known reality	• Scratching • Grabbing, hair pulling • Biting • Hitting, slapping, punching • Pinching • Spitting • Kicking • Pushing, shoving, knocking into someone • Striking or throwing objects • Inappropriate touching (self or others) • Urinating, smearing • Undressing • Self-harm • Absconding • Removal of lines, masks, catheters, dressings, incontinence pads • Non-compliance, resistive behaviour (e.g. refusing medication, blood tests)

5 TRIGGERS AND ANTECEDENTS

5.1 Triggers and antecedents are factors which occur prior to an individual's challenging behaviour. These factors may include the care environment or setting, individuals or interventions, activities or objects, thoughts or feelings, pain or discomfort.

5.2 For example a person may become overwhelmed, when a high number of healthcare professionals undertake a care intervention in close proximity to them.

5.3 Observing, identifying and documenting triggers and antecedents is the first part of a proactive strategy for minimising an individual's stress or distress. This is because, once identified, many of these situations can be avoided or changed.

6 PRECURSORS

6.1 Challenging behaviours can occur without warning and staff need to be aware of, recognise and identify precursors. Precursors are behaviours and are different to triggers, which are factors that can lead to challenging behaviour.

6.2 Precursors can often be very subtle and leave staff feeling 'uncomfortable', or they may signpost the onset of challenging behaviour.

6.3 Common recognisable cues include:

- Tense and angry facial expressions
- Increased and prolonged restlessness, pacing, body tension
- Increased breathing, muscle twitching and dilated pupils
- Increased volume of speech and swearing
- Refusal to communicate, withdrawal, irritability
- Prolonged eye contact
- Confusion of thought processes, poor Concentration
- Delusions or hallucinations
- Verbal threats or gestures
- Verbalising an intention that suggests distress, e.g. 'I want to go…'
- Replicating behaviour which preceded earlier disturbed or challenging episodes
- Reporting anger or violent feelings
- Generally, anything that seems out of character, e.g. excessive crying or laughing hysterically.

7. REASONS FOR CHALLENGING BEHAVIOUR

7.1 There is always a cause of clinically related challenging behaviour, even if it is not evident at the time. An overall approach that looks to prevent distress by identifying, categorising and understanding its reasons should reduce the likelihood of these potentially 'unforeseen' events occurring. The main categories are:

- Physical factors
- Cognitive factors
- Psychological and emotional factors
- Environmental or social factors

8. REASONS FOR CHALLENGING BEHAVIOUR – SUMMARY

This table is not exhaustive and is only examples of what may cause challenging behaviour.

Physical	Cognitive	Psychological/ emotional	Environmental/social
• Hypoxia • Hyperglycaemia • Hypoglycaemia • Electrolyte abnormality • Dehydration • Constipation • Infection • Pain • Visual or hearing impairment • Sleep deprivation • Medication (effects) • Illicit drugs or alcohol • Drug or alcohol withdrawal • Pre or postoperative • Hunger, thirst • Incontinence, urgent toilet needs • Earache • Epilepsy	• Communication problems (expression and understanding) • Memory loss • Difficulty with language or dialect • Reduced spatial awareness • Learning disabilities • Disorientation • Poor executive function (reasoning, planning, foresight) • Loss of insight • Autism	• Fear • Anxiety • Anger • Depression • Social isolation • Mania • Fixed beliefs or current thinking • Separation anxiety • Loss of self-worth	• Noise • Lights • Temperature • Overcrowding, or busy environment • Inappropriate signage • Lack of information • Long waiting times • Cultural factors • Lack of continuity of staffing, or care • Loss of routine • Unfamiliar surroundings • Pace of surroundings • Lack of meaningful activity • Over-stimulation • Under-stimulation • Imposed boundaries or routine • Stopping a habit/behaviour (e.g. smoking)

9. Physical factors

9.1 The physical causes which may lead to challenging behaviour include features of an individual's condition that pre-dispose him or her to distress (such as sensory impairments e.g. a loss of sight, hearing) unpleasant symptoms, pain and discomfort. They can all cause irritability and agitation or trigger distress.

9.2 Patho-physiological changes that cause delirium can be a significant factor and it is worth mentioning them specifically. Delirium is a short term confused state, or worsening of pre-existing confusion, due to a physical cause. It comes on suddenly (days to hours), fluctuates with time and is characterised by cognitive impairment and inattentiveness (distractibility) or drowsiness. Delusions, hallucinations and emotional changes (fear, anger) are common and symptoms are often worse at night. Delirium usually resolves with treatment of the underlying cause, but it may persist and rarely does not always recover. Suspicion of delirium requires assessment by a suitably skilled doctor – Refer to Clinical Guidelines for the Diagnosis and Management of Delirium.

9.3 Poor sleep is common in illness and in hospital, and leaves people fatigued and irritable. Hunger, thirst and urinary symptoms are associated with strong urges in an individual and may manifest as challenging behaviours if they cannot be communicated.

10. Cognitive factors

10.1 Cognitive factors include the inability to remember new information, explanations or instructions, the loss of inhibitions, poor judgment and planning and importantly communication problems.

10.2 They often result in an inability to articulate needs or a difficulty in understanding and interpreting the communication of those around them (both verbal and non-verbal) and can all lead to distress or difficult behaviours.

10.3 Staff needs to translate the reasons for challenging behaviour into unmet needs before identifying strategies to meet these needs.

10.4 Staff and carers can sometimes lack an understanding of communication impairment and overestimate a person's ability to understand information and make choices.

11. Psychological or emotional factors

11.1 Individuals suffering from delusions, especially paranoid, can feel they are being threatened and this can lead to defensive and challenging responses on their part. People with personality disorders may have difficulty foreseeing the consequences on others of their actions and may become acutely distressed. Fear is powerful in provoking difficult or aggressive behaviours. Anger can arise at a time of threat, as part of bereavement, or if needs are not being met.

12. Environmental or social factors

12.1 Factors relating to an individual's surroundings (e.g. excessive noise) can be provocative particularly if they are prolonged or persistent and may also interfere with the individual's rest and sleep. People with cognitive impairment often find care surroundings overwhelming and over-stimulating and may not keep up with the speed or volume of information or activity they are exposed to.

12.2 A lack of stimulation and activity, engaging in meaningless activity or over-activity can lead to frustration in individuals. This may be exacerbated by a lack of communication and dialogue between staff and patients or service users, poor care planning and a lack of coordination of activities between multi-disciplinary teams (MDTs).

12.2 Finally, a lack of understanding of an individual's culture and related behaviour can lead to frustration and agitation on their part. This can lead to a lack of trust, misinterpretation of their behaviour and miscommunication. Cultural sensitivity is important in dealing with this kind of challenging behaviour.

APPENDIX 4: VIOLENCE AND AGGRESSION ACTION CARD

VIOLENCE/AGGRESSION ACTION CARD

A PATIENT WHO EXHIBITS AGGRESSIVE OR VIOLENT BEHAVIOUR (PHYSICALLY OR VERBALLY)

FOR USE BY: Senior Staff **LIASE WITH: Site Management/Matron/Senior staff**

ENSURE 'ALL' RELEVANT ACTIONS ARE DOCUME NTED!

CORE RESPONSIBILITIES:

- Are staff OK? Is the patient ok?
- Does the member of staff /patient require medical?
- Does security/police need to be contacted? [redacted]
- Does the member of staff need a break period from the bay/cohort bay?
- Consider if the staff involved can continue working and if so, do they need to work elsewhere?
- If restraint or rapid tranquilisation used, record details in patient notes and increase observations refer to Trust Policy on Rapid Tranquilisation.
- Debrief with the rest of the team
- Refer to Trust Policy on Violence and Aggression
- Complete Incident Report on Datix
- Inform Matron of incident

ASSESS AND CONSIDER POTENTIALLY REVERSIBLE CONDITION, PAIN, INFECTION, ETC.

- Identify any clinical explanation for aggressive behaviour (i.e. head injuries, infection, medication, delirium or dementia etc.)
- Medication review by the medical team
- Review/Create Challenging Behaviour Management Plan (accessed from Forms on Security page on Hub) and patient risk assessment to identify a plan of appropriate measures of control
- If patient remains unsettled, consider calling the security team on [redacted] to also alert to possible reoccurrences and possible requirement for Police attendance

M AT RO N'S RE S PO NSIB I L IT IES:

- Follow up with staff involved as soon as possible after the incident
- Consider referral to Occupational Health or Counselling Service
- Hold team debrief
- Refer to Trust Policy on Violence and Aggression
- Make other staff aware through safety brief
- Consider enhanced observations

WHEN AN INCIDENT OF VIOLENT OR ANTI-SOCIAL BEHAVIOUR OCCURS OUTSIDE TRUST BUILDINGS, THE PERSON AT THE SCENE MUST CONSIDER/ADOPT THE FOLLOWING ACTION:

- Request Security team via [redacted], if the nature of the assault more serious, request the police via [redacted]
- Always ensure others within the immediate area such as patients, staff, relatives are protected and where/when possible moved to a safe environment
- Provide a detailed brief to the site manager as soon as possible, also to the security team upon their arrival
- Support the security team if needed/requested until conclusion met

APPENDIX 5: MANAGING RISK AND ASSESSING BEHAVIOURS

1. RISK FACTORS

2. Risk factors increase the likelihood of challenging behaviour and require quick management decisions. Risk factors may include a person's previous history and current clinical presentations. Historical and current factors may operate independently or interact together, and they may combine with environmental and situational triggers to heighten the risk of challenging behaviour.

3. The following factors point to an increased risk of challenging behaviour:

Person	Environment	Situational
Historical factors • History of aggressive/violent behaviour • History of intent to harm others • History of mental condition(s)/self-harm/suicide attempts • Cognitive impairment • Previously detained under a section of the Mental Health Act • Forensic, criminal related history, e.g. prisoners in hospital etc. • History of abuse or trauma • History of substance and alcohol abuse or withdrawal • History of disruption to service delivery and resources, e.g. damage to property, equipment, disruption to staffing levels etc. **Current presentation** • Specific diagnoses, physical, cognitive, (especially communication) and psychological/emotional factors.	• Environmental factors, e.g. new environments, busy, active, crowded treatment areas • Other agitated or distressed patients or service users • Lack of meaningful activities.	• Activities being undertaken, e.g. washing, dressing, giving medications etc. • Services being provided and the client group • Staff member, e.g. inconsistent staff attitudes, awareness and approach • Staffing, e.g. staffing levels, skill levels and training • Certain times of day • Patient, e.g. mix/tensions, patient on patient incidents • Restrictions, denial or confrontation, e.g. a person wanting to leave, cigarette requests.

4. PREVENTING THE RISK OF CHALLENGING BEHAVIOUR

4.1 Preventing the risk of challenging behaviour relies on meeting personalised care needs: *'Care where the patient is an equal partner with the healthcare professional and where both parties work together to make an assessment, identify options for the delivery of the most appropriate care. The care provided is holistic and the 'whole person' sits at the centre of the care package, which may be delivered by a range of health and social care professionals.'* (NHS Education for Scotland, 2010)

4.2 This approach is based on positive staff attitudes, high levels of tolerance, compassion and empathy. Dignity is important and requires that the individual is kept comfortable, valued, respected, is in control, and that they have choices in their treatment and care.

Empathic understanding means seeing problems from the perspective of the patient or service user.

It requires strong leadership, skilled staff confident in their own abilities and adequate resources. It requires training, practice and often role-modelling by people who know how to do it and can share their expertise.

In acute health settings, staff are often instilled with the belief that they need to work quickly in order to be effective. However, the approach presented here relies on staff being able to talk to the patient or service user and understand their psychological, emotional and physical care needs.

Personalised care means staff building positive relationships with the person being cared for, their family and carers. The rewards equally apply to those delivering the care as well as the person being cared for, as staff tend to feel empowered and supported by this approach.

Staff should understand that the way they interact is vital in helping the patient communicate the reasons for their distress and their unmet needs. They also need to be aware (and this should be reiterated through training) of how their interaction with the patient can positively or negatively reinforce challenging behaviours and of the need to communicate with them in a sensitive way.

A collaborative approach is the most effective way of preventing a person's challenging behaviour, which involves all staff having a unified understanding of an individual's behaviours, antecedents, triggers, reinforces and consequences and what everyone needs to do to prevent the behaviours. This understanding requires developing a personal profile and wherever possible observing and analysing what is happening and designing effective interventions – a functional assessment can assist where possible

5. MANAGING THE RISK OF CHALLENGING BEHAVIOUR

Challenging Behaviour Management Plan

The Challenging Behaviour Management Plan accessed from Forms on Security page on Hub is a risk assessment and communication tool that is used to support staff and patients in identifying potential triggers to challenging behaviour. The information provided ensures any risks are communicated to the Security and Site Management teams. This information assists wards in providing appropriate resources and identifies the most effective support required to mitigate potential risk to patients and staff.

6 MANAGEMENT TOOLS AND TECHNIQUES

Aggressive behaviour can nearly always be explained by the "fight or flight" reaction to a situation that is deemed "dangerous" by the victim. In such situations, the following points need to be remembered (however where a diagnosis of delirium has been made, refer also to the Clinical Guidelines for the Diagnosis and Management of Delirium):

- Reduce noise and stimulation
- Allow patients to "wander" safely
- Do not physically restrain patients unless they are a real danger to themselves or others. If absolutely necessary, use the minimal force possible.
- Remember that a uniform may not inspire confidence and may have the reverse effect
- Provide 1:1 care. Use friends or relatives if they are happy to come in; usually

relatives are more than happy to be involved in the care, but additional staff may be needed, particularly over the first 24 hours

- Ensure adequate hydration, nutrition and comfort
- Do not be offended if the patient takes a dislike to you. Do not argue with the patient. Find someone that has a good rapport to do the bulk of the care; but make sure that they are supported and have regular breaks during an acute confusion period, as this is very energy demanding.
- Use of bed rails. This may increase the patient's feeling of being trapped or held against their will. It often results in injury to the patient by either entrapment in the bed rails or climbing over the bed rails and falling from a greater height. A Risk Assessment from the Slips, Trips & Falls Policy (Inpatients) may be required. If necessary nurse the patient on a Hi-Lo Bed on the floor, or put the bed to its lowest height and place Crash Mats around the bed.
- Use a calm but firm approach so that the patient feels there is someone in control of the situation. Keep the voice calm and reassuring; do not shout or speak unnecessarily loudly. Keep commands/information short and concise; the patient will not be able to deal with too much information at once.
- Maintain consistency of approach by the whole team by through good handovers.
- Avoid the use of sedatives if at all possible. If this is the only safe way of managing the patient it should be used as a last resort and expert advice should be sought regarding appropriate drugs and dosage.

7 Keeping patients and visitors informed

The provision of information to patients, their relatives and friends and ensuring that patients' concerns and complaints are dealt with quickly and fairly is extremely important and can prevent the risk of violence. This is particularly the case in situations of acute distress and/or long waiting periods and is more relevant to areas such as the Emergency Department and Outpatients.

8 Keeping staff informed

Staff involved with patient care should ensure information is communicated to relevant staff, e.g. at handover, particularly when the following applies:

- New members of staff are involved
- New patients are admitted
- There has been a change in the patient's medical/physical state, medication, behaviour or mood, etc.
- Known violent patients/clients are being transferred from one department to another
- Where domiciliary visits are made to patients with a known or suspected history of aggressive or violent behaviour. Further details are available in the separate Lone Working Policy

9 Environment

It is important that the workplace environment and surroundings are subject to Risk Assessments in line with the Trust Risk Assessment Policy & Procedure. Where a risk assessment is to be made regarding violence & aggression a Matron or Senior Nurse will carry out the assessment. Further advice and guidance can be obtained from the Local Security Management Specialist.

The patient's environment can have a significant impact on their behaviour, specialty areas, mobility, etc. Items available to them within their environment may also become a hazard to others and/or a means to facilitate self-harm. As part of the CBMP consideration should be given to:

- Bed location – can the patient be managed in a bay or is a side room more appropriate, will their behaviour impact on the care and/or recovery of other patients including demands on nursing time
- Potential weapons – remove any non-essential items that may be used to strike and/or be thrown including patients personal property, consider using plastic cutlery and non-ceramic crockery, ensure that "hot drinks" are not hot enough to scald/injure
- If appropriate, remove sharps bins from the immediate vicinity of the patient, be aware of items on your person such as scissors
- Ensure the patient's visitors do not compromise safety by passing unsuitable items or substances during visits. Consider checking patient's property and local environment following visits.
- Giving each patient a defined personal space
- Providing distraction activities where appropriate
- Encouraging play areas and activities for younger patients with disturbed behaviour
- Providing activities and wandering space for patients with dementia
- Monitoring the mix of patients
- Removing aggressive patients to a single room or cubicle to protect both the health and safety of other patients and that of the aggressor himself/herself
- For patients with dementia and delirium there is also an argument for cohorting patients to reduce the risk of incidents of falls and aggression
- Request check of personal belongings for offensive weapon(s) and potential incendiary devices (matches, cigarette lighters).

10 Personal Safety of Staff

As well as managing the care of the patient concerned, the personal safety of all disciplines and groups of staff must be ensured as far as is reasonably practicable. Although patient care is the primary focus this must not be at the expense or risk of personal injury where the task being attempted is not of an essential and/or life preserving nature.

- Routine, non- essential tasks - bed making, room cleaning, patient hygiene etc. should not be undertaken or attempted when the patient is showing challenging behaviour (unless there is a risk to skin breakdown leading to pain and further aggression)
- Ensure that all staff that may have reason to have contact with the patient – doctors, nurses, (including departments such as x-ray, fracture clinic, cardiology), housekeepers, porters, chaplain – are aware of the potential or actual risk/s in dealing with the patient
- To avoid a one on one confrontation situation consider setting a minimum 2:1 staff to patient ratio at all times and document this in the patient care plan
- Report all challenging behaviour incidents involving the patient by completing a Trust incident report on Datix and ensure the CBMP is regularly updated and that new and/or revised information is communicated to all relevant staff

Line managers should be aware that caring for challenging behaviour patients can be demanding and stressful and staff caring for challenging patients may require additional

management support. In more serious or traumatic cases line managers should ensure staff are debriefed and if necessary counselling should be offered to staff. Refer to Action Card at Appendix 4.

11 Care planning

Risk assessment and management should inform the care plan as to whether specific interventions are required to manage challenging behaviour. The risk assessment documentation should sit alongside the care plan and should be cross-referenced and updated accordingly if new risks emerge.

12 De-escalation

If prevention has failed, is failing or has never had a chance to work, staff need to be skilled in de-escalation. This is based around highly developed communication skills, fostering good relationships, empathy, calming, non-confrontation, minimising threat, negotiation, compromise, agreeing to any reasonable requests, distraction, activities and changes of staffing which are all key here.

13 Doing nothing/ watch and wait

Doing nothing and 'watch and wait' are important strategies in high risk situations where it is safe to apply them, although they require staff confidence as they may seem counter-intuitive. Challenging behaviour around the time of transition (e.g. hospital or care home admission, or ward or bed moves) often settles down within 2 or 3 days without intervention other than trying to keep the individual, staff and other people safe and offering comfort and reassurance. The latter meets psychological and emotional needs and improves the individual's experience of care.

14 Leave and return

'Leave and return' is a strategy when someone is resisting care. Staff need to employ good judgment here. If a patient or service user absolutely needs medical intervention or another essential intervention (e.g. a soiled incontinence pad needs changing), brief physical interventions may be necessary. But in the majority of cases things can wait (washing or shaving, for example). Constant informal risk assessment is needed, along with adequate supervision, opportunities to discuss and debrief dilemmas and staff being trusted to use their judgment.

15 Better understanding and tolerance

Some challenging behaviours may be difficult, or unnecessary, to stop (e.g. wandering or persistent 'vocalisation'). It is important for staff to be able to understand these behaviours, tolerate them (where they are not offensive), accommodate them within the confines of the care environment, keep the patient or service user and others safe and sometimes mitigate effects. For example, someone who is persistently shouting may have to be isolated to reduce stimulation and keep the environment tolerable for others, as well as to avoid provoking others or 'setting them off'.

16 Observation

Observation that goes beyond normal therapeutic engagement and assists in building relationships with patients or service users should be considered for the immediate and long term prevention and management of challenging behaviour. It must not be intrusive, should respect dignity and privacy and must be conducted safely. Organisations should

have an action plan for checking availability of internal staff for observation (e.g. staff bank, temporary staff, central response team, movement of staff from other areas). An observation policy should clarify observation levels according to risk and what is expected of staff (a prior knowledge of the person's history is desirable) and how to initiate or discontinue higher level support.

17 Physical intervention and rapid tranquillisation

It is important for staff to be able to recognise situations where physical intervention and/or rapid tranquillisation (refer to Clinical Guidelines for Rapid Tranquilisation of Adults and / or Pharmacological Management of Disturbed Young People including Rapid Tranquilisation are required. Clinical staff need to be confident about when these short term intervention strategies are required, e.g. immediate control of a dangerous situation and when they are not required, i.e. where de- escalation, non-pharmacological means, or use of more routine medication (e.g. pain relief) should be attempted first.

During care planning, 'advance directives' (decisions) may be considered by asking a person to indicate what forms of treatment they would or would not prefer, should they lack capacity to refuse or consent in the future. This includes any treatment preferences that they may have in the event that they become challenging. Where a person has memory/understanding issues a formal capacity assessment is necessary and a plan made in their best interest following the process set out in the MCA Code of Practice taking into account views of relatives and those close to the patient.

APPENDIX 6: SANCTIONS MANAGEMENT

1. A staged approach will be generally undertaken to manage any sanctions in respect of **intentional** violence and aggression. In such cases a 'Verbal Warning' would precede any 'Written Warning' and this would precede any 'Acceptable Behavioural Contract' or 'Exclusion'. There is no requirement to escalate the response in any particular order should the situation warrant immediate action.

1.1 Verbal Warning

Where a patient, relative or visitor is violent or abusive, the member of staff or senior member of staff should explain to the patient what is and is not acceptable behaviour and he/she should outline what the possible consequences of any further repetition of unacceptable behaviour could be. An experienced member of staff and / or security should always witness this explanation. Identification of any triggers for the behaviour may be useful in future prevention.

The main aim of the Verbal Warning process is twofold:

- To ascertain the reason of the behaviour displayed as a means of preventing further incidents or reducing the risk of them reoccurring; and
- To ensure that the patient, relative or visitor is aware of the consequences of further unacceptable behaviour.
- In the case of a patient, it may be appropriate to issue a Code of Conduct leaflet which contains information useful to prevent further escalation in their behaviour.
- The incident and local actions taken must be reported and investigated in accordance with the Trust incident reporting procedures. The fact that a Verbal Warning has been given should be recorded in the patient's notes.

NB: A Verbal Warning should be delivered no more than twice.

1.2 Written Warning

If having issued one or more verbal warnings, further incidents are reported, the local manager should consider if appropriate to issue a warning letter. Template letter is at **Appendix 6.1**

Any warning letters must be attached to the relevant electronic incident report.

The presence of a mental disorder should not preclude appropriate action from being taken, and it is important to note that the incident must still be recorded in accordance with directions.

1.3 Application

Applications detailing the reason for a 'Warning Letter' should be made directly to the Trust Local Security Management Specialist. The evidence will be reviewed by the Local Security Management Specialist.

1.4 Authorising & Serving

Where it is felt that there is sufficient evidence the case will be referred to the Chief People Officer or the Deputy Director of Estates and Facilities in their absence for authorisation. The serving of the 'Warning Letter' will be recorded delivery or by the Local Security Management Specialist. The 'Warning Letter' will be attached to the

appropriate incident report and the Security Management Specialist will monitor and review all 'Warning Letters' issued.

1.5 Acceptable Behavioural Contract

An Acceptable Behavioural Contract is an option that can be considered for patients, relatives or visitors, to address unacceptable behaviour where verbal warnings or a warning letter have failed, or as an immediate intervention depending on the circumstances.

An Acceptable Behavioural Contract is a written agreement between the parties aimed at addressing and preventing the recurrence of unacceptable behaviour and can be used as an early intervention process to stop unacceptable behaviour from escalating into serious behaviour both on Trust premises and in the community environment.

Where for example it is decided that an Exclusion is not justified but unacceptable or inappropriate behaviour has been identified of a patient or visitor the Trust retains the right to request that the person(s) agree to conduct themselves in a manner which is none threatening or abusive and which is not detrimental to the treatment of themselves or any other patient or safety of any Trust employee or NHS property.

The person(s) will be required to sign an Acceptable Behavioural Contract which will detail the manner of acceptable behaviour required for the continued treatment of themselves or another - see **Appendix 6.2**

1.6 Application

Applications detailing the reason for an Acceptable Behavioural Contract should be made directly to the Trust Local Security Management Specialist. The evidence will be reviewed by the Local Security Management Specialist.

1.7 Authorisation & Serving

Where it is felt that there is sufficient evidence the case will be referred to the Chief People Officer or the Deputy Director of Estates and Facilities in their absence for authorisation. The serving of the Acceptable Behavioural Contract will be either by recorded delivery or in person by the Local Security Management Specialist and / or in conjunction with the Police.

The Security Management Group will monitor all Acceptable Behavioural Contracts in force and the circumstances quarterly. Acceptable Behavioural Contracts will be reviewed every 12 months. Where an Acceptable Behavioural Contract has been signed by a patient a copy will be held on the patient's notes. A record of the Acceptable Behavioural Contract will be retained by the Local Security Management Specialist for a period of three years.

Where a person has an Acceptable Behavioural Contract in force but fails to comply with the conditions the person should be reported to the Local Security Management Specialist for consideration of Exclusion in line with this policy.

2. Exclusion

2.1 The Trust reserves the right to exclude any person or persons, who, in the considered opinion of the Trust, threatens the safety and or security of the Trust's employees, patients, visitors or property by:

Having been Convicted or Cautioned for a Criminal Offence, which has been committed on Trust premises or grounds, or
In the case of a juvenile, is the subject of a Formal Warning or Final Reprimand

2.2 Where the above criteria is not met but a person or persons:

Causes Trust employees, patients or visitors to fear for their safety, or

Prevents Trust employees or their agents delivering healthcare, or

In the professional opinion of the Trust Security Management Specialist or Acute Security Manager and / or in the opinion of a Trust Senior Manager is a threat to the safety and/or security of the Trust's employees, patients, visitors or property, an emergency exclusion order may be issued by the Trust Security Management Specialist or Acute Security Manager and/or a Trust Senior Manager.

2.3 It is not the intention of the Trust to prevent any excluded person from attending the site where they are:

- In need of emergency treatment or care, or
- Fulfilling a pre-arranged hospital appointment.

2.4 It is recognised that there must be sufficient justification for exclusion.

- The Trust must be able to clearly show the process by which any decision was made and in what way the named person is a perceived threat.
- The Trust must be able to show details where any decision has been reviewed such as altering any period of exclusion, and by whom.
- The Trust should determine whether the exclusion covers the whole of the Trust or selected sites or areas.
- The Trust must be able to show that the named person has been advised of any relevant decisions and by whom.

2.5 However, where an excluded person requires or wishes to visit Trust property for one or more of the reasons below then that person must seek permission to do so by writing to the Trust's Chief People Officer:

- Visiting a relative who is an in-patient within the Trust.
- In order to take part in bona fide lawful business on Trust property.

They must include full details of the reason for them visiting the site, the time and duration of any visits and include a contact home address and telephone number, and give the Trust not less than 48 hours' notice to respond (not including weekends or Bank Holidays). This will allow time for the Trust to advise the excluded person of any decision.

2.6 The Chief People Officer, in consultation with the Chair of the Security Management Group will decide whether permission will be given to enter Trust property.

2.7 Any decision to refuse access to the excluded person will be made on the following criteria:

- The circumstances do not fall within guidelines laid out in section 2.4.
- It is believed the excluded person still constitutes a significant risk to persons or property.

2.8 Where permission is granted the excluded person can be advised verbally (a written record will be made for the file) or by letter if appropriate. They will be instructed to collect from the relevant site main reception and keep in their possession to show if requested by any representative of the Trust, a letter from the Divisional Director for the Operations Support Division giving permission to enter the site within laid down parameters.

2.9 It is recognised that it may be impossible for an excluded person to give sufficient notice in extreme circumstances such as when a relative is suddenly taken seriously ill and the named person attends at that time. In such cases the named person will advise staff immediately upon their arrival at the site that they are excluded, but circumstances had prevented them from complying with the requirements to give a minimum 48 hours' notice as laid out in section 2.5.

2.10 In such circumstances staff dealing with the named person will ensure the Chief People Officer or the Deputy Director of Estates and Facilities in their absence is advised that an excluded person is visiting the site and the circumstances of that visit.

2.11 If further visits are likely the Chief People Officer in consultation with the Chair of the Security Management Group and Police, will determine what action is required. The excluded person will be contacted and advised of any decision and previously laid down procedures will be followed.

3. EXCLUSION PERIOD

3.1 Exclusion periods can be made for any period of time but are likely to be for periods of one to five years. After each 12-month period a risk assessment will be made by the Chief People Officer in consultation with the Chair of the Security Management Group and Police, to determine whether exclusion is still relevant and a record of that process and decision will be made.

3.2 Any decision to subsequently alter the length of any period of exclusion will be ratified at the next Security Management Group meeting.

3.3 The excluded person will be notified in writing of the result of that annual risk assessment.

3.4 An emergency exclusion order will usually be issued for a period of 14 days, or until ratified or overturned by the Chair of the Security Management Group and Chief People Officer if sooner, but will not exceed 31 days.

4 PROCEDURE

4.1 The Trust may consider information from any person or agency, advising that a named person maybe someone whom they believe should be the subject of exclusion notice.

4.2.1 Detailed records must be obtained and kept by the Chief People Officer The Trust must be in a position to confirm all its actions, when they were made and by whom. These records must include (where available and applicable):

- Circumstances of the incident under discussion to include details of the provider of the information.
- Full name, address, date of birth and physical description of the named person (photograph if available).
- Highlight any specific warnings e.g. violence to staff or carries weapons, etc.
- A summary of any deliberations by the Trust.
- Any corroborative information or documentation that can be obtained and its source.
- All details of any correspondence between the Trust and the named person or other persons connected.
- Details of any further incidents involving the named person and any action instigated by the Trust.
- Details of any legal procedures.
- Any other relevant information.
- Records to be kept for a minimum of three years after exclusion period ends.

4.3 Where an emergency exclusion order has been issued by the Trust Local Security Management Specialist and/or a Trust Senior Manager it must be ratified or overturned by the Chair of the Security Management Group and the Chief People Officer (or their deputies) at the earliest opportunity. A written record of the decision must be made and tabled at the next Security Management Group meeting.

4.4 Where a person is to be excluded then the Chief People Officer will ensure a written notice of the Exclusion is delivered by hand to their last known address. Details of when and by whom the letter was delivered are to be attached to the file. The Exclusion notice will include:

- Confirmation that the Trust has decided formally to exclude them from Trust property (listing all the Trust addresses or selected areas or properties as appropriate).
- The reason for the period of Exclusion.
- Duration of the Exclusion.
- Any exemptions to the Exclusion (listed in sections 2. and 2.5)
- The procedure for an appeal.
- The consequences of breaching the terms of the Exclusion notice.
- How to contact the Chief People Officer
- The Trust reference number if applicable.

4.5 If any person breaches their Exclusion notice then an injunction may be sought from the Court.

5 APPEAL

5.1 A named person has the right of appeal against an Exclusion notice by writing to the designated contact within the Trust who will be:

Chief People Officer
Royal Devon and Exeter Hospital (Wonford)
Barrack Road
Exeter
EX2 5DW

5.2 The appellant has the right to be accompanied by a friend or colleague not acting in a legal capacity and will be advised of this at the appropriate time by the Chief People Officer.

5.3 The appeal panel will consist of two Trust Board Directors (one Executive and one Non-Executive Director). The decision of the panel will be final and binding and the named person will be informed in writing of their decision by the Chief People Officer.

ANNEX 1: WARNING LETTER

Royal Devon and Exeter
NHS Foundation Trust

< insert address>

Dear <insert name>

Warning letter – unacceptable behaviour

The Royal Devon & Exeter NHS Foundation Trust has evidence which suggests on the <insert date> you
<insert name> used/threatened unlawful violence/acted in an anti-social manner to a member of NHS staff/whilst on NHS premises **(delete as applicable)**.

Behaviour such as this is unacceptable and will not be tolerated. This Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse.

Such behaviour also deprives the Trust of valuable staff time and resources and may result in other patients having their treatment delayed or postponed. Just as the NHS has a responsibility to you, so you have a responsibility to use its resources and treat NHS staff in an appropriate way

Should there be any repetition of this type of behaviour; consideration will be given to taking action against you.

Such action may include the following:

- Excluding you from premises
- Seeking an Acceptable Behaviour Agreement
- Reporting to the police where your behaviour constitutes a criminal offence and fully supporting any prosecution they may pursue.
- Consideration of a private criminal prosecution

If you do not agree with the details contained in this letter about your alleged behaviour or feel that this action is unwarranted, please contact in writing < insert details of local complaints procedure> who will review the decision in light of your account of the incident(s).

A copy of this letter will be retained for 12 months and where appropriate kept with your Medical Records.

Yours faithfully,

Local Security Management Specialist

ANNEX 2: ACCEPTABLE BEHAVIOUR CONTRACT

Royal Devon and Exeter
NHS Foundation Trust

Date

Acceptable Behaviour Contract between Royal Devon & Exeter NHS Foundation Trust and *(Insert name here)*

I am writing to you as the Local Security Management Specialist (LSMS) for Royal Devon & Exeter NHS Foundation Trust. The LSMS has responsibility in all aspects of security operational matters relating to the deterrence, prevention, detection, investigation and management of security in Royal Devon & Exeter NHS Foundation Trust.

One of my roles is to protect NHS staff from abusive and violent behaviour and NHS resources from misuse and it is in connection with this that we are writing to you. I have received (number) reports in which it is alleged that on (date) whilst attending ****** , you [details of incident or offence] causing [details of impact] .

Behaviour such as this is unacceptable and will not be tolerated. Royal Devon & Exeter NHS Foundation Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse, property loss or damage. Such behaviour also deprives Royal Devon & Exeter NHS Foundation Trust of valuable resources, causes other patients unacceptable distress and directly affects their quality of care and treatment whilst a patient on Royal Devon & Exeter NHS Foundation Trust premises.

It is my view that your actions in the above incident could be considered as constituting criminal offences, in particular -
[Details of offence]

The NHS has a responsibility to provide a service, those using the service have a responsibility to use its resources and treat its staff in an appropriate way.

When attending NHS premises in the future you must comply with the following conditions:

- You will treat all people and property with respect that you come into contact with whilst on NHS Property.
- You will not use abusive, insulting or threatening words or behaviour to any member of Trust over the phone or in person.
- You will not use or threaten violence towards Royal Devon & Exeter NHS Foundation Trust staff, patients or visitors.
- You will pursue any complaint using the NHS procedure for doing so.

If you fail to act in accordance with these conditions and continue to demonstrate unacceptable behaviour, consideration will be given to taking action against you.
Such action will include the following:

- Reporting to the police where your behaviour constitutes a criminal offence and fully supporting any prosecution they may pursue.

- Seeking a court order to restrict your behaviour.

- Excluding you from the Trust for anything other than emergency medical care.

If any legal action is necessary any costs incurred will be sought from you and these may be considerable.

Enclosed are two copies of this letter for your attention. I would be grateful if you could sign the attached agreement at the declaration and return one of these in the envelope provided.

This agreement (should you sign it) will be reviewed in 12 months' time. If your behaviour causes no further concern and no further incidents have been reported to us it will be withdrawn.

If you do not agree with the conditions set out in this letter, or have any other representations to make in relation to this matter these should be submitted in writing to;

Security Management
Royal Devon & Exeter NHS Foundation Trust
[redacted]

Yours faithfully

Local Security Management Specialist

Royal Devon and Exeter
NHS Foundation Trust

ACCEPTABLE BEHAVIOUR CONTRACT AGREEMENT

This agreement is between:

Royal Devon & Exeter NHS Foundation Trust and (*Insert Name*)

Date of Birth:

I agree to the following in respect of my future behaviour -

- I will treat all people and property with respect that I come into contact with whilst on NHS Property.
- I will not use violence, or foul or abusive language or threatening behaviour towards any person while on NHS premises.
- I will not threaten violence or use foul or abusive language towards any NHS staff while on the telephone.
- I will follow the NHS procedure when making a complaint.

Declaration

I accept the conditions set out above and agree to abide by them

accordingly. Signed:

Dated:

Royal Devon & Exeter NHS Foundation Trust

Signed: Print name:

Position: Local Security Management Specialist Dated:

APPENDIX 7: COMMUNICATION PLAN

Royal Devon and Exeter NHS Foundation Trust

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the policy	All Staff
The key changes if a revised policy	Removal of restrictive practices guidance Amendments to align with NDHT policy Amendments to align with NHS England Violence Prevention and Reduction Standards
The key objectives	Provide guidance and advice for all employees of the Trust and persons providing services on the management of violence, aggression, challenging behaviour
How new staff will be made aware of the policy and manager action	Local induction process
Specific Issues to be raised with staff	Staff to be made aware of main changes as described above
Training available to staff	Conflict Resolution Training is provided via E-Learning Breakaway and Safe Handling training is delivered face-to-face to staff identified in the Trust's Training Needs Analysis and / or Risk Assessment.
Any other requirements	None
Issues following Equality Impact Assessment (if any)	None
Location of hard / electronic copy of the document etc.	The original of this policy, will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

APPENDIX 8: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Policy on Violence Prevention and Reduction
Division/Directorate and service area	Estates and Facilities Management, Security Dept
Name, job title and contact details of person completing the assessment	[redacted] Security Management Specialist, [redacted]
Date completed:	April 2021

The purpose of this tool is

- **Identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. **What is the main purpose of this document?**

   To outline responsibilities and best practice in the management of violence and aggression.

2 **Who does it mainly affect?** (Please insert an "x" as appropriate:)

Carers ☒ Staff ☒ Patients ☒ Other (please specify)

3 **Who might the policy have a 'differential' effect on, considering the "protected characteristics" below**? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)***Please insert an "x" in the appropriate box*** *(x)*

Protected characteristic	Relevant	Not relevant
Age	☒	☐
Disability	x	
Sex - *including: Transgender, and Pregnancy/Maternity*	☐	☒
Race	☒	☐
Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. **Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to…** (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

Please specify any groups you think may be affected in any significant way

5 **Do you think the document meets our human rights obligations?** ☐Yes

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• ***Fairness*** *– how have you made sure it treat everyone justly?* • ***Respect*** *– how have you made sure it respects everyone as a person?* • ***Equality*** *– how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity*** *– have you made sure it treats everyone with dignity?* • ***Autonomy*** *– Does it enable people to make decisions for themselves?*

6 **Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?**

Please give a brief summary- identifying:

Race
Racial harassment is known to undermine confidence of ethnic minority staff. The policy directly recognises and addresses racially based violence and aggression from patients to staff. The issue is clearly recognised and managers are made responsible for challenging racist attitudes. The policy makes managers responsible for challenging harassment, clearly defines racial hate crime as being within its scope and recognises that race of the carer can be a trigger of violent or aggressive behaviour from patients.

Age
Elderly patients can be especially violent and aggressive, due to delirium or confusion. The policy directly recognises and addresses this issue and refers to published guidelines. Practical advice is made available on best practice in managing violence and aggression from confused, elderly patients. A detailed appendix is provided, outlining the causes of violence and aggression in some confused and delirious patients and how best to manage this

Disability
Disability (in the person requiring restraint) is directly mentioned as a factor which would lead to restraint being applied with extra caution.

6. **If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact** please note this below and how this will be monitored/addressed.

"Protected characteristic":	None
Issue:	

How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	