



COLLEGE CENTRE FOR QUALITY IMPROVEMENT



Charity reg. No. 228636

National Audit of Violence

Module 3a National Report

Prepared by Graham Hinchcliffe, Maureen McGeorge and Leanne Shinkwin
Email: audit-of-violence@cru.rcpsych.ac.uk

© 2007 The Royal College of Psychiatrists For further information contact Enquiries@cru.rcpsych.ac.uk



Contents

Section	Page
Introduction	2
Background information	
Gender	4
Age	5
Ethnicity	6
Occurrences during the incident	7
Feedback on local action points	
Assessing and managing risk	10
Antecedents and warning signs	13
The use of observation for the short term management of violence	15
The use of de-escalation tactics	17
The use of other interventions	19
The use of physical interventions (hands-on restraint)	21
The use of rapid tranquillisation	23
The use of seclusion	24
The use of rapid tranquillisation and seclusion	25
The use of mechanical restraint	25
Post incident	26
Contact details	28
Appendix 1	
Part B Action Plan	29

Introduction

1. Overview of Module 3a

Module 3a focused on the management of actual violent incidents. Each participating ward was asked to review a series of three violent incidents against a structured 'good practice' checklist. The aim of this audit was to encourage staff groups to review their practices and identify the strengths and areas for improvement of the approaches they used to manage each incident. This exercise supported the principles of peer-review and 'learning from mistakes' and was designed to illuminate a variety of possible areas for improvement, from ideas for changes to ward routine, to suggestions for updates to existing policy and procedures.

2. Content of the audit tool

The audit tool contained a **structured checklist** and an **action plan** (Appendix 1). The structured checklist was based upon the NICE 2005 Guideline, *Violence – the short term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments*. The action plan was a simple framework for gathering feedback from participating wards. The complete audit tool can be found in the 'NAV audit tools and guidance' section of our website, www.rcpsych.ac.uk/nav.

3. Audit methods

Selecting three incidents

The guidance for the audit explicitly recognised that local definitions of what constituted 'a severely challenging/violent incident' would vary considerably between wards and organisations. Teams were therefore encouraged to refer to their own local definitions and to try to identify incidents that fulfilled some of the following criteria:

- they took place within the last month (but not so recently that staff felt unduly traumatised by the experience);
- they involved different 'types' of incidents e.g. actual bodily harm, damage to property;
- they necessitated the application of different management approaches e.g. de-escalation, medication, hands-on restraint, seclusion;
- they involved different 'teams' of staff;
- they offered the potential for group learning.

Preparing for a review meeting

Teams were asked to arrange a convenient time for all of the staff who had been involved in managing the incident to meet together. In advance of the meeting, the person who led the management of the incident was asked to complete the structured checklist as thoroughly and comprehensively as possible, aiming to complete the free-text comments boxes as well as the 'yes/no' questions. This was then to be circulated to the rest of the team and used to promote discussion at the actual review meeting.

The review meeting

Team members were encouraged to discuss and agree 'ground rules' for the meeting, with a view to ensuring that everyone would feel confident that their contributions to the meeting would be listened to by everyone present, and that the discussions would be constructive and would lead to positive changes. The group then worked together through the completed checklist in the following way:

- The person who led the management of the incident presented a brief description of the incident for discussion by the group.
- The person who led the management of the incident then worked through each of the relevant sections of the checklist in turn, firstly giving a brief overview of their responses and observations, before opening it up to discussion amongst the group.
- The group then completed the relevant sections of the Action Plan.

4. Data management

Data collection

The data collection period began in October 2006 and continued until March 2007¹. Data was collected using a paper-based version of the Action Plan and then submitted via an on-line link on the 'National Audit of Violence' web page www.rcpsych.ac.uk/nav-data to the SnapSurveys database software.

Data analysis

The survey data was extracted from the SnapSurveys database. The quantitative data was then analysed and presented using Microsoft Excel. The qualitative data was exported into Microsoft Word and analysed manually.

5. Data presentation

134 wards submitted at least one action plan, with a total of 344 completed forms, 70% of which came from services for working age adults and 30% from services for older people. Some wards reported that they were unable to complete this component of the audit because no incidents had occurred during the data collection period. This report is based upon the collated national findings of the action plans, specifically:

- **Background information:** quantitative data about the perpetrator of each incident under review. Each section heading relates to each question asked in the action plan, broken down by working age adult's services and older people's services. Bar charts have also been used to allow a clear comparison of the results. Percentages are presented without decimal points (e.g. 56%, rather than 56.4%), resulting in some 'rounding up' of scores, meaning that sometimes total scores will appear to be 99% or 101%.

Note: the selection of incidents was left to the discretion of local teams. The resulting quantitative data is not, therefore, systematic.

- **Feedback on local action points:** qualitative data relating to each of the sections of the structured checklist, organised according to emergent themes.

6. Use of this report

The bulk of the learning from this component of the audit programme will have been generated through the local processes described. This report is intended to serve two functions: summarise the learning, reflecting both the richness and the diversity of local ideas for improvement; offer local teams a further opportunity to reflect on ways in which they might address local concern.

¹ The initial deadline of the end of February was extended at the request of many participants.
National Audit of Violence
Module 3a National Report

Background information

Gender

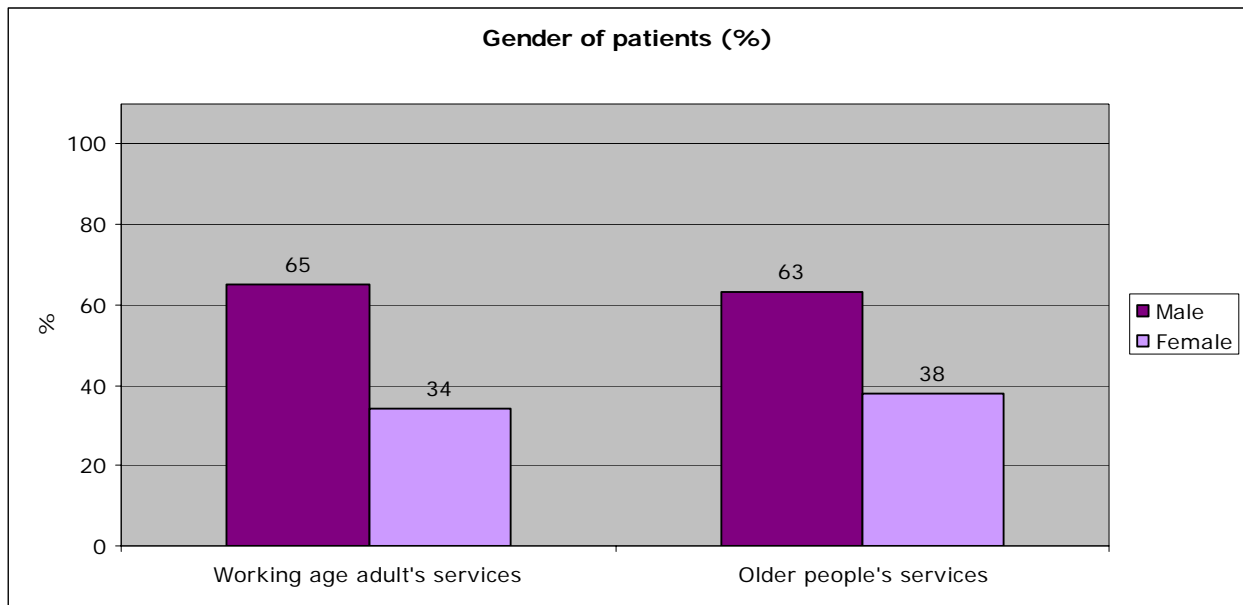
What is the gender of the person involved?

Working age adult's services

Gender	n	%
Male	157	65%
Female	82	34%
No reply	1	0%
Total	240	99%

Older people's services

Gender	n	%
Male	65	63%
Female	39	38%
No reply	0	0%
Total	104	101%



Age

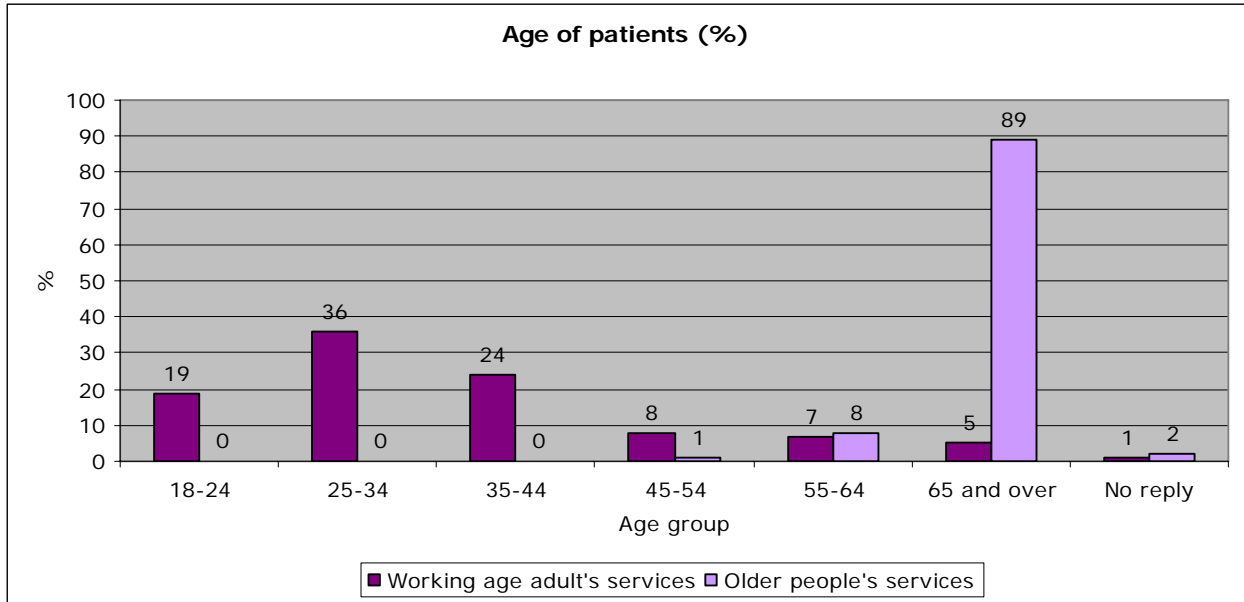
How old is the person involved?

Working age adult's services

Age	n	%
18-24	46	19%
25-34	87	36%
35-44	57	24%
45-54	20	8%
55-64	16	7%
65 and over	11	5%
No reply	3	1%
Total	240	100%

Older people's services

Age	n	%
45-54	1	1%
55-64	8	8%
65 and over	93	89%
No reply	2	2%
Total	104	100%



Ethnicity

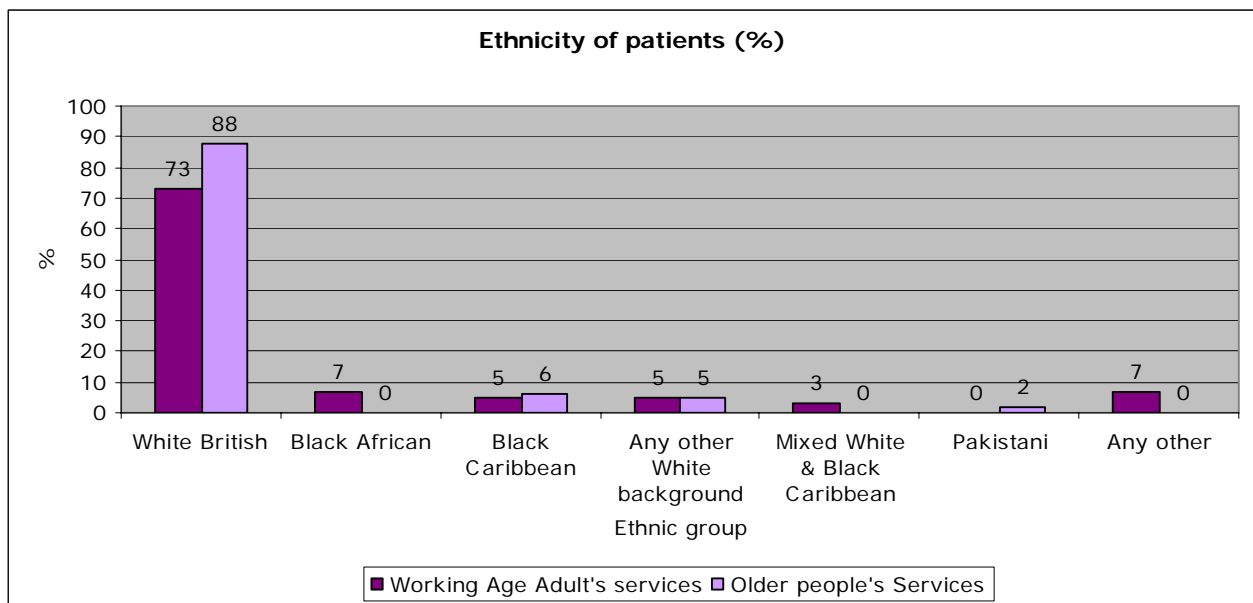
What is the ethnic group of the person involved?

Working age adult's services

Ethnicity	n	%
White British	174	73%
Black African	17	7%
Any other	17	7%
Black Caribbean	13	5%
Any other White background	11	5%
Mixed White & Black Caribbean	8	3%
Total	240	100%

Older people's services

Ethnicity	n	%
White British	91	88%
Any other White background	5	5%
Black Caribbean	6	6%
Pakistani	2	2%
Any other	0	0%
Total	104	101%

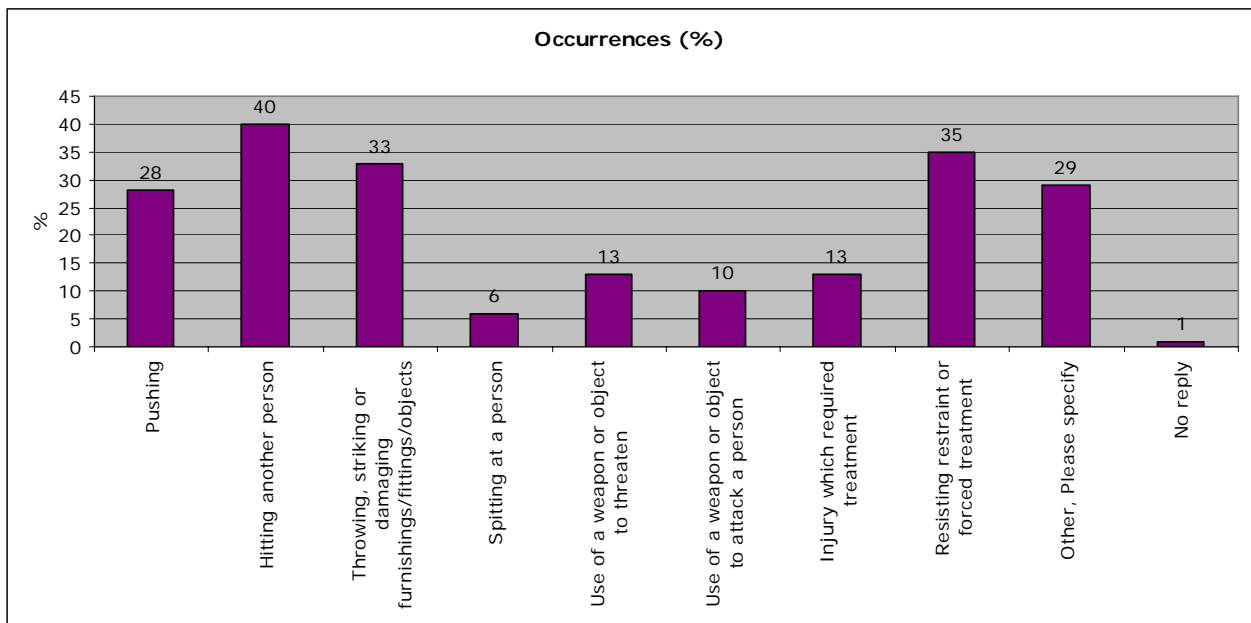


Occurrences during the incident

Which of the following occurred during the incident?

Working age adult's services

Occurrences during incidents	number of occurrences	% of total incidents that involved this behaviour
Pushing	66	28%
Hitting another person	95	40%
Throwing, striking or damaging furnishings/fittings/objects	79	33%
Spitting at a person	14	6%
Use of a weapon or object to threaten	30	13%
Use of a weapon or object to attack a person	24	10%
Injury which required treatment	31	13%
Resisting restraint or forced treatment	84	35%
Other, Please specify	70	29%
No reply	3	1%

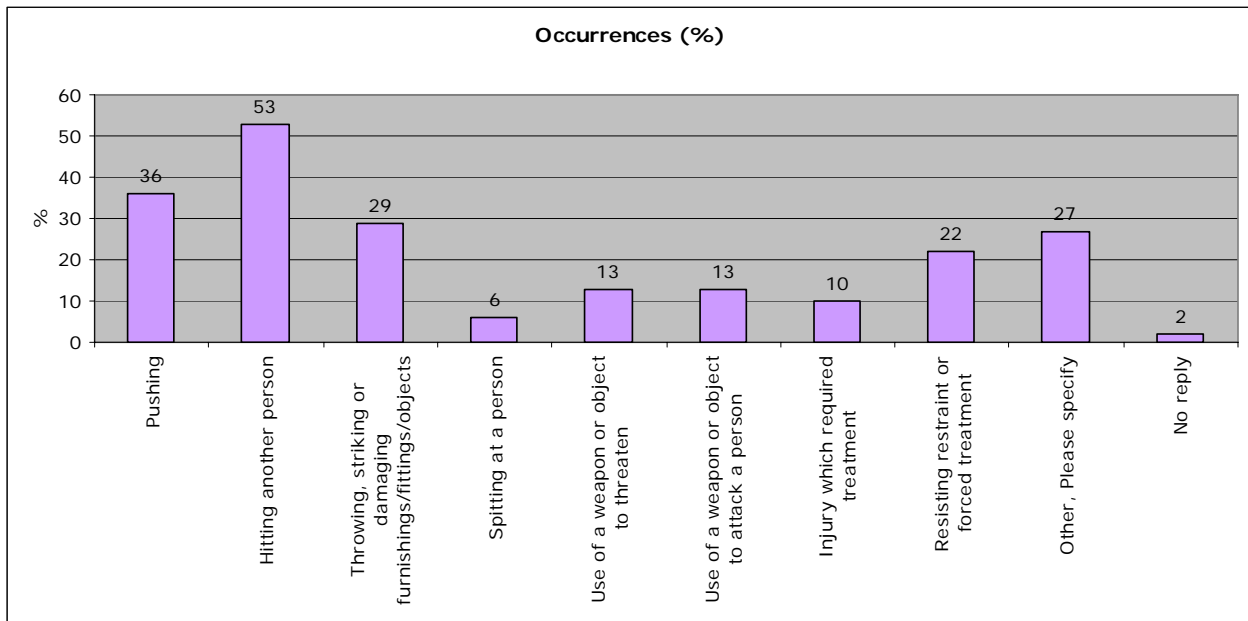


Occurrences during the incident

Which of the following occurred during the incident?

Older people's services

Occurrences during incidents	number of occurrences	% of total incidents that involved this behaviour
Pushing	37	36%
Hitting another person	55	53%
Throwing, striking or damaging furnishings/fittings/objects	30	29%
Spitting at a person	6	6%
Use of a weapon or object to threaten	14	13%
Use of a weapon or object to attack a person	13	13%
Injury which required treatment	10	10%
Resisting restraint or forced treatment	23	22%
Other, Please specify	28	27%
No reply	2	2%



Occurrences during the incident

Other (please specify)

Working age adult's services

Other (please specify)	n
Verbal aggression/ abuse	37
Threats	31
Raised voices	25
Self Harm / attempted suicide	9
Attempted absconsion	8
Biting	5
Kicking	4
Throwing liquid (hot drinks, urine)	4
Racist abuse	3
Screaming/Shouting	3
Smashing windows	2
Refusing medication/care	2
Head butting	2
Starting fires	2
Removing clothing	1

Older people's services

Other (please specify)	n
Verbal aggression/ abuse	24
Raised voices	23
Threats	23
Biting	5
Refusing medication/care	3
Smashing windows	3
Screaming/Shouting	2
Throwing liquid (hot drinks, urine)	1
Removing clothing	1
Barricading	1
Kicking	1

Feedback on local action points

ASSESSING AND MANAGING RISK
<p>Severely challenging/violent behaviour can never be predicted with 100% accuracy. Since the components of risk are dynamic and may change according to circumstance, risk assessment (of the environment and the patient) should be ongoing and care plans based on an accurate and thorough risk assessment.</p>
CHANGES RELATING TO CLINICAL PRACTICE
<p>Multi-disciplinary team</p> <ul style="list-style-type: none"> • Review: <ul style="list-style-type: none"> - medication - risk assessment and management - mental state - contingency management plan - antecedents • Clarify process for reviewing/changing level of observation • Develop a system that supports Healthcare Assistants to attend ward rounds and contribute to CPA reports and meetings
<p>Nursing handovers</p> <ul style="list-style-type: none"> • Discuss needs/management • Review full assessment of mental state • Share history of risk/past events • Discuss care plans • Develop a handover protocol that ensures that handovers are care plan-related • Develop a handover process for hotel staff • Ensure night staff are fully briefed
<p>Involve other professionals</p> <ul style="list-style-type: none"> • Psychologist • C & R team (advise on best practice) • Assertive Outreach Team • Pharmacists • Speech therapists
<p>Involve family/carers</p> <ul style="list-style-type: none"> • Regarding coping strategies • In care planning • Continue to work with them to gain history through interpreter
<p>Involve patient</p> <ul style="list-style-type: none"> • In understanding: <ul style="list-style-type: none"> - antecedents - relapse indicators - trigger factors and protective factors • Allow time for long-stay patients to ventilate frustration about others being discharged • Ensure there is adequate access to interpreters
<p>Risk assessment</p> <ul style="list-style-type: none"> • Update/simplify tools • Consider alternative tools • Complete risk assessment on admission and review weekly • Clarify frequency and levels of assessment needed • Carry out more in-depth risk assessment • Ensure senior clinicians are present at every review to support junior staff • Implement trust standards for assessment and management of risk • Build risk assessment tool into patient electronic database
<p>Care management</p> <ul style="list-style-type: none"> • Consider Mental Health Act assessment • Spend more time with patients on their arrival • Review timing of interventions • Increase observation levels

<ul style="list-style-type: none"> • Offer PRN if level of arousal increases
<p>Advance directives</p> <ul style="list-style-type: none"> • Promote within trust • Ensure they contain choice between rapid tranquillisation, restraint or seclusion • Ensure all staff read policy • Research their implementation and effectiveness • Request a copy routinely on admission
<p>Record keeping and reporting</p> <ul style="list-style-type: none"> • Update care plans in accordance with assessed risk • Write clear, concise care plans • Document history more carefully • Ensure discussions about medication and other patient management decisions are recorded in the notes
<p>Debriefing</p> <ul style="list-style-type: none"> • Provide forum for staff and patients to discuss reactions and feelings about inappropriate aggression and resolve patient/staff conflict • Investigate lessons learned through incident reporting
<p>Provide information</p> <ul style="list-style-type: none"> • About risk factors and management plan (to all relevant parties) • Display trust policy on PMVA
<p>DEVELOP THERAPEUTIC WARDS</p>
<p>PATIENT TRANSFER</p> <ul style="list-style-type: none"> • Nurse on low stimulus area • Move to extra care area • Consider direct admission to a secure setting if known risk of violence • Review appropriateness of placement i.e. patient with a learning disability • Move to e.g. a PICU
<p>STAFF ISSUES</p>
<p>Staff training</p> <ul style="list-style-type: none"> • Review induction training package • Review individual needs, as required • Provide mandatory training to all staff • Improve access to control and restraint training • Provide ward-based training • Incorporate teaching sessions into handovers • Promote discussion on PMVA, including approaches and techniques • Provide training relating to: <ul style="list-style-type: none"> - risk assessment and associated toolkit - understanding dementia and unpredictable mood/behaviour - responses when weapons present - care planning for violent incidents and how to reduce them - making positive connections - working with people with personality disorders - use of electronic records
<p>Staffing levels, skill mix and deployment</p> <ul style="list-style-type: none"> • Ensure night time levels are adequate to deal with risk • Ensure bank staff are adequately trained • Let managers know about incidents so that staff levels can be adjusted accordingly • Review use of bank and agency staff • Ensure use of agency staff is a last resort • Review skills mix on shifts • Ensure there is always one male member of staff on duty
<p>Back-up</p> <ul style="list-style-type: none"> • Update other wards on current risk issues
<p>AUDIT AND MONITORING</p> <ul style="list-style-type: none"> • Care plans • Use of risk assessment tool • Patterns of incidents • Team leaders to audit risk assessment documentation weekly and raise shortcomings with staff in supervision.

POLICY AND PROCEDURE
<ul style="list-style-type: none"> • Review eligibility criteria for admission • Make staff aware of out-of-hours policy
EQUIPMENT AND ENVIRONMENT
<p>Equipment</p> <ul style="list-style-type: none"> • Consider installing a tannoy in bedrooms as a means of communicating with patients in the event of a serious incident occurring • Buy safe crockery and plastic cutlery • Limit access to hot water
<p>Environment</p> <ul style="list-style-type: none"> • Replace glass with a material that will withstand damage • Search garden area and remove potential weapons • Move to purpose-built facility • Ask to change windows as glazing limits visibility • Consider use of mirrors • Staff to monitor objects lying around
WARD ROUTINE
<ul style="list-style-type: none"> • Review hotel staff timetable of duties

ANTECEDENTS AND WARNING SIGNS

Certain features can serve as warning signs to indicate that a patient may be escalating towards severely challenging/violent behaviour.

CHANGES RELATING TO CLINICAL PRACTICE

Multi-disciplinary team

- Discuss antecedents/warning signs with full team
- Review management of Section 17 leave

Nursing handovers

- Discuss antecedents/warning signs
- Give night staff a full and comprehensive handover
- Discuss outcome of risk assessment
- Develop a formulation to help staff understand patients' aggression

Involve other professionals

- Continue current police training placements on ward to assist them to develop insight into mental health issues.

Involve family/carers

- In discussion of likes/dislikes

Involve patient

- Encourage patient choice through advance directives
- Discuss trigger factors and warning signs
- Explain why certain medication has been given
- Encourage patients to approach staff when anxious/tense
- Consider appropriateness of family visit so soon after transfer
- Encourage patients to talk about how they feel
- Develop mutually acceptable goals with patient for more appropriate expression of anger

Assessment

- Identify antecedents using 'Dementia Care Mapping', if appropriate
- Assess presenting mental condition
- Review known triggers regularly
- Use behaviour monitoring chart over 24-hour period to identify antecedents/warning signs
- Assess whether relapse factors are present
- Ensure physical condition is kept under close review
- Check previous risk assessments, medical notes and discharge summaries

Care management

- Improve the quality of care planning via supervision
- Allow patients to remain in bed until 9am as early morning is time when incidents occur

Interventions

- Use listening skills and problem solving
- Consider use of PRN (sooner)
- Assist patients in reducing cognitive distortion
- Consider use of relaxation techniques
- Offer time out and reduction of stimulation
- Encourage 1:1, preferably in quiet area
- Use more staff to reduce distress

Recording keeping and reporting

- Record antecedents in care plans with appropriate actions
- Generate a 'do and don't list' linked to known triggers
- Review whether documentation is detailed enough to give a clear history of behaviour

PATIENT TRANSFER

- Minimise bed transfer as this can trigger confusion/outburst
- Nurse disinhibited patients in single-sex areas

STAFF ISSUES
<p>Staff training required</p> <ul style="list-style-type: none"> • The recognition of antecedents and warning signs (all staff according to need) • Dementia care (for less experienced staff) • PMVA and dementia (in-house) • Working with people with psychosis • Cultural awareness • 'Promoting Safe and Therapeutic Services' training (all staff) • The importance of observation and the recording and passing on of information (staff of all grades) • The management of sudden explosive incidents (all staff)
<p>Staffing levels, skill mix and deployment</p> <ul style="list-style-type: none"> • Review staff skill mix on shift • Ensure adequate staffing levels and minimise use of bank and agency staff • Bring to the attention of managers the contribution of low staffing levels to risk of violence • Ensure staff are in corridor outside for support, if needed, when reviewing high risk/unpredictable patients • Ensure staff nurse only patients they are familiar with
<p>Back-up</p> <ul style="list-style-type: none"> • Ensure neighbouring wards are aware they may need to attend promptly if alarms are triggered
EQUIPMENT AND ENVIRONMENT
<p>Environment</p> <ul style="list-style-type: none"> • Remove any items deemed dangerous from the patient's room
OTHER
<ul style="list-style-type: none"> • Bring to the attention of managers the contribution of significantly delayed discharge to increased frustration, anxiety and risk in general • Address language barriers via clinical governance

THE USE OF OBSERVATION FOR THE SHORT-TERM MANAGEMENT OF VIOLENCE

The primary aim of observation should be to engage positively with the patient. This involves a two-way relationship, established between a patient and a staff member, which is meaningful, grounded in trust, and therapeutic for the patient². Observation is an intervention that is used both for the short-term management of severely challenging/violent behaviour and to prevent self-harm. The recommendations and good practice points below are specifically directed towards the use of observation as an intervention for the short-term management of severely challenging/violent behaviour.

Designated levels of observation should only be implemented after positive engagement with the patient has failed to dissipate the potential for severely challenging/violent behaviour.

CHANGES RELATING TO CLINICAL PRACTICE

Multi-disciplinary team

- Review levels weekly, unless needs dictate a higher frequency
- Record behaviour periodically and use MOAS/prescription chart/blood sugar chart to look at patterns
- Move from *reactive* to *proactive* approach to modifying observation levels

Nursing staff

- Establish therapeutic relationships with patients whilst under observation

Involve patient

- Encourage positive engagement with patients to explain the reasons for the decision to adjust observation levels (before it is implemented)
- Encourage patients to approach staff when feeling unsafe to request 1:1 time
- After incident, ensure staff talk through incident looking at reason for behaviour and implications
- Invite patient to move to a non-stimulating environment
- Ask patient to take time out in their own room

Involve other professionals

- Flag up good practice to other wards at weekly senior managers meeting
- Discuss levels of observation in the community, while mentally well

Assessment

- Increase level of observation during initial assessment to determine degree of deterioration of mental state

Interventions

- Use fresh air/garden, deep breathing, diversion

Record keeping and reporting

- Document reason for choice of level of observation
- Document that decision was discussed with patient
- Complete accurate records of all patients on special observations (in nursing and medical notes and in care plans and risk assessments)
- Improve documentation

Provide information

- Display a copy of trust observation policy in a prominent place

PATIENT TRANSFER

- Liaise with PICU/acute unit with regard to transfer (if risk to other patients and staff)

STAFF ISSUES

Staff training required

- Search techniques
- Observation training (all staff)
- Observation (in the context of rapid tranquillisation)
- Assimilate good practice points into training programme

² United Kingdom Central Council for Nursing, Midwifery and Health Visiting (2002) *The Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care*. London

<p>Staffing levels, skill mix and deployment</p> <ul style="list-style-type: none"> • Ensure flexible/appropriate levels for observation • Ensure staff involved in observation are confident and will engage with the patient • Ensure staff do not undertake extended periods of observation • Ensure staff are familiar with patients that they are observing • Ensure adequate staffing levels and minimal use of bank and agency staff • Review number of staff qualified to undertake observation
<p>AUDIT AND MONITORING</p> <ul style="list-style-type: none"> • Adherence to trust observation policy
<p>POLICY AND PROCEDURE</p> <ul style="list-style-type: none"> • Review observation policy • Review escort policy to minimise risk of objects being secreted in the garden
<p>EQUIPMENT AND ENVIRONMENT</p> <p>Equipment</p> <ul style="list-style-type: none"> • Remove equipment that could be used as a weapon <p>Environment</p> <ul style="list-style-type: none"> • Consider changing ward layout as the day area is too big • Provide extra care area

THE USE OF DE-ESCALATION TACTICS

De-escalation should be employed early on in any potentially severely challenging/violent situation. A patient's anger needs to be treated with an appropriate, measured and reasonable response. De-escalation techniques should be employed prior to other interventions being used.

CHANGES TO CLINICAL PRACTICE

Systems changes

- Consider use of triage model
- Stagger admissions throughout the day, avoiding mealtimes, as this leaves ward short staffed

Involve patient

- Ask patients to tell staff when they are angry
- Allow patient to vent emotions and listen
- Encourage 1:1 therapeutic time with patients
- Encourage patients to write down how they are feeling
- Give patients the option of moving to a designated quiet area and follow up with opportunities for engagement

Interventions

- Distract via conversation
- Use empathic questions
- Give space
- Offer PRN when antecedents/warning signs have been identified
- Consider physical de-escalation e.g. football, punch bag
- Provide more explanation of procedures that are offered to patients
- Encourage patient to stay in low stimulus environment
- Make sure other patients are removed from the area
- Take patient into the garden
- Remove all potential weapons

PATIENT TRANSFER

- To a specialist unit
- To another area of the ward
- To ICU area

STAFF ISSUES

Staff training

- Review training needs
- Provide training relating to:
 - De-escalation techniques (all staff/refresher)
 - Person-centred care
 - PMVA training (within 6 weeks of commencing post)
 - Conflict resolution (all staff)
 - The distinction between secondary and tertiary prevention level de-escalation
 - The effective use of the environment
 - The use of alarms
- Staff to discuss best approaches on de-escalation for the confused patient
- Staff to explore whether the ward culture encourages the (over prompt) use of PRN
- Increase emphasis on de-escalation in C & R training
- Use incidents as discussion points in training
- Provide briefing on NICE Guideline (all staff)
- Develop awareness of staff attitudes towards patients and how they may contribute to the escalation of violence; consider the implications for training, audit and supervision

Staffing levels, skill mix and deployment

- Reduce reliance upon temporary staff who are not able to access appropriate training
- Ensure bank staff who may work in other areas such as forensics and may have a more assertive approach to use a softer, hands-off approach where possible with older adults
- Ensure the person carrying out de-escalation is the member of staff who has best rapport with the patient at the time

<p>Back-up</p> <ul style="list-style-type: none"> • Review back-up system for summoning help
<p>AUDIT AND MONITORING</p>
<ul style="list-style-type: none"> • Patient notes, to ensure paperwork is up-to-date
<p>EQUIPMENT AND ENVIRONMENT</p>
<p>Equipment</p> <ul style="list-style-type: none"> • Conduct amnesty on alarms • Order more alarms • Clarify procedure for checking all personal alarms are working correctly
<p>Environment</p> <ul style="list-style-type: none"> • Review use of bedrooms as quiet areas • Make environment safe • Consider creating a de-escalation room • Redesign ward to prevent further serious incidents • Refurbish ward to include de-escalation and quiet area

THE USE OF OTHER INTERVENTIONS

Where de-escalation techniques have failed to calm a patient, it may be necessary to make use of additional interventions, such as hands-on restraint, rapid tranquillisation, and seclusion to manage the incident. These interventions should only be considered once de-escalation techniques have been tried and have not succeeded in calming the patient. When determining which interventions to employ, advance directives should be taken into account.

CHANGES RELATING TO CLINICAL PRACTICE

Systems changes

- Ensure advocacy is in place
- Introduce the use of advance directives for all patients
- Introduce use of Security Management System (SMS) reporting
- Increase activities on the ward
- Consider introducing a system for accessing the seclusion room on a neighbouring ward
- Deliver a clearer message that violence is not tolerated
- Communicate reminders in community meetings about respect issues

Involve patient

- In identifying possible trigger factors
- Remove patients to an area where they can discuss their feelings
- Listen more when they need help/display warning signs
- Have a session to reflect on any incident/their behaviour
- Ask patients to sign a pre-admission contract regarding drug/alcohol screening and acceptable behaviour
- Give time and space for expression of anger and frustration
- Reward patients for good behaviour

Other professionals

- Police to deal with assault on a criminal justice level
- Interventions relating to culture to be provided by outside agencies
- Refer for psychology input
- Discuss response times with local police

Care management

- Implement solution-focused work
- Consider formal assessment under MHA 1983

Interventions

- Use rapid tranquillisation (initially oral) if de-escalation fails
- Use of physical restraint if de-escalation fails
- Use quiet areas until self-control is regained
- Use less stimulating environments

Record keeping and reporting

- Develop local template for reporting
- Develop a local template for reporting use of physical interventions

STAFFING ISSUES

Staff training required

- The role and function of Security Management Service
- Awareness of PMVA policy and associated levels of training
- The use of SMS reporting mechanisms
- The Code of Conduct
- The use of Time-Out procedures
- The use of advance directives
- The legalities of other interventions
- PMVA (all staff)
- The removal of weapons
- Age-specific use of interventions

Staffing levels, skill mix and deployment

- Ensure extra staff are brought in, where necessary
- Review skills mix
- Review the need for occupational therapy and psychology input to the ward

<ul style="list-style-type: none"> • Change the culture of the ward so that nurses are aware that therapeutic activity is as important as other routine work • Review staffing levels at busy times i.e. 11am and 3pm
Back-up <ul style="list-style-type: none"> • Call for assistance from staff on other wards
EQUIPMENT AND ENVIRONMENT
Environment <ul style="list-style-type: none"> • Consider use of access gate and CCTV at site entrance
POLICY AND PROCEDURE
Policy <ul style="list-style-type: none"> • Changes to reflect guidelines on calling other agencies eg. police • Review documentation regarding risk/benefit around use of PRN medication • Review effectiveness of contract for patients who are admitted for detoxification • Ensure the trust's 'zero tolerance' policy is fully implemented

THE USE OF PHYSICAL INTERVENTIONS (HANDS-ON RESTRAINT)

Definition: skilled, hands-on method of physical restraint involving trained designated healthcare professionals to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment. Its purpose is to safely immobilise the individual concerned.

(NICE, 2005)

Note: There are real dangers with continuous hands-on restraint in any position. Physical intervention should be avoided if at all possible, should not be used for prolonged periods, and should be brought to an end at the earliest opportunity. To avoid prolonged physical intervention an alternative strategy, such as rapid tranquillisation or seclusion (where available) should be considered.

CHANGES TO CLINICAL MANAGEMENT

Multi-disciplinary team

- Assess contra-indications of the use of hands-on restraint
- Develop a system to regularly review the use of restraint
- Develop a proactive approach to managing patients that minimises the incidence of violence
- Agree a consistent approach to the use of physical interventions
- Review problems with non-attendance of the junior doctors

Involve patient

- Talk to patient in an attempt to calm and reassure them throughout the restraint
- Listen to patient while they are being restrained

Involve other professionals

- Work with staff from other wards to develop a more proactive approach to managing incidents

Care management

- External facilitator to review care plans to ensure a consistent approach is being used
- Ensure the process of physical risk assessments includes a physiotherapist and doctor

Interventions

- Develop ethos amongst staff that restraint is a 'last resort'
- Agree hierarchy of interventions which follow after an incident of physical assault
- Pulse oximeter to be used during restraint
- Patients to be held in restraint as short a time as possible
- Team to ensure care plan is followed

Record keeping and reporting

- Create more robust documentation system
- Complete relevant documentation
- Inform manager at the earliest opportunity if physical restraint is used
- Inform medics/consultant at the earliest opportunity if physical restraint is used
- Team to consider how best to document that consideration has been given to a patient's physical wellbeing during and post restraint

Debriefing

- Review access to debriefing service, e.g. by 'phone, to be developed
- Introduce local ward debrief (for staff and patients)
- Organise regular post incident reviews
- Devise debriefing form
- Offer debriefing session(s) up to a period of one week after the event

STAFF ISSUES

Staff training

- Provide training relating to:
 - The use of restraint (elderly-specific)
 - The importance of documenting physical care needs and observations during restraint
 - The importance of leadership in the management of a violent incident
 - Physical intervention skills (adults of working age)

<ul style="list-style-type: none"> - Providing Safe and Therapeutic services • Consider how to make PMVA training more realistic e.g. use of scenarios • Ensure staff carrying out restraint are up-to-date with training • Ensure staff take responsibility for their own personal development • Increase staff to be more awareness of vital signs, breathing, circulation etc • Team to discuss the use of pain compliance as a last resort intervention
<p>Staffing levels, skill mix and deployment</p> <ul style="list-style-type: none"> • Review need for two staff on at night who are able to carry out hands-on restraint • Review need for at least one male nurse on the unit at night in order to offer patients the choice of whom they would like to talk with • Ensure the training, strength and agility of the response team matches the needs of the resident population • Minimise use of bank and agency staff • Use only trained staff in applying hands-on restraint
<p>POLICY AND PROCEDURE</p>
<p>Policy</p> <ul style="list-style-type: none"> • Review local policy on monitoring vital signs
<p>ENVIRONMENT AND EQUIPMENT</p>
<p>Environment</p> <ul style="list-style-type: none"> • Assess environment before using physical interventions

THE USE OF RAPID TRANQUILLISATION

All medication given in the short-term management of disturbed/violent behaviour should be considered as part of Rapid Tranquillisation (including PRN medication taken from an agreed rapid tranquillisation protocol or as part of an advance directive)

(NICE, 2005)

Medication, skilfully given, can safely and effectively be used to manage severely challenging/violent behaviour. The aim of rapid tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the patient or to others. The patient should be able to respond to spoken messages throughout the period of calming.

CHANGES TO CLINICAL MANAGEMENT

Multi-disciplinary team

- Review all PRN medications and their usage
- Review medical cover if rapid tranquillisation is to be considered
- Implement weekly review of prescriptions of PRN medication for use as rapid tranquillisation
- Improve access to doctors
- Review rapid tranquillisation pathway with pharmacy
- Check charts are written up with rapid tranquillisation medication
- Check patients are not allergic to prescribed medication
- Check prescribed medication is available on the ward
- Check previous administration to ensure dosage remains within BNF limits
- Ensure different routes of administration are prescribed
- Ensure BP machine is working
- Resolve conflicts that exist about rapid tranquillisation training in older people's services
- RMO to seek update on best use of medication to manage violence in the elderly
- Medical teams to ensure they are aware of the necessity for good documentation and agree levels of observation and review dates
- Regularly review medication used to treat agitation and psychosis

Involve patient

- Explain why rapid tranquillisation is being offered and its possible effects
- Consider formal debrief following rapid tranquillisation incident

Recording and reporting

- Record that observations have been carried out
- Ensure that all relevant documentation is completed and that all staff are informed

STAFFING ISSUES

Staff training required

- Resuscitation
- MH Act
- Use of medical devices
- Advance directives
- Use of rapid tranquillisation
- Promoting Safe and Therapeutic Services to be included as part of appraisal and KSF
- Intermediate Life Support
- Physical dangers of rapid tranquillisation in the elderly

POLICY AND PROCEDURES

- Review protocol to offer oral medication before intra-muscular medication
- Review/formalise procedure for observations following rapid tranquillisation
- Prioritise development of rapid tranquillisation policy

AUDIT AND MONITORING

- The use of rapid tranquillisation

THE USE OF SECLUSION

Definition: The supervised confinement of a patient in a room, which may be locked to prevent others from significant harm, its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others. Seclusion should be used as a last resort, for the shortest possible time. Seclusion should not be used as a punishment or threat; as part of a treatment programme; because of shortage of staff; or where there is any risk of suicide or self harm. Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention.

(NICE, 2005)

CHANGES TO CLINICAL MANAGEMENT

Multi-disciplinary team

- Discuss the use of bedrooms as a quiet area i.e. ethics and patients rights
- Carry out a full MDT review following a period of 8 hours continuous seclusion

Involve patient

- Give adequate opportunity to discuss reason for using seclusion
- Consider formal debrief with patients following use of seclusion
- Inform patients that seclusion will be reviewed at least every 2 hours
- Encourage patients to talk and write about incidents

Recording and reporting

- Document clinical team decision on use of seclusion and rationale for decision

STAFFING ISSUES

Staff training

- Provide C & R and Breakaway training (and refresher courses)
- Staff to familiarise themselves on induction with the seclusion policy
- Staff to update themselves on the requirements to document and review the use of seclusion

Staffing levels, skill mix and deployment

- Ensure sufficient female members of staff are always available

AUDIT AND MONITORING

- Regular audit of the use of seclusion

POLICY AND PROCEDURES

- If seclusion room is on another ward, clarify guidelines regarding who is responsible for patient issues such as toileting/medication

ENVIRONMENT AND EQUIPMENT

Environment

- Review need for a dedicated seclusion room
- Lack of toilet facilities highlighted. Explore alternatives.

THE USE OF RAPID TRANQUILLISATION AND SECLUSION

CHANGES TO CLINICAL MANAGEMENT

MULTI-DISCIPLINARY TEAM

- Review rapid tranquillisation pathway with pharmacy

Involve patient

- Provide opportunity to reflect on behaviour

Recording and reporting

- Contact senior nurse if seclusion considered necessary and arrange transfer to PICU
- Develop monitoring form for use post rapid tranquillisation

Care management

- MH assessment required

STAFFING ISSUES

Staff training

- Institute disciplinary action for staff not undergoing relevant training sessions/failing to pass necessary tests
- Provide training relating to:
 - the NICE Guideline
 - the use of seclusion

POLICY AND PROCEDURES

- Produce guidance for staff who work in PICU
- Review rapid tranquillisation policy
- Review seclusion policy

ENVIRONMENT AND EQUIPMENT

Environment

- Consider providing a quiet area which would benefit some aroused patients and enable them to calm down

THE USE OF MECHANICAL RESTRAINT

Mechanical restraints are not first-line response or standard means of managing severely challenging/violent behaviour in mental health care settings. In the event that they are used, it must be a justifiable, reasonable and proportionate response to the risk posed by the patient, and only after a multidisciplinary review has taken place. Legal, independent expert medical and ethical advice should be sought and documented.

CHANGES TO CLINICAL MANAGEMENT

Recording and reporting

- Seek and document all legal, independent expert medical and ethical advice

STAFFING ISSUES

Staff training

- Include as discussion point in PMVA training

POST INCIDENT

CHANGES TO CLINICAL MANAGEMENT

Multi-disciplinary team

- Discuss incidents and review risk assessments
- Conduct a full review within 24 hours
- Hold formal reviews where incident necessitates
- Discuss effects of medication with pharmacist and doctor
- RMO to look into which medication is best for patients who display aggression
- Team to agree how and when patients are informed about changes in management plans

Involve patient

- Engage in positive conversations soon as possible after incident to establish if patient understands why such interventions were used
- Provide opportunities to write about the incident
- Continue with patient choice regarding rapid tranquillisation and environments to be nursed in
- Involve patient in all debriefs, where possible
- Offer debriefing, looking at antecedents and impact of behaviour on others
- Utilise interpreter at every opportunity e.g. discussions with nursing staff, reviews

Care management

- Use person-centred approach at all times
- Consider use of advance directives
- Ensure physical cause for behaviour has been ruled out
- Increase access to therapeutic interventions and activities
- Hold risk management meeting
- Review observation levels
- Introduce systems of hourly checks for all patients
- Review medication

Other professionals

- Encourage involvement of police
- Increase role of LSMS in violent incidents
- Raise attitude of police officers at nursing/police forum

Debriefing

- Hold formal/informal meeting as soon as possible following all incidents
- Encourage staff to express their concerns regarding incident
- Offer staff counselling
- Hold staff support groups to relieve emotional stress
- Hold serious untoward incident meeting (if necessitated)
- Carry out root cause analysis, develop an action plan, and communicate this to team (if necessitated)
- Encourage staff to use patient debrief form for witnesses to incidents
- Ensure injured staff are supported by H&S department
- Ensure there is multi-disciplinary team representation at debriefs
- Undertake incident reviews using NAV tool
- Identify a debrief template suitable for use in acute in-patient services
- Formalise/improve post incident reviews
- Offer witnesses to the incident the opportunity to have a debrief
- Review access to reflective practice group to ensure Healthcare Assistants have opportunity to attend on a regular basis
- Encourage a culture where the importance of debriefing is recognised
- Provide debriefing for all staff who are involved in applying physical restraint
- Provide support and counselling for staff who are subjected to verbal threats and abuse

Recording and reporting

- Accurately record events in patient case files, following NMC guidelines
- Complete an incident form for every aggressive/violent incident
- Report and discuss incidents at every handover
- Ensure all incidents are reviewed by local managers

PATIENT TRANSFER

- Consider transfer to a more secure unit

<ul style="list-style-type: none"> • Move patient to a secure unit
STAFFING ISSUES
Staff training required <ul style="list-style-type: none"> • Managing violence in dementia care wards • Dementia awareness • Confidence in supporting others after an incident • Breakaway training (non-clinical staff)
Staffing levels, skill mix and deployment <ul style="list-style-type: none"> • Carry out urgent review of skill mix
AUDIT AND MONITORING
<ul style="list-style-type: none"> • Number, type and location of all aggressive incidents • Involvement of individual staff members in managing incidents of violence and results
POLICY AND PROCEDURES
<ul style="list-style-type: none"> • Develop debriefing policy and procedure for patients, staff and visitors • Revise post incident review to include a structure to be applied following every incident, regardless of intervention used • Remind staff about policy relating to patients having lighters • Clarify role of pager-holder within the service • Review procedure for visits to patient if they are in an agitated state • Review visiting procedure for newly-admitted patients • Review policy for linking with care co-ordinator during an in-patient episode
OTHER
<ul style="list-style-type: none"> • Consider function of ward: reduction in beds needed to allow staff to give patients more time and improve safety • Review support given to family members • Review preparation of new staff joining more secure wards • Team members to discuss creative ways of maintaining and building team morale • Provide a rapid and effective process for making claims for damage to staff property

Contact details

If you would like to discuss this report or any aspects of the audit, please contact the Audit Team on the details below:

National Audit of Violence
Royal College of Psychiatrists' Centre for Quality Improvement
4th Floor, Standon House
21 Mansell Street
London
E1 8AA

Tel: 020 7977 6645/6

Email: audit-of-violence@cru.rcpsych.ac.uk

Website: www.rcpsych.ac.uk/nav

Leanne Shinkwin

Project Administrator

Email: lshinkwin@cru.rcpsych.ac.uk

Graham Hinchcliffe

Project Administrator

Email: ghinchcliffe@cru.rcpsych.ac.uk

Maureen McGeorge

Programme Manager

Email: mmcgeorge@cru.rcpsych.ac.uk

Appendix 1

PART B: ACTION PLAN

Review of severely challenging/violent incidents

BACKGROUND INFORMATION			
1. Please tick which of the following occurred during this incident:			
• Pushing			
• Hitting another person			
• Throwing, striking or damaging furnishings/ fittings/objects			
• Spitting at a person			
• Use of a weapon or object to threaten			
• Use of a weapon or object to attack a person			
• Injury which required treatment			
• Resisting restraint or forced treatment			
• Other (<i>please specify</i>):			
2. How old is the person involved (i.e. the subject of this review)?			
3. What is the gender of the person involved?			
4. What is the ethnic group of the person involved? (please circle)			
White British	White and Black Caribbean	Indian	Black Caribbean
Other white	White and Black African	Pakistani	Black African
Chinese	White and Asian	Bangladeshi	Other Black
Other Ethnic Group	Other Mixed	Other Asian	Other (<i>please specify</i>):

	Action(s) required	Person responsible	To be completed by (date)	Completed (date)
SECTION 1 Assessing and managing risk				
SECTION 2 Antecedents/warning signs				
SECTION 3 The use of observation for the short-term management of violence				
SECTION 4 The use of de-escalation tactics				

	Action(s) required	Person responsible	To be completed by (date)	Completed (date)
SECTION 5: The use of other interventions				
SECTION 5A: The use of physical interventions (restraint)				
SECTION 5B: The use of rapid tranquillisation				
SECTION 5C: The use of seclusion				

	Action(s) required	Person responsible	To be completed by (date)	Completed (date)
<p>SECTION 5D:</p> <p>The use of rapid tranquillisation and seclusion</p>				
<p>SECTION 5E:</p> <p>The use of mechanical restraint</p>				
<p>SECTION 6:</p> <p>Post-incident</p>				