



COLLEGE CENTRE FOR QUALITY IMPROVEMENT



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Healthcare Commission National Audit of Violence 2006-7 Final Report - Older people's services

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Executive summary

This report describes the findings from the 2006/7 phase of the National Audit of Violence which was funded by the Healthcare Commission and managed by the Royal College of Psychiatrists' Centre for Quality Improvement. A total of 69 NHS trusts and independent sector organisations took part in the programme, representing 78% of all eligible participants in England and Wales. Work focused on two specialties – older people's services and acute services. Data was collected between October 2006 and March 2007. This report presents the findings from older people's services.

- The Health and Safety at Work Act (1974) states that "It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees". The audit found that 64% of nurses on older people's wards reported that they had been physically assaulted. These figures were higher than any other staff group in this specialty, or in services for adults of working age. As one nurse explained, *"Sometimes it feels very much part of the daily routine to be either verbally or physically abused by patients."* There are many causes of violence on wards. Trusts must use their local audit findings to develop plans that address their problems.
- The Government expects that 'Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation' (Core Standard C20a), yet over 40% of staff did not have access to a personal alarm, and 25% of nurses described the emergency alarm system on their ward as ineffective. Many environmental precipitants to violence are amenable to improvement and should be tackled as a matter of urgency.
- The NICE Guideline (2005) details the training that those involved in preventing and managing violence on wards should receive: the audit revealed that staff in older people's services were less likely than their colleagues in services for working age adults, to have been trained. For example: although almost 80% of nurses were involved in managing incidents, only 66% of those had received the recommended training; many staff complained that their training was not tailored to the particular needs of older people's services. Trusts must deal with shortfalls in training as a priority.
- The Government's Core Standard C13a requires that healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect. The audit found high levels of compliance with the associated standards: 92% of patients reported that they had been cared for in a dignified manner; only 5% felt that their religious or cultural need had not been respected. Trusts should commend their staffs' good practice. The NSF for Older People (2001) expects that older people will be treated as individuals and enabled to make choices about their own care. The audit revealed high levels of satisfaction with their experiences: 81% of carers reported that they had been asked to share information about their relative/friend's likes, dislikes and fears; 98% said that they had witnessed staff caring for patients in a meaningful, person-centred way. This good practice should be shared between organisations.

Local and national reports have been sent out to all participating wards and regional action planning workshops were held to support local teams to take forward service improvements. A series of 'change management' workshops are also being held to train staff to lead change within their services.

The full report contains detailed findings and many quotations from participants that can help those who need to take action to get to the heart of the problems.

Foreword

This is the second time that the Healthcare Commission and Royal College of Psychiatrists have joined forces to examine the needs of patients and staff with regard to violence in inpatient mental health services. For this audit, the focus has been on older people's services, and comparison with their working age adult counterparts. So often the serious problems facing mental health services are believed to be confined to working age adults. This valuable report shows that violence and unsatisfactory conditions for staff and people admitted to hospital, apply equally to older people's services. It may surprise some that nurses in older people's units are more likely to be physically assaulted.

Some of the most disturbing reading relates to those services that report lack of staff training, service-led rather than needs-led care and poor systems of incident reporting and governance. One cannot help but be reminded of the well publicised abuse cases in neglected older people's mental health services over the past decade, and it is alarming to see such issues still unresolved. The Royal College of Psychiatrists and the Healthcare Commission remain resolute in their opposition to such neglect and will continue to work with others to highlight these issues and offer support and guidance to services wishing to improve their practice. Although it is yet to be tested, the new criminal offence of ill treatment or neglect of a person who lacks capacity introduced in the Mental Capacity Act might well be relevant in such circumstances.

The audit shows that understaffed wards and unsatisfactory physical environments that expose patients and professional carers to unnecessary risk remain common. Lack of opportunity for physical exercise with little choice of therapies or activities for patients and poor training in key areas are further important deficiencies. The problems arising from mixing patient populations should ring alarm bells for any service intending to create mixed age or mixed dementia and functional wards, as this puts patients and staff at increased risk of violence. This is not what needs-led and person-centred services are about. It is however heart warming that carers and patients recognise the difficult situations that clinical staff have to manage, and in the large majority of cases, believe that they still consistently deliver care with respect and dignity.

This report gives a clear direction to changes needed to improve the experience of hospital admission and reduce risk of violence. All services must read it thoroughly and look at their own performance carefully, honestly and quickly.

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Participating trusts/organisations

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¹ Plus local team members Mick O'Driscoll and Annie Clarke

² Plus local team members Noreen Jeffery, Sharmila Ramchurn, Alan Saunders and Sivas Sivassubramaniam

Non-participating trusts/organisations

Barnsley PCT, Berkshire Healthcare NHS Trust, Bradford District Care Trust, Cygnet Health Care Limited, Dorset Healthcare NHS Trust, Gloucestershire Partnership NHS Trust, Hambleton & Richmondshire PCT, Herefordshire PCT, Hillingdon PCT, Isle of Wight Healthcare NHS Trust, Mersey Care NHS Trust, Morecambe Bay PCT, Norfolk and Waveney Mental Health NHS Trust, North Dorset PCT, Pontypridd & Rhondda NHS Trust, Portsmouth City Teaching PCT, Sheffield Care Trust, Shropshire County PCT, Warwickshire PCT, Swindon PCT.

Key Messages

Findings from the audit clearly reveal that in many wards, both the level and severity of violence was unacceptable. The impact on staff, patients and visitors was constant and intolerable. A considerable amount of this violence was 'unintentional' – acted out by people who were no longer able to control their impulses. Many respondents openly recognised this. However, this awareness had not reduced the pain of their injuries, nor the fear that another incident might happen. Nursing staff were bearing the brunt of this violence and should be applauded for the job that they are doing to protect others. They too need, and deserve, to be protected by the organisations that employ them.

The 1998 and 2005 Guidelines³ on violence offer services explicit topic-specific recommendations that could be used to minimise risk and maximise safety in inpatient services. As neither Guideline explicitly recognised the particular needs of people with organic disorders, the Steering Group for the Audit Programme developed additional standards that reflected these needs. The Audit Programme examined the extent to which these standards and recommendations had been implemented.

Patient mix: The findings suggest that in some wards, people with functional mental health problems and dementia, or old frail people and working age adult psychiatric patients, are being nursed in the same environment. This clearly contravenes nationally recognised good practice⁴ and should be addressed as a matter of urgency.

Understanding the needs of patients: in most wards, patients were being cared for using person-centred approaches. Several carers were eager to point out that this was being achieved in the face of considerable constraints, such as low staffing levels and the absence of activities.

Being treated with respect and dignity, and given privacy and choice: compliance with these standards was consistently high, suggesting that good practice prevailed in most wards. As the audit invited feedback from a range of external visitors to the wards, levels of confidence in this finding can be taken as high. Where problems in meeting standards were described, these were often linked to low staffing levels.

The provision of meaningful occupation: there was much room for improvement in relation to these standards. The findings revealed that the reduction in the risk of violence associated with reduced levels of boredom, and the benefits to physical and mental well-being associated with opportunities for activities, were not being maximised. Problems were greatest in services for people with organic disorders – where the challenges to engage people in a meaningful way were further complicated by the conditions that affected them.

³ Wing, J.K., Marriott, S., Palmer, C. and Thomas, V. (1998) *The Management of Imminent Violence: Clinical Practice Guidelines to Support Mental Health Services*. Occasional Paper OP41. London: Royal College of Psychiatrists.

³ National Institute for Clinical Excellence (2005) *Violence: The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments*. Clinical Guideline 25, NICE, London.

⁴ Department of Health (2001) *National Service Framework for older people*. Department of Health: London
Royal College of Psychiatrists (2006) *Raising the standard*. Royal College of Psychiatrists: London

Being listened to and given adequate information: the provision of information is a fundamental right. It is clear that many people resident in older people's services were not being given this right. The data indicated the presence of good practice – even in relation to information-sharing with people with organic disorders - however, more needed to be done to share this expertise.

Environmental safety: many wards were struggling to provide care in unsuitable environments. The impact of environmental failings were described most acutely by the staff who spend the greatest amounts of time on these wards, namely, nurses and non-clinical staff.

In relation to maximising safety, the findings indicated that in many wards, more could be done to protect patients and staff – by improving alarm systems and/or alarm response procedures, and/or by ensuring that specific safety features were provided - such as a room specifically for the purpose of reducing arousal and/or agitation.

A series of questions were asked about aspects of ward design that related specifically to the needs of people with dementia, e.g. the avoidance of long-corridors and dead-ends, use of colour-coding and signage. Findings suggested that much more could be done to support patients to remain oriented, thereby reducing the risk of them becoming distressed.

In spite of the environmental failings described above, patients, visitors and carers were considerably more likely to comment positively about the ward, rather than negatively. Most frequently, these comments related to the general atmosphere of the ward, and they acknowledged the considerable role of the staff team in creating a positive living space.

Ward communication systems: the qualitative data suggested that there was considerable variation in the effectiveness of communication systems that were operating within wards: at one extreme, these appeared comprehensive and highly valued by staff; at the other, staff reported feeling unacknowledged, unvalued, and unsafe. Linked to this, there were wards where the dominant culture was supportive and nurturing, where staff felt they could rely upon their colleagues, and where learning and development was supported. There were others where a combination of staff shortages, poor skills mix, inexperienced managers, unresponsive senior managers, and poor (multi-disciplinary) team working meant that staff were constantly 'fire-fighting' to maintain safety on their ward. These problems appeared to be exacerbated by the increasingly complex mix of the resident population: people with dementia being cared for alongside people with functional disorders; frail, older people being nursed with relatively fit, perhaps challenging, people. From the data, it appeared that some staff had "given up".

Staff training, supervision and supports: access to training relating to the prevention and management of violence in older people's services was variable, with many staff being expected to apply specialised interventions - such as rapid tranquillisation and hands-on restraint - to vulnerable patients, without any training. Where training was available, many staff reported that it was not tailored to the very particular and varying needs of the populations served. The underlying message: that in the absence of adequate training, many staff (and therefore patients), were being exposed to an unreasonable level of avoidable risk.

Experiences of, and satisfaction with, supervision varied enormously. The data suggested that there is no single system that suits all needs, with some staff preferring more formal arrangements than others. What was clear however, was that staff who are expected to deal with people who have very differing and challenging needs, and who are working in

environments where the threat of being physically assaulted is high, must have ready access to advice and support from a senior colleague.

Both the qualitative and quantitative data suggested that most ward teams, including members of the multi-disciplinary team, were highly cohesive. There were, however, differences in some wards between people's experiences of support from other front-line colleagues, and the extent to which they, in turn, felt supported by their senior managers.

Being supported in relation to actual incidents: where problems did exist, these most commonly related to two issues: a lack of confidence in reporting systems; and lack of post-incident supports for patients. With high levels of experienced violence, neither problem can be ignored. In order to develop strategies that minimise the risk of violence, accurate data is required about actual levels of incidents. This can only be achieved if the ward culture actively encourages and supports the reporting and recording of all incidents.

Introduction

General background

This is the second time that the Healthcare Commission has funded a full-scale national audit of violence in mental health services. In the 2003-5 phase of work, the focus for the audit was mental health and learning disabilities inpatient wards in England and Wales. Sixty provider organisations, representing over 260 individual wards and units, took part. The effectiveness of the audit as a driver for improvement was evident at a local and national level.

Local-level impact

Following on from the audit, the Healthcare Commission undertook an independent evaluation to establish whether the audit had been effective in driving forward service improvements.

Between September and December 2005, action plans and progress reports were collected from the trusts that had taken part in the audit. A sample of trusts were then visited or spoken to about the improvements that they had been able to bring about following on from the audit and its findings. The study indicated that the audit was perceived to be a success by staff working on the participating wards, in clinical leadership roles, and in clinical governance departments. For some, their successes were relatively simple – for example, moving public telephones to more private areas, the introduction of routine incident debriefing, and increasing patient involvement in ward decision-making. Others had engaged in complex, time-consuming and sometimes costly ventures – for example, relocating smoking facilities, installing electronically-controlled blinds to assist temperature control, working with local police to minimise substance misuse, or purchasing new alarm systems. The follow-up survey concluded that many trusts had used the findings from the audit to drive improvements.

"In all situations where the therapeutic environment was improved, levels of aggression were diminished. Staff reported that they felt greater job satisfaction and retention of staff was easier. Junior staff particularly felt that senior management and the boards were willing to listen and had not necessarily experienced this previously. They put this down to the fact that the audit was very 'hands on' for ward staff and, in this, they were the 'experts' Patients felt that their opinions counted especially when their views were used in planning activities and in debriefing sessions. Some felt that staff dealt with issues in a more caring, confident and containing manner."

Healthcare Commission, 2006.

Appendix 1 contains case study examples from three of the participating trusts.

National-level impact

At a national level, the findings provided significant input to a wide range of policy, guidance, and initiatives (Appendix 2).

The 2006/7 audit

The 2006/7 phase of the audit focused on two specialities – older people’s services and acute services. This report presents the findings from the former. These findings are variable, and some will make for bleak reading - particularly when compared with the results from services for adults of working age. It is hoped that the launch of this report will ignite a new wave of measures, locally and nationally, that will support the improvements that are so desperately needed.

Overall participants in the National Audit of Violence, 2006/7

The Healthcare Commission directed the selection of participants for the audit programme. A letter was sent, signed jointly by the Chief Executive of the Healthcare Commission, and the Director of the Royal College of Psychiatrists’ Research and Training Unit, to all eligible providers of mental health services in the NHS and independent sectors in England and Wales. The letter expressly asked them to include the following mental health wards:

- one acute psychiatric ward;
- one older people’s ward;
- one ‘other’ adult mental health ward.

A total of 69 trusts/organisations registered to take part in the audit programme, representing 78% of all eligible participants. The table below gives a breakdown of participants by ward ‘type’. During the life of the project, these figures fluctuated slightly due to reconfigurations of trusts and ward closures.

| Ward ‘type’ | No. units | |
|--|------------|-----------|
| | England | Wales |
| Acute | 76 | 13 |
| Psychiatric Intensive Care Unit (PICU) | 25 | 2 |
| Forensic | 14 | 3 |
| Rehabilitation | 5 | 1 |
| Older People – functional | 16 | 3 |
| Older People – organic | 24 | 5 |
| Older People – mixed ⁵ | 26 | 2 |
| TOTAL | 186 | 29 |

At time of registration onto the programme, participants were asked to complete a **Declaration of Understanding** (Appendix 3), detailing the mutual expectations between their organisation, and the Audit Team at the Royal College of Psychiatrists’ Centre for Quality Improvement. Sixty-nine signed documents were returned.

⁵ The category ‘Older people – mixed’ was not an original category on the Contextual Information Checklist, however, many wards selected both ‘Older people – organic’ and ‘Older people – functional’ when describing their service.

Definition of terms

Each ward was categorised into one of 7 service 'types'. This was done to allow the findings to be grouped so that participating wards could benchmark their results against other similar-type wards. The categories were defined as follows:

- Acute: any mental health acute in-patient service
- PICU: any psychiatric intensive care unit for people with a primary diagnosis of mental health problems
- Forensic: any forensic service for people with a primary diagnosis of mental health problems
- Rehabilitation: any long-stay in-patient mental health service not covered by the above e.g. continuing care, rehabilitation wards
- Older people - functional: any mental health service specifically for the care for older people (generally over 65 years) with functional mental illness
- Older people - organic: any mental health service specifically for the care for older people (generally over 65 years) with organic mental illness
- Older people – mixed: any mental health service specifically for the care for older people (generally over 65 years) with either functional or organic mental illness

Methods: Older People's Services

The audit standards

The standards were drawn largely from two sources:

- The Royal College of Psychiatrists' Guideline 'The Management of Imminent Violence' (1998)³.
- The NICE Guideline 'The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments' (2005)³.

The Healthcare Commission asked all mental health providers to include one ward for older people. Given that the scope for the 2005 NICE Guideline excluded services for people with dementia, two separate pieces of work were undertaken with the project's expert Steering Group.

1. All of the standards for adults of working age were reviewed to ascertain which were/were not applicable in older people's services: the majority of standards relating to the prevention of violence and the minimisation of risk were deemed appropriate; standards relating to aspects of the clinical management of violence e.g. the use of rapid tranquillisation or seclusion, were modified or removed. Additional standards were introduced to reflect the particular support needs of older people, in general, and people with dementia specifically.
2. The methods for the audit were revised to take account of the needs of older people with dementia.

The audit tools

A range of approaches were used to gather feedback from all groups of people who were likely to be affected by violence or the threat of violence, either through residing in, working in, or spending significant amounts of time in the participating wards. The 'unit of analysis' throughout the programme was the individual ward.

- **Contextual data:** a proforma was used to gather systematic information about the participating wards to support bench-marking and networking.
- **Module 1:** an anonymised questionnaire survey for staff, patients and visitors to the wards. The questionnaires examined the supports that each group received to maximise safety, and minimise risk that a violent incident would occur. Each questionnaire contained a mixture of closed 'yes/no' questions, and free text boxes for comments. Local project teams were guided to aim for a response rate of at least 50% from staff, and 20 questionnaire returns from patients⁶. Additional data collection methods, tools and guidance were developed for older people's services for people with dementia, where the questionnaire format was unsuitable i.e. a carer questionnaire and framework for third-party observation.
- **Module 2:** an environmental audit where staff and non-staff teams rated the environment against a set of evidence-based standards and agreed ideas for improvement.
- **Module 3a:** the structured review of a series of up to three violent incidents, where staff groups worked through a 'good practice' framework, and agreed an action plan for improving the management of future incidents.
- **Module 3b:** an audit of case notes/drug charts relating to the use of rapid tranquillisation.

The audit programme

Once trusts and organisations had registered onto the audit programme, they were sent a 'Project Management Pack' which detailed the main elements and materials for the programme, including guidance on how to set up the project locally. As part of this, they were encouraged to establish a local project team that would oversee the programme of work. It was advised that this team had strong leadership and direct links to its trust board, or equivalent, to ensure that the process and outcomes from the audit would be supported.

The programme began with a series of regional workshops where these local teams were brought together to learn about the programme and begin planning how they would manage and support it in their own organisations.

The data collection period differed for each module of the programme. The contextual data were gathered at the beginning of the programme, collated according to service 'type', and circulated to participants to support them in identifying possible benchmarking partners. The collection of Module 1 data ran from October 2006 to the end of January 2007⁷. Data collection for Modules 3a ran throughout, beginning in October 2006 and ending at the end of February 2007. Data for Modules 2 and 3b were collected between the beginning of January and the middle of March 2007⁸.

The audit reports

Reports were sent out at the end of each phase of data collection:

- **Contextual data:** each participating trust/organisation was sent a breakdown of the national summary tables (Appendix 4).

⁶ If the service was very small and/or had a long-length of stay, individual advice was given about adjusting this target.

⁷ The original deadline of the end of December 2006 was extended at the request of the majority of participants.

⁸ The original deadline of the end of February 2007 was extended at the request of the majority of participants.

- **Module 1:** participating wards that completed data collection during the originally specified deadline i.e. before the end of December 2006, were sent a report containing their quantitative and qualitative local findings, they were then sent another report containing their local and the national findings after the deadline had passed. Wards that completed data collection after the end of the data collection period were sent one report containing both their local and the national findings. Reports of the national quantitative data, broken down according to service 'type' i.e. 'functional', 'organic' and 'mixed' are available via the National Audit of Violence website www.rcpsych.ac.uk/nav-reports, as are reports of the national data broken down by country i.e. England versus Wales.
- **Module 2:** each trust/organisation was sent reports detailing the compliance with each standard for each participating ward, relative to the overall national findings. Participants also received an analysis of the national qualitative data relative to each standard, detailing good practice, the types of problems people were experiencing, and ideas for improvement.
- **Module 3a:** the background information about each incident i.e. gender, age, ethnicity of patient, what forms of violence were involved, i.e. pushing, hitting, was collated and presented for working age adult services and older people's services (Appendix 7). Participants also received an analysis of the overall qualitative data, detailing the various interventions that had been identified to address short-falls in practice.
- **Module 3b:** only wards that submitted 5 cases received a local report which compared their percentage compliance with each standard, relative to the national figure (Appendix 8).

The audit data

Module 1 survey

Of the original 79 older people's wards who committed to participate in the audit, 75 wards submitted data before the national deadline⁹. Nationally, the survey generated a sizeable response.

| Respondent Group | National | Older peoples – organic | Older peoples – functional | Older peoples – mixed |
|---|--------------------------|-------------------------|----------------------------|-----------------------|
| Nursing staff i.e. qualified/unqualified/student nurses | 835 | 384 | 162 | 326 |
| Clinical staff e.g. psychiatrists, occupational therapists, psychologists, pharmacists, managers, social workers | 118 | 47 | 25 | 52 |
| Non-clinical staff e.g. domestic staff, catering staff, porter, maintenance staff | 113 | 51 | 20 | 45 |
| Patients | 261 | 20 | 110 | 132 |
| Visitors e.g. patient family members, benefits officers, hospital admin staff etc. | 205 | 90 | 45 | 70 |
| Carers/Next of kin (Module 1 only) | 192 | 113 | 14 | 60 |
| Third party observers (Module 1 only) | 76 | 35 | 9 | 16 |
| TOTAL | 1800¹⁰ | 740 | 385 | 701 |

⁹ Of these 75, 71 submitted enough data to receive a local report. One ward submitted data after the national deadline.

¹⁰ The overall total number of returns presented by 'ward type' does not add up to the overall national figures for older people's services. This is because the analysis by 'ward type' was carried out as a secondary analysis and at

In addition to the quantitative data, the questionnaires generated 2675 individual comments from participants (these comments ranged from one line, to half a page).

Module 2 audit of the environment

The local and national results were sent out in May 2007 based upon data received from 117 wards (working age adults and older people's services). Sixty cases were from older people's services, as detailed below:

| | | | | | |
|--|----|-----------------------------|----|----------------|----|
| National Older People's Services = 60 | | | | | |
| Organic disorders | 24 | Functional disorders | 12 | 'Mixed' | 24 |

Module 3a

Of the original 79 wards who committed to participate in the audit, 44 entered data for Module 3a, 28 wards submitted the recommended number of 3 cases.

| | | | | | |
|--|----|-----------------------------|---|----------------|----|
| National Older People's Services = 44 | | | | | |
| Organic disorders | 16 | Functional disorders | 9 | 'Mixed' | 19 |

Module 3b

The local and national results were sent out in July 2007, based upon data received from 41 individual wards, 23 wards submitted the minimum 5 cases required to receive a local report.

| | | | | | |
|--|----|-----------------------------|---|----------------|----|
| National Older People's Services = 41 | | | | | |
| Organic disorders | 18 | Functional disorders | 6 | 'Mixed' | 17 |

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| <p>Copies of the various reports and a database of local action plans can be found on the programme's web pages: www.rcpsych.ac.uk/nav. Any other queries should be addressed to the project team at: audit-of-violence@cru.rcpsych.ac.uk.</p> |
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that time, it became apparent that some wards for adults of working age had, in error, completed the questionnaire for older people's services, and vice versa. This data was subsequently removed and accounts for the difference of 26 across all respondent groups. However, with such a large total number of respondents, the removal of these cases would have little effect on the overall national results.

National Findings

Contextual information

The results are shown in full at Appendix 4, for England (n=61 wards) and Wales (n=11 wards). **Note:** due to the small number of Welsh wards, extreme caution should be exercised in interpreting the comparative data.

Location: the majority of wards in both England and Wales were located in a mixed urban/rural location (England=61%, Wales=73%).

Bed state: the numbers of beds ranged from 10-32 in England, and 10–24 in Wales, and in England the majority were operating with a bed occupancy of less than 100% (median=91%); this figure was higher in Wales at 100%.

Number of patients detained under the Mental Health Act: although there were a few exceptions (upper range of 9 and 8 in England and Wales, respectively), most wards had limited numbers of detained patients (mean England=3, Wales=2).

Number of consultants with allocated beds: unlike services for working age adults, the numbers of consultants per ward were generally low, with a median of 2 in both countries, and upper ranges of 5 and 4 in England and Wales, respectively.

Recruitment and retention of nursing staff: the number of **funded qualified** posts was the same in both countries (mean=11), however, the range in England was greater (0-19) than in Wales (9-15). Both countries had a mean of 10 **filled qualified** posts. In relation to **funded unqualified** posts, although the mean figure was lower in England than Wales (12, relative to 14 per ward), their range was considerably higher (5-31), compared with Wales (7-21). In England, the mean number of unfilled posts after both 3 and 6 months was lower than in Wales (0.5 compared with 1), but the upper range was notably higher (7 compared to 4, suggesting there are greater recruitment problems in some parts of England).

Administrative support: the majority of wards in both countries could expect to receive between 1 and 29 hours of administrative support per week (England=66%, Wales=55%). In Wales, however, 45% of wards could expect no admin support (compared with 7% in England), while in England, 28% of wards could expect to receive more than 30 hours per week (compared with 0% in Wales).

Policies and procedures: wards were asked about whether they had various policies and procedures in place relating to the prevention and effective management of violence.

- **Risk assessment and management:** in both countries, levels of compliance with this standard were above 90%.
- **Alarm systems:** compliance rates were low in both countries (England 80% and Wales 55%).
- **Accessibility of doctor to attend alarms:** both countries rated poorly at 49% (England) and 55% (Wales).

- **Systems for post-incident support review:** figures were disappointingly low in Wales (55%) compared with England (79%). Wards were also asked whether staff, patients who were involved, carers/family, other patients, and visitor witnesses were able to access these supports. Results were consistently lower in Wales, compared with England (staff: England=84%, Wales=55%; patients who were involved: England=61%, Wales=45%; carers/next of kin: England=61%, Wales=45%; other patients: England=41%, Wales=27%, and visitor witnesses: England=44%, Wales=36%).
- **Searches of patients:** the results were similar for England (77%) and Wales (73%).
- **Children visitors:** compliance rates were similar and high, at 90% and 82% (England and Wales, respectively).
- **Observing high risk patients:** the results, again, were high at 93% and 82% (England and Wales, respectively).
- **Safety of women:** both countries rated low compliances of 46% (England) and 36% Wales, although some of the wards were male-only (10% England and 18% Wales).
- **Using/recording restraint:** the large majority of wards were compliant with this standard (England 85% and Wales 82%), with many of the remainder being rated as 'not applicable', due to them not using restraint.
- **Using/recording rapid tranquillisation:** in England, a similar effect was evident in relation to this intervention with 72% of wards rating this standard as 'met' and a further 18% as 'not applicable', however, in Wales 27% of wards rated this as 'unmet'.
- **Using/recording seclusion:** again, in England, most wards were able to rate this standard as either 'met' or 'not applicable' (36% and 57%, respectively). In Wales, however, 36% of wards rated the standard as 'unmet'.
- **Locking the ward:** in Wales, an impressive 100% of wards met this standard, compared with 72% of English wards, although 15% had rated this as 'not applicable'.
- **Preventing and dealing with harassment and abuse:** again, Wales attained a compliance level of 100%, compared with only 92% of English wards.
- **Supporting patients with disabilities:** the margin of difference between the two countries widened with Wales rating this standards as 100% 'met', compared with only 66% of English wards.
- **The provision of staff training relating to the short-term management of disturbed/ violent behaviour:** 100% of Welsh wards had a policy in place compared with 92% of English wards, however, the level of detail contained in the policy varied, specifically: in England, 85% of policies specified the **level** of training (based on risk assessment), a similar figure to Wales (82%); in England, 90% of policies specified **how often** staff should receive training (compared with 100% in Wales); in England, only 77% of policies described the techniques that would be taught (compared with 100% in Wales), and; in England, 85% of policies specified the need for annual refresher training, compared with 100% of Welsh policies.
- **Protocol to ensure police and staff are aware of the procedures and roles in emergency situations:** only 52% of English wards met this standard, compared with 73% of Welsh wards, though some wards clearly did not have reason to work with the police and rated this standard as 'not applicable' (8% in England, 18% in Wales).

Findings from Modules 1 and 2

Presentation of data

- The table of figures for each question relates to the Module 1 national survey data for older people's services (OPS). Each number indicates the percentage of the total number of respondents from each group i.e. nursing staff, patients, etc - who answered 'yes' or 'no' to each question.
- The text beneath each table offers a summary description of the overall trends across the different respondent groups, and between the different service 'types' i.e. older peoples – organic, older peoples – functional, older peoples – 'mixed'. **Please note:** caution should be exercised in weighting the responses from smaller service types and/or respondent groups (please refer to the table on page 18, for further details). Particular trends that have emerged from the data will be raised in the Discussion section.
- Where appropriate, anonymised quotes from Module 1 have been used to illustrate the common themes that came out of the qualitative data.
- Additional data has been drawn from the Module 2 Environmental Audit.

Notes about the report

- Percentages are presented without decimal points (e.g. 56%, rather than 56.4%), meaning that some totals will be 99% or 101%.
- Quotes have undergone a standard spelling and grammar check but otherwise remain unchanged
- One of the key aims of the audit is to support services to make improvements by comparing their local findings with the national figures, and developing action plans that will help them to deliver positive changes. The audit data was collected between October 2006 and February 2007. It is hoped that the some of the problems identified through the audit will already be the subject of local improvement programmes.

Setting the scene

Experiences of severely challenging/violent behaviour in wards and its management

All respondent groups were asked about their experiences of severely challenging/violent behaviour on the ward, and their perceptions of how these incidents had been managed. Three graded questions were asked to establish **the severity of incidents**.

- Have you personally¹¹ been made to feel **upset/distressed** by a patient's severely challenging/violent behaviour?
- Have you personally been **threatened or made to feel unsafe**?
- Have you personally been **physically assaulted**?

| | Upset/distressed | | Threatened/made to feel unsafe | | Physically assaulted | |
|-----------------------------|------------------|----|--------------------------------|----|----------------------|----|
| | Yes | No | Yes | No | Yes | No |
| Nursing staff | 54 | 46 | 66 | 34 | 64 | 36 |
| Clinical staff | 26 | 74 | 30 | 70 | 20 | 80 |
| Non-Clinical staff | 30 | 70 | 30 | 70 | 23 | 77 |
| Patients | 29 | 71 | 14 | 86 | 6 | 94 |
| Visitors | 11 | 89 | 10 | 90 | 5 | 95 |
| Carer/Next of kin | 43 | 57 | 26 | 74 | 14 | 86 |
| Third party observer | 27 | 73 | 19 | 81 | 19 | 81 |

Relative to the other groups, nursing staff were most likely to experience **all levels** of violence. An alarming 64% reported that they had been physically assaulted. In relation to the first two questions, the figures did not differ markedly between services of different type i.e. for people with organic disorders, people with functional disorders, or 'mixed' wards. Clinical and non-clinical staff were significantly less likely to have been assaulted than their nursing colleagues. Patients, visitors, carers/next of kin and third party observers reported a greater likelihood of feeling upset/distressed, rather than being exposed to more serious threats. For all groups, except non-clinical staff and third party observers, the risk of physical assault was greatest in services for people with organic disorders ('yes': nurses=73%; clinical staff=24%; patients=21%; visitors=7%; carer/next of kin=16%). These findings clearly indicate that staff were carrying out an excellent job 'buffering' others from the threat of violence. Almost 400 respondents chose to comment on this section. The majority of these comments came from nursing staff, and many made disturbing reading. Large numbers of nurses described the common nature of violence on the wards:

"The rate is high and scary"

"Sometimes it feels very much part of the daily routine to be either verbally or physically abused by patients."

As the latter quote explained, these incidents ranged from invasions of personal space or verbal/racial abuse, through to actual bodily harm. Numerous nursing staff described their own experiences, sometimes in very graphic and shocking terms:

¹¹ The following alternative wording was used in the carer/next of kin questionnaire 'has your relative/friend'; and third party observer questionnaire 'did you witness anyone'.

"I expected to be assaulted on every shift I worked. I was punched frequently, kicked often, which resulted in acute inflammation of the knee. I was scratched, squeezed, jumped out on, hit with a fire extinguisher, had furniture thrown at me, including a wheelchair. I have been head butted and spat at, the latter resulting in severe eye infection. Our male patients are often fairly fit and well built and often remember techniques from experiences as a member of the armed forces."

The impact of violence (or the threat of violence) cannot be overstated, as these people explained.

"To be threatened by someone you want to care for hurts deep inside, but you understand that they are hurting deep somewhere and this is their only response to feeling isolated, frustrated, imprisoned, angry, unable to understand, or so that they can feel in control of something." (a nurse)

"It is devastating and frightening when one has been personally affected by violence from the patients. It shakes you completely and you lose confidence in your own work-related skills. The first time a patient hit me I found it hard to be near him and help him. I did it when I had to, but it was hard." (a nurse)

"My relative is very frightened by some of the patients on the ward and has gone very quiet since going in there. I also feel very intimidated by some of the patients when visiting." (a carer)

Many people – most obviously those working, living, or spending time with patients with organic disorders, including the nurse quoted above – expressed enormous compassion and understanding, accepting that the behaviours were generally unintentional.

"Difficulties arise with clients with cognitive deficits who become aggressive when needs are not met/challenged. Incidents occur with minimal warning, and are often instantly forgotten." (a nurse)

"I was hit on the nose a few months ago but it did not bother me. The patient could not help it." (a patient)

"I personally expect this type of behaviour from our patients, but it is part of their illness, not a personal attack on me." (a nurse)

A considerable number of quotes communicated a sense of hopelessness – with individual members of staff often describing their experiences as 'part of the job', as this nurse explained:

"[I've] been assaulted physically many times, but it is part of our work. We have accepted before taking the job that we are dealing with mentally disturbed patients and have accepted that we may be physically harmed/assaulted ... the patients cannot help their behaviour".

In contrast, many other respondents challenged this tendency to accept violence as inevitable, citing several causal factors - some associated with individuals, others with the organisation - all of which will be explored later in this report.

Triggers for violence

Non-staff groups (patients, visitors, carers and third party observers) were asked about what they felt 'triggered' violence on the ward. Almost 200 people commented. A number of common themes emerged.

Firstly, people spoke about problems associated with the physical and mental condition of the resident population, as this visitor explained:

“Patients’ illness. Some seem to be worse than others. Patients are elderly and confused and are not aware they are being abusive, either physically or verbally.”

Secondly, links were made between excessive noise levels, and violence, as this carer described:

“Extraneous noises. Shouting and screaming by other patients”.

Thirdly, many respondents described problems associated with boredom and the lack of activities, as a third party observer explained:

“It is my opinion that many of these violent and aggressive incidents are caused by boredom and frustration and were the patients more involved in therapeutic activity then I feel the incidents would be less frequent.”

Fourthly, people commented on conflict between patients or, as one patient described:

“Other patients pestering me.”

Other less common themes were: factors associated with a poor environment, particularly the lack of space and/or access to external space; staff attitudes and/or behaviours; inadequate staffing levels; difficulties associated with the ‘mix’ of patients that were living together; factors linked to the restrictiveness of the living situation.

The management of severely challenging/violent incidents

Respondents were then asked about their general perceptions about how these incidents had been managed:

- Do you think that staff deal effectively with severely challenging/violent behaviour **between patients?**
- Do you think that staff deal effectively with severely challenging/violent behaviour **towards staff from patients?**

| | Between patients | | Towards staff from patients | |
|-----------------------------|------------------|----|-----------------------------|----|
| | Yes | No | Yes | No |
| Nursing staff | 91 | 9 | 88 | 12 |
| Clinical staff | 92 | 8 | 87 | 13 |
| Non-Clinical staff | 97 | 3 | 98 | 2 |
| Patients | 92 | 8 | 92 | 8 |
| Visitors | 94 | 6 | 96 | 4 |
| Carer/Next of kin | 98 | 2 | 98 | 2 |
| Third party observer | 89 | 11 | 92 | 8 |

The figures were generally high, suggesting that although levels of violence were high, that staff teams were pulling together to support each other. Over 450 people chose to comment on these questions. By far the majority of comments were positive, with large numbers of staff praising their colleagues, as these two quotes from nurses illustrate.

“Although we do get service users who display challenging and violent behaviour, all staff are made aware of the behaviour that the service user can display, and by working as part of the team I always feel safe as I know that staff are there to support me.”

“Staff are supportive on the ward and are excellent at supporting each other through stressful times. Staff are competent and trained in managing difficult situations. Challenging/aggressive behaviour overall tends to be associated with nursing interventions or personal care needs. Care plans are implemented and risks identified and discussed within the team and an agreed plan of action is implemented.”

Many visitors, carers and patients commended staff efforts, as these quotes illustrate:

“The staff appear to deal effectively with extremely challenging and violent patients, in a positive and caring way”. (a visitor)

“Staff are alert and recognise ‘trigger’ points. They make great efforts to protect patients. They are very supportive of each other and work as a team.” (a carer)

Although the margin was small, there was an interesting difference between how nursing and clinical staff, versus visitors and third party observers, perceived the relative effectiveness of management of incidents ‘between patients’ and ‘towards staff’. This would seem to relate to the commonly quoted observation that low staffing levels often meant that violence between patients went unnoticed by staff, as this carer described:

“I am very often witness to the onset of a conflict between two patients, sometimes the staff are not near enough to help prevent an incident happening, it would be good to have at least one member of staff walking around the ward at all times.”

All respondent groups were asked whether they would feel comfortable to confidentially report an incident of **staff abuse towards a patient**. Reassuringly, the large majority of respondents agreed that they would. The lowest expressed confidence, however, came from patients with 21% saying they would not feel comfortable. Only two patients commented negatively on this, while several were clear in their statements that they felt able to talk to staff.

| | Yes | No |
|-----------------------------|-----|-----------|
| Nursing staff | 92 | 8 |
| Clinical staff | 93 | 7 |
| Non-Clinical staff | 90 | 10 |
| Patients | 79 | 21 |
| Visitors | 96 | 4 |
| Carer/Next of kin | 93 | 7 |
| Third party observer | 92 | 8 |

The use of physical interventions

All groups were asked whether they felt that any of a range of physical interventions were being used “too quickly” to manage severely challenging/violent incidents.

| | Using medication | | Using hands-on restraint | | Using seclusion | |
|-----------------------------|------------------|----|--------------------------|----|-----------------|----|
| | Yes | No | Yes | No | Yes | No |
| Nursing staff | 14 | 86 | 9 | 91 | 3 | 97 |
| Clinical staff | 23 | 77 | 10 | 90 | 5 | 95 |
| Non-Clinical staff | 16 | 84 | 7 | 93 | 9 | 91 |
| Patients | 21 | 79 | 14 | 86 | 13 | 87 |
| Visitors | 12 | 88 | 7 | 93 | 5 | 95 |
| Carer/Next of kin | 11 | 89 | 5 | 95 | 6 | 94 |
| Third party observer | 7 | 93 | 8 | 92 | 4 | 96 |

It is perhaps not surprising that the perception of nursing staff differed from that of patients, but it is reassuring to note that visitors and other external respondents (carer/next of kin and third party observers) were generally **even less likely** than nurses to feel that physical interventions were being used too quickly. Nevertheless, over one hundred people chose to comment on these questions. Four common explanations were offered for why staff might be using interventions too quickly.

Firstly, because of the lack of experience, training, or understanding amongst the team that was being expected to manage these incidents, as these quotes illustrate:

“I feel that staff feel the need to resort to hands on restraint too quickly as this is the only training that is available with regards to managing violent behaviour and so really this is the only tool at our disposal. If other training in other non physical techniques were available I feel that this may reduce the frequency of hands on restraint.” (a nurse)

“[Nurses] lack of confidence in their own or others' abilities to defuse a situation effectively.” (a nurse)

“Because there is a panic if anyone has a label of being aggressive and a lack of understanding why or what triggers their aggression ...” (a carer)

The second commonly cited explanation related to ‘fear’, and the need to bring the situation ‘under control’ as quickly as possible, as these nurses explained:

“At times I feel that this is the only way to keep others safe, the clientele is very difficult and can be upsetting others on the ward which can escalate to a more severe problem.”

“To calm the patient down and avoid more harm to others.”

Others were more cynical and suggested a third explanation - that an over-reliance on physical approaches might be linked to poor attitudes and laziness, as these staff explained:

“I feel that 60% of staff here cannot deal with challenging situations effectively i.e. due to lack of patience and understanding, personal attitude.” (a nurse)

“For quick fix effect, so that it is another colleague's problem in the next shift.” (a clinical staff member)

“Often it can bring about an end to a situation by removing the person or administering medication. To verbally de escalate a situation can take a lot longer, although I prefer to use verbal de escalation. Each situation is different and requires a different response.” (a nurse)

The final commonly cited suggestion related to poor staffing levels on the ward, as these quotes from various respondents explained:

"We sometimes use medication to help relax the service user but if we had more staff we could spend more time with our service users." (a nurse)

"My mother on occasion would become agitated in the evening. I believe if staff could have spent more time with her there would have been no need to give her medication." (a carer)

"Lack of staff support while on night duty results in excessive medication." (a clinical staff member)

Concluding comments on experiences of severely challenging/violent behaviour in wards and its management

The findings suggest that, in many wards, levels of violence were unacceptable. The impact on staff, patients and visitors was constant and intolerable. A considerable amount of this violence was 'unintentional' – acted out by people who were no longer able to control their impulses. Many respondents openly recognised this. This awareness, however, did not reduce the pain of the injury, nor the fear that another incident may happen. Nursing staff were bearing the brunt of this violence and should be applauded for the job that they were doing to protect others. They too need, and deserve, to be protected by the organisations that employ them.

An overview of current practice

How organisations support people in unsafe environments

The Guidelines³ identify a range of ways in which staff, patients and visitors can expect to be supported to minimise the risk that they will experience violence on the ward. The audit asked the various respondent groups about the extent to which these supports were available to them. Some sections applied to all respondent groups, others to specific groups.

Understanding the needs of patients (carers/next of kin and third party observers)

Two respondent groups were asked a series of questions relating to the ways in which the ward had worked with them, and their relative/friend, to ensure that they could be cared for in ways that minimised the risk of them demonstrating severely challenging/violent behaviour¹². Over 70 individual comments were received.

Firstly, they were asked about the way that their relative/friend's care had been planned.

| | Carer/Next of kin | | Third party observer | |
|---|-------------------|----|----------------------|----|
| | Yes | No | Yes | No |
| On admission, were you asked to share information on your relative/friend's likes, dislikes and fears? | 81 | 19 | 92 | 8 |
| On admission, were you asked to highlight your relative/friend's strengths and abilities, as well as their problems and needs? | 73 | 27 | 83 | 17 |
| Were you asked to provide background information to staff about your relative/friend's former occupation(s), the people they love/have loved, etc? | 77 | 23 | 94 | 6 |
| Have you been aware of staff making use of any of the information or items you have provided your relative/friend's favourite music, family photographs, personal items and effects, etc, in caring for them? | 77 | 23 | 91 | 9 |

Respondents from both groups were generally positive about their experiences, though consistently more so in the third party observer group. Some typical quotes that describe experiences:

"All I can say is when my uncle was transferred to this ward everybody was concerned because he was not eating or drinking so asked me to come in at supper time and observe to see if there was anything that they were doing wrong, after a few discussions a routine was worked out for my uncle and he began eating and drinking." (a carer)

"Patients and staff were asked to complete personal profiles for each patient which described their likes and dislikes and hobbies etc." (a third party observer)

¹² Third party observers were asked to comment based upon their observations.

"[They] asked me how he likes being showered, does he like a bath or a shower, little things that I know – doesn't like food touching each other on the plate, little personal things they asked me. Quite thorough." (a carer)

Next, they were asked two questions relating to their observations of the care received by patients on the ward:

| | Carer/Next of kin | | Third party observer | |
|--|-------------------|----|----------------------|----|
| | Yes | No | Yes | No |
| Have you witnessed staff caring for patients in a meaningful, person-centred way? | 98 | 2 | 96 | 4 |
| Do staff recognise when patients are in need of help e.g. feeling hungry or thirsty, or being in discomfort or pain? | 100 | 0 | 98 | 2 |

With compliance ratings from both groups close to 100%, many respondents praised staff teams for their efforts:

"Because I visit the ward daily I do not always go at the same time of day. Therefore I see the ward at various degrees of activity sometimes busy, very busy, very occasionally a quiet period, but whatever time of day, I have not seen anyone ignored who is in need of anything, for whatever reason." (a third party observer)

"Person centred care is the underlying philosophy on the Ward, there are training sessions on induction and these are repeated during the year as an ongoing rolling training programme. Dementia care mapping also takes place on the Ward." (a third party observer)

"I am very happy [with] the way the staff care for my mother. They have got to know her very well." (a carer)

"I think every effort is made to look after patients needs, sometimes when staff are busy this may take a little longer. I have found that when pain is reported that the staff act very quickly and get medical help immediately." (a carer)

Concluding comments on understanding the needs of patients

The findings from this section of the data suggested that in most wards, patients were being cared for using person-centred approaches. Several carers were at eager to point out that this was being achieved in the face of considerable constraints, such as low staffing levels and the absence of activities. The following quote from a carer is fairly typical:

"Staff really try to understand and meet the needs of my relative."

Being treated with respect and dignity, and given privacy and choice (patients, carers/next of kin and third party observers)

Patients, carers and third party observers were asked a number of questions about how they felt they (or their relative/friend) had been treated during their stay. Over 180 individual comments were received.

Religious and cultural needs

Firstly, they were asked whether the ward respected religious and cultural needs, e.g. religious festivals, diet.

| | Yes | No | N/A |
|-----------------------------|-----|----|-----|
| Patient | 62 | 5 | 33 |
| Carer/Next of kin | 58 | 3 | 39 |
| Third party observer | 72 | 3 | 25 |

The figures above indicate that for those patients who did have specific religious or cultural needs, these were consistently being met. Very few respondents commented on this aspect of their experience.

Respect and dignity

Respondents were then asked whether staff treated patients with respect.

| | Yes | No |
|-----------------------------|-----|----|
| Carer/Next of kin | 99 | 1 |
| Third party observer | 99 | 1 |

Again, results (above) suggested excellence in practice by members of the team, as these quotes also illustrate:

"The patients always look smart and clean but if (as is the case of my husband) a shave is declined, he is not forced". (a carer)

"I visit the ward on a daily basis ... and can honestly say that I have always seen patients, staff and visitors treated with the utmost respect and dignity." (a third party observer)

Linked to this, respondents were asked the question 'Have patients been cared for in a dignified manner'?

| | Yes | No |
|-----------------------------|-----|----|
| Patient | 92 | 8 |
| Carer/Next of kin | 98 | 2 |
| Third party observer | 99 | 1 |

Another highly rated question - though less so by patients. The qualitative data suggested that where problems did exist, these were associated with mixed sex wards, laundry complications with clothes going missing, and low staffing levels impacting on patients' access to nurses when they needed them. In general, the comments were positive:

"Should a patient begin to do something which would compromise their dignity, the staff are quick to act and avert the situation." (a carer)

Medication

Patients were asked whether they had privacy when they were being given medication. A disappointing 40% answered 'no', though only one patient chose to comment on this and stated that it was 'not needed'.

Respondents were asked whether they had ever asked for their medication to be reviewed.

| | Yes | No |
|-----------------------------|-----|----|
| Patient | 29 | 71 |
| Carer/Next of kin | 36 | 64 |
| Third party observer | 28 | 72 |

Of those that had, the large majority had been successful, as the table below demonstrates

| | Yes | No |
|-----------------------------|------------|----|
| Patient | 84 | 16 |
| Carer/Next of kin | 100 | 0 |
| Third party observer | 93 | 7 |

Personal preferences

People were then asked whether patients' personal preferences e.g. in relation to food and drink choices, going to bed, and clothing, were respected. Levels of compliance were consistently high across all respondent groups, as the table below shows. Where problems were described, these were most commonly associated with lack of food choice, and patients having to wear clothing that belonged to other patients because theirs had been lost.

| | Yes | No |
|-----------------------------|-----------|----|
| Patient | 88 | 12 |
| Carer/Next of kin | 92 | 8 |
| Third party observer | 97 | 3 |

Opportunities to go outside/leave the ward

Respondents were asked whether patients had opportunities to go outdoors/leave the ward. The responses (table below) were disappointingly low, with one-quarter of patients, almost one-third of carers/next of kin, and one-fifth of third party observers, answering 'no' to this question. This echoed the finding from the Environmental Audit where this standard was rated as 'met' in only 76% of wards. These problems were most noticeable in wards for people with organic disorders, where 32% of patients, 29% of carers/next of kin, and 27% of third party observers answered 'no'. A few people explained problems associated with the ward not being on the ground floor, and/or problems finding enough staff to escort patients outside.

| | Yes | No |
|-----------------------------|-----|----|
| Patient | 76 | 24 |
| Carer/Next of kin | 69 | 31 |
| Third party observer | 82 | 18 |

Access to staff

All groups were asked whether they agreed that they were able to speak to staff when they needed to, for example, if they are concerned or upset. Reassuringly, in all groups, less than 10% of respondents said they couldn't.

| | Yes | No |
|-----------------------------|-----|----------|
| Patient | 91 | 9 |
| Visitor | 97 | 3 |
| Carer/Next of kin | 98 | 2 |
| Third party observer | 97 | 3 |

Where problems did exist, this seemed to be linked most commonly to staff shortages, about which respondents were often highly sympathetic, as this quote from a third party observer illustrates:

"Apart from the time restrictions on staff nurses due to an enormous amount of paperwork they still managed to spend time with patients and family members."

All groups were then asked whether they felt that their concerns had been taken seriously and acted upon. Findings from the majority of groups were exceptionally high, with less than 5% of respondents answering 'no' (see table below). The overall figure for patients was lower ('no'=12%), although this figure was highest in services for people with organic disorders (21%) (n=19). Very few patients chose to comment on their experiences.

| | Yes | No |
|-----------------------------|-----|-----------|
| Patient | 88 | 12 |
| Visitor | 96 | 4 |
| Carer/Next of kin | 95 | 5 |
| Third party observer | 96 | 4 |

Advance statements

Patients were asked whether, when they were admitted to the ward, they were asked about what they would, and would not, wish to happen if their behaviour became severely challenging/violent; only 9% said that this had happened. They were then asked whether they had been asked about their trigger factors and early warning signs of severely challenging/violent behaviour and how these should be managed; only 12% said that this had happened - yet no-one chose to comment directly on either question, suggesting that it might not have been seen as important/relevant to them.

Concluding comments on being treated with respect and dignity, and given privacy and choice

Compliance with these standards was consistently high, suggesting that good practice in these areas prevails in most wards. As the audit invited feedback from a range of external visitors to the wards, levels of confidence in this finding can be taken as high. Where problems in meeting standards were described, these were often linked to low staffing levels.

Being offered meaningful occupation (patients, carers/next of kin and third party observers)

The links between boredom levels and severely challenging/violent behaviour are well-recognised and documented. The audit asked patients, carers/next of kin and third party observers a series of questions about the extent to which patients were being given access to a range of activities. Over 170 people commented on this section.

Daily opportunities to take part in group interaction and/or recreation

Firstly, they were asked about whether patients had daily opportunities to take part in group interaction and/or recreation (table below). Perhaps not surprisingly, carers were far more likely than either other group to feel that these were not available, perhaps reflecting their higher expectations for their loved ones. Again, unsurprisingly, all respondent groups in services for people with organic disorders rated a lower level of compliance than either 'mixed' or 'functional' wards ('yes': patient=65%; carer/next of kin=53%; third party observer=84%).

| | Yes | No |
|-----------------------------|-----|-----------|
| Patient | 82 | 18 |
| Carer/Next of kin | 62 | 38 |
| Third party observer | 91 | 9 |

Daily opportunities for physical activity/ exercise

The next question asked whether patients had daily opportunities for physical activity/ exercise. The range of responses to this question was much narrower, with no fewer than one-third of respondents saying this did not happen (see table below). The figures, again, were lowest in 'organic' services ('yes': patient=45%; carer/next of kin=43%; third party observer=67%). Despite this poor response, relatively few respondents chose to comment on their experiences.

| | Yes | No |
|-----------------------------|-----|-----------|
| Patient | 62 | 38 |
| Carer/Next of kin | 57 | 43 |
| Third party observer | 68 | 32 |

Choice of therapies and activities (during the day)

Next, respondents were asked about the choice of therapies that were available during the day (table below). The average figure for non-compliance amongst the groups grew closer to an alarming 50%.

| | Yes | No |
|-----------------------------|-----|-----------|
| Patient | 52 | 48 |
| Carer/Next of kin | 50 | 50 |
| Third party observer | 53 | 47 |

These figures were very similar to the ones received when respondents were asked whether patients had an adequate choice of activities available during the day. Again, services for people with organic disorders came out worst, with 68% of patients, 69% of carers/next of kin and 40% of third party observers answering 'no'.

| | Yes | No |
|-----------------------------|-----|-----------|
| Patient | 56 | 44 |
| Carer/Next of kin | 49 | 51 |
| Third party observer | 58 | 42 |

Many carers described their experiences and concerns:

"As my mother is physically active and loves exercise and activities, I feel there are not enough of these to keep her stimulated. There are a lot of staff about but not keeping the more able active. Even playing a simple game of cards or board game would be beneficial."

"I have never seen any activities undertaken with any patients although I only visit in the afternoon. My visits might just coincide with a quiet time. Patients just seem to wander around or sit alone."

"Patients tend to sit around watching TV. An OT does visit but I understand this resource has recently decreased. Physiotherapy services have also recently been withdrawn."

The comments from patients described a mixture of positive and negative experiences, but these two comments described the experience of boredom, and its impact for some:

"The days seem very long and ditto the evenings, but that may be inevitable, considering the lack of adequate therapy for patients suffering from various mental and emotional problems."

"Sometimes I get upset and time seems to go slowly."

Choice of activities (during the evening and at weekends)

Finally, people were asked about the adequacy of 'out-of-hours' activities. Perhaps unsurprisingly, the figures dropped even further (table below). Many people described the sheer absence of activities of any sort. The problems were greatest in 'organic' services ('no': patients=79%; carer/next of kin=74%; third party observer=41%).

| | Yes | No |
|-----------------------------|-----|-----------|
| Patient | 33 | 67 |
| Carer/Next of kin | 28 | 73 |
| Third party observer | 48 | 52 |

Concluding comments on the provision of meaningful occupation

Clearly there is much room for improvement in relation to these standards. The findings revealed that the reduction in the risk of violence associated with reduced levels of boredom, and the benefits to physical and mental well-being associated with opportunities for activities, were not being maximised. Problems were greatest in services for people with organic disorders – where the challenges to engage people in a meaningful way were further complicated by the conditions that affected them.

Being listened to and given adequate information (patients only)

Patients were asked questions about their experiences in relation to a series of different situations. Comments were received from 45 individuals.

| | Yes | No |
|---|-----|----|
| Have you been given enough information about why you have been admitted to the ward? | 64 | 36 |
| Have you been given enough information about how the ward is run, e.g. visiting times, complaints procedure, ward rounds? | 71 | 29 |
| Are you satisfied with your involvement in decisions about your care (e.g. treatment and medication)? | 79 | 21 |
| Have you been given enough information about how to get advice or help from someone who does not work here, e.g. an advocate? | 40 | 60 |
| Have you been put under close observation during your admission to this ward? | 36 | 64 |
| If you have been put under close observation during your admission to the ward: | | |
| Was the reason you were put under observation explained to you? | 83 | 17 |
| Were you told how long observation was likely to be maintained? | 38 | 63 |

Compliance rates from wards for people with organic disorders were generally lower, probably reflecting the difficulties associated with delivering information to people with cognitive problems. The comments received contained a mixture of positive and negative feedback, seeming to reflect that some wards were better at keeping people informed and involved than others, as these two contrasting quotes illustrated:

"When I first entered the ward I was given all the information I needed".

"I feel I have to 'ferret' out information."

The content of the comments was highly individualised and no common themes emerged.

Concluding comments on being listened to and given adequate information

The provision of information is a fundamental right. It was clear that many people resident in older people's services were not being given this right. The data indicated the presence of good practice, even in relation to information-sharing with people with organic disorders. However, more needs to be done to share this expertise.

A safe physical environment (all respondent groups)

The 1998 and 2005 Guidelines¹ contain substantive recommendations about the ways in which organisations can minimise risk in relation to the physical environment. Many of these relate to the provision of specific safety features; others, to environmental precipitants of violence. The audit examined compliance with these standards in relation to four areas:

- Environmental safety
- Environmental privacy and security
- Environmental comfort
- Supporting individual needs

Over 650 individual comments were received on these subjects.

Environmental safety

The audit asked questions relating to the presence or absence of a range of recommended safety features.

De-escalation area

When patients have become distressed or angry, have you generally been able to access a quiet area/separate room on the ward where they can be supported by staff?

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 78 | 22 |
| Clinical staff | 80 | 20 |
| Non-Clinical staff | 87 | 13 |

The responses (above) from all three staff groups were similar and comments frequently related to problems with space; as one nurse simply put it:

"There is no space to accommodate distressed or angry patients."

Alarm systems

All staff groups were asked about the adequacy of alarm systems on the ward.

| | Is the emergency alarm system on this ward effective? | | Is a personal safety alarm available for your use? | | Does the ward have a consistent and rehearsed response to emergency alarm calls (including personal safety alarm calls)? | |
|---------------------------|---|----|--|----|--|----|
| | Yes | No | Yes | No | Yes | No |
| Nursing staff | 75 | 25 | 57 | 43 | 61 | 39 |
| Clinical staff | 82 | 18 | 54 | 46 | 69 | 31 |
| Non-Clinical staff | 86 | 14 | 54 | 46 | 85 | 15 |

Comments relating to alarm systems indicated that the provision of effective equipment and systems was not always given a high priority. Some nursing staff commented that the ward did not have a system and/or a planned response, and others reported that their alarm

system did not operate effectively in all parts of the ward, leaving staff feeling exposed and vulnerable. Some wards clearly struggled to provide personal alarms to all staff, even though their use would be valued by staff, as this nurse explained:

"We would really like personal alarms so when we are attacked ... we can get help."

This seemed to be less of a problem on wards for people with functional disorders (yes=68%), compared with either 'organic' (yes=57%) or 'mixed' wards (yes=54%). This was also reflected in the responses to related standards in the Environmental Audit.

| Standard | Met | Not Met |
|--|-----|---------|
| Furniture is arranged so that alarms can be reached and doors are not obstructed | 78 | 22 |
| There are accessible alarms in interview rooms, reception areas, and other areas where one patient and one staff member work together | 55 | 45 |
| There is a system that ensures that all alarms (for example panic buttons and personal alarms) are well maintained and checked regularly | 69 | 31 |

Additional safety standards

The Environmental Audit asked teams to rate compliance with a number of safety standards:

| Standard | Met | Not Met | PEAT ¹³ | N/A |
|---|-----|---------|--------------------|-----|
| Sight lines are unimpeded | 31 | 69 | | |
| There are good routes of entry and exit in the event of an emergency e.g. fire, disturbed/violent behaviour | 67 | 19 | 14 | |
| A crash bag is available within 3 minutes ¹⁴ | 71 | 24 | | 5 |
| Crash bag equipment is maintained and checked weekly ¹⁵ | 83 | 10 | | 7 |
| There is a designated area or room specifically for the purpose of reducing arousal and/or agitation. This is in addition to a seclusion room | 55 | 45 | | |
| There is a designated seclusion room which is 'fit for purpose' | 7 | 9 | | 84 |
| A copy of the policy for preventing and dealing with all forms of harassment and abuse is displayed prominently | 59 | 41 | | |

In general, levels of compliance were low. In relation to observations and sight lines, the kinds of problems experienced were summarised by this quote from a nurse:

"[The] ward is not suitable for elderly patients, [it is] too spread out with long distances between bedrooms, lounges and dining room. Also, being located on the third floor, there is no access to a garden unless accompanied, which is usually impossible due to limited staffing."

The finding that almost one-quarter of wards that used rapid tranquillisation, seclusion or physical interventions did not have ready access to a crash bag is extremely worrying: some teams explained that the specified range of equipment was incomplete, or that there were problems in accessing the equipment quickly; on a positive note, many reported that the problem was now being addressed.

¹³ PEAT – Patient Environmental Action Team, applicable in England but not Wales

¹⁴ This standard was preceded by the guidance note 'this would apply in settings where rapid tranquillisation, physical intervention and seclusion might be used.'

¹⁵ See footnote 14

Environmental privacy and security

Single-sex areas

Patients were asked about whether they had to share space with members of the opposite sex when they did not want to: overall, 16% of patients did not feel that this standard was being met. When broken down according to ward 'type', the greatest problems were on 'functional' wards, where 20% of patients answered 'no' to this question. Although this figure seemed high, only two patients provided comments, and did so in general terms, stating a preference for single sex wards. A few staff commented about the impact of mixed sex wards, none favourably:

"It is a mixed ward, makes it unsafe for females on the male corridor." (a nurse)

"A return to single sex wards as it seems to be men who are most disruptive and abusive." (a carer)

Personal privacy issues were also addressed in the environmental audit. Levels of compliance were often low.

| | Met | Not Met | PEAT | N/A |
|---|-----|---------|------|-----|
| There are single sex toilets | 79 | 21 | | |
| There are single sex washing facilities | 76 | 24 | | |
| There are single sex day areas | 26 | 57 | 9 | 9 |
| There are single sex sleeping accommodation | 81 | 5 | 14 | |

For those wards that were experiencing problems, some were able to find simple solutions such as improving signage. For others, more costly solutions were needed, such as buying another hoist. For a number of wards, the sheer lack of space meant that short-term solutions were practically and financially impossible. Others explained that the very needs of their resident population meant that privacy could not be guaranteed e.g. when an elderly person with dementia wandered into a single-sex area. In relation to sharing day areas, some wards stated that they made a positive choice to encourage integration and that single-sex areas went unused.

Patient 'mix'

Problems associated with the more general issue of patient 'mix' were raised by a large number of respondents, as the following quotes illustrate:

"On the unit there is a mix of frail and challenging clients, which makes it stressful for both clients and staff." (a nurse)

"The mix of patients is not good. Some need more attention than others and in the case of my 'patient' it is very upsetting to listen to violent threats and sometimes violent behaviour." (a carer)

"The mix of vulnerable frail patients with aggressive paranoid patients with the added problems of confusion and wandering make for a volatile unstable environment." (a nurse)

Private spaces

The Environmental Audit asked additional questions that related to specific 'types' of private spaces.

| Standard | Met | Not Met | PEAT | N/A |
|---|-----|---------|------|-----|
| Provision is made for children visiting the ward | 67 | 19 | 2 | 12 |
| There is a separate area to receive patients with police escorts | 31 | 36 | | 33 |
| Patients have access to an outside area which is adequately fenced to ensure privacy and security | 76 | 24 | | |
| Patients can lock their bedroom doors (with external staff override) | 41 | 47 | | 12 |
| Patients can lock bathroom doors (with external staff override) | 72 | 14 | | 14 |
| Patients can lock toilet doors (with external staff override) | 86 | 12 | | 2 |

Although compliance with the standard relating to access to external space was worryingly poor at only 76%, surprisingly few teams chose to comment on this.

Patients were asked about storage of and access to their belongings: satisfaction levels were generally good (see below) and few comments were offered.

| | Storage | | Access | |
|-----------------|---------|----|--------|----|
| | Yes | No | Yes | No |
| Patients | 75 | 25 | 91 | 9 |

The Environmental Audit addressed the same issue with the standard 'Personal effects are safe and accessible' which was rated as **met by 50% of wards**, surprisingly lower than the patients' own rating, perhaps reflecting differing expectations between patients and the teams carrying out the Environmental Audit.

Environmental comfort

The standards explored the extent to which wards were able to offer a comfortable environment in which known potential triggers for violence – over-crowding, noise, uncomfortable temperatures, etc – were minimised.

Adequate space

All respondent groups were asked whether they felt there was enough space on the ward.

| | Yes | No |
|-----------------------------|-----|----|
| Nursing staff | 60 | 40 |
| Clinical staff | 72 | 28 |
| Non-Clinical staff | 75 | 25 |
| Patients | 84 | 16 |
| Visitors | 87 | 13 |
| Carer/next of kin | 83 | 17 |
| Third party observer | 88 | 13 |

The quantitative results (above) showed that nursing staff were most likely to rate space on the ward as inadequate.

This finding was also reflected in the qualitative data, with many nurses opting to comment on the associated problems, sometimes referring to the ward in general terms:

"If numbers are high it becomes cramped and can become noisy and stressful to be in."

At other times, references were made to specific environmental shortfalls:

"You need a proper quiet room, really".

In the Environmental Audit, the standard 'There is a perception of space and overcrowding is avoided' was rated as 'not met' by 22% of wards.

Noise levels

All groups were asked about excessive noise levels during the day and during the night.

| | During the day | | During the night | |
|-----------------------------|----------------|----|------------------|----|
| | Yes | No | Yes | No |
| Nursing staff | 55 | 45 | 18 | 82 |
| Clinical staff | 26 | 74 | 12 | 88 |
| Non-Clinical staff | 35 | 65 | 10 | 90 |
| Patients | 27 | 73 | 21 | 79 |
| Visitors | 17 | 83 | | |
| Carer/next of kin | 25 | 75 | | |
| Third party observer | 20 | 80 | | |

Nursing staff were more likely than any other respondent group to rate day time noise levels as 'excessive', although over one-third of non-clinical were apparently unhappy too. This finding may have related to the fact that these two groups generally spend more time on the ward than others. Nurses on wards for people with organic disorders were far more likely to rate daytime noise levels as excessive, relative to their colleagues in either 'functional' or 'mixed' wards (67%, compared with 37% and 46%, respectively). Interestingly (though perhaps not surprisingly), patients were most likely to rate night-time noise levels as excessive. Overall, very few respondents commented on the problems associated with noise levels, and those that did described either environmental factors (e.g. loud TVs, slamming doors), or noisy patients. The fact that so many staff gave a negative rating to noise levels, and yet so few chose to comment, may reflect the fact that dealing with noise was seen as 'part of the job'.

The Environmental Audit asked local teams to rate themselves against the standard 'Noise levels are adjusted to meet the needs of the people living/residing on the ward'. This standard was rated 'not met' by 16% of wards. Linked to this, teams were asked to look at compliance with the standard 'There are adequate quiet spaces for patients for prayer and quiet reflection', which was not met by 24% of wards.

Temperature levels and ventilation

All groups were asked about their experiences of the temperature on the ward.

| | Too hot | | Too cold | |
|-----------------------------|-----------|----|-----------|----|
| | Yes | No | Yes | No |
| Nursing staff | 58 | 42 | 40 | 60 |
| Clinical staff | 35 | 65 | 20 | 80 |
| Non-Clinical staff | 57 | 43 | 18 | 82 |
| Patients | 30 | 70 | 25 | 75 |
| Visitors | 30 | 70 | 13 | 87 |
| Carer/next of kin | 23 | 77 | 11 | 89 |
| Third party observer | 19 | 81 | 14 | 86 |

Nursing and non-clinical staff were far more critical of over-heated temperatures, perhaps reflecting the fact that they are the groups most likely to be exposed to them and expected to work in them. Similarly, nurses were most likely to rate the ward as too cold: the comments indicated that drops in temperature were most common during the night, which would have impacted on nursing staff more than any other group.

Other aspects of environmental comfort

All groups were asked whether the ward was homely and comfortable in respect of lighting and appropriate décor and music. Nursing and clinical staff were more negative than other respondent groups (see table below).

| | Yes | No |
|-----------------------------|-----------|----|
| Nursing staff | 68 | 32 |
| Clinical staff | 63 | 37 |
| Non-Clinical staff | 87 | 13 |
| Patients | 83 | 17 |
| Visitors | 79 | 21 |
| Carer/next of kin | 81 | 19 |
| Third party observer | 86 | 14 |

Criticisms were commonly linked to the limitations imposed by the design/layout, the condition of the furnishings/décor, or the 'clinical' nature of the ward, as the following quotes from nursing staff illustrate:

"Most of the bedrooms okay - a couple [are] too small ... too warm in lounge - windows do open but don't open very wide ... not homely, comfortable and acceptable - carpets are past sell by date; very drab."

"The finish of the ward is clean and practical but could be more homely."

"Gloomy, depressing, unstimulating environment."

Visitors and carers were generally more accepting of the environmental limitations and often spoke positively of the efforts made by staff to make the ward homely, as the following quotes described:

"Clinical looking in parts, but it is a hospital so to be expected." (a visitor)

"Every effort is made to make patients comfortable and provide a suitable environment." (a carer)

Visiting arrangements

Two of the non-staff groups were asked about whether open visiting was encouraged. Wards for people with functional disorders were considerably less likely than either wards for people with organic disorders or 'mixed' wards to encourage open visiting. This may have been linked to the requirement for 'organic' wards to be more flexible around the visiting needs for people who were resident on a long-term basis.

| | Yes | No |
|----------------------|-----|----|
| Carer/next of kin | 85 | 15 |
| Third party observer | 72 | 28 |

Additional 'comfort' standards

The Environmental Audit looked at a number of other factors that contribute to the creation of a pleasant, comfortable and therapeutic environment. National compliance with these basic standards was often disappointingly low.

| Standard | Met | Not Met | PEAT | N/A |
|---|-----|---------|------|-----|
| All areas look clean | 66 | 12 | 22 | |
| All areas look friendly | 66 | 19 | 16 | |
| All areas smell clean | 60 | 19 | 21 | |
| There is access to natural daylight | 76 | 9 | 16 | |
| There is access to natural fresh air | 81 | 19 | | |
| Internal smoking areas/rooms have powerful ventilation and are fitted with a smoke-stop door(s) | 28 | 34 | 7 | 31 |
| There is an activity room on the ward | 71 | 29 | | |
| There is a day room with a television | 98 | 2 | | |
| Meals and other foods (finger foods) are available outside of mealtimes | 93 | 7 | | 0% |

In relation to cleanliness, however, many visitors and carers chose to comment favourably, as the following quote illustrates:

"The ward is generally clean. Staff are quick to clear any 'mess'." (a carer)

Supporting individual needs

The Environmental Audit asked about whether the ward provided suitable access and facilities for people who have special needs. This standard was 'not met' by 24% of wards. It also asked about aspects of ward design that related specifically to the needs of people with dementia:

| Standard | Met | Not Met | PEAT | N/A |
|---|-----|---------|------|-----|
| Long, narrow corridors, numerous doors, or corridors that lead to locked doors and dead-ends, are avoided | 62 | 38 | | 0% |
| Doors are colour-coded to help patients to identify rooms. There are clear and simple signs at a visible height | 40 | 60 | | 0% |
| The ward environment helps patients become and remain oriented | 79 | 21 | | 0% |

The findings suggested there was considerable room for improvement. While many wards stated that there was nothing that could be done to remedy their problems, short of closing the ward, others described do-able and often affordable solutions: improving lighting, use of colour, or signage; adding mirrors; breaking up long corridors using pictures or furniture.

Concluding comments a safe physical environment

It is clear that many wards were struggling to provide care in unsuitable environments. The impact of environmental failings would seem to be felt most acutely by the staff who were spending the greatest amounts of time on these wards, namely, nurses and non-clinical staff.

In relation to maximising safety, the findings indicated that more could be done to protect patients and staff – either by providing better alarm systems and/or response procedures, or by ensuring that specific safety features were provided - such as a room specifically for the purpose of reducing arousal and/or agitation.

In spite of the environmental failings described above, patients, visitors and carers were considerably more likely to comment positively about the ward, rather than negatively, as the following quotes illustrate:

“Every effort seems to be directed in maintaining a clean and comfortable environment for the patients and visitors.” (a patient)

“The ward has an open, accepting environment. Clients can move around, sit where they like. There are quieter areas and also a more visually stimulating area.” (a visitor)

Most commonly, these comments related to the general atmosphere of the ward, and acknowledged the considerable role of the staff team in creating a positive living space, as these quotes illustrate:

“Friendly atmosphere, welcoming and safe.” (a third party observer)

“Always a pleasant atmosphere, staff always pleasant and helpful.” (a visitor)

Strong communication systems and positive ward culture (all staff groups)

This section relates to experiences of the staff working on the ward and examines aspects of team working and communications. Over 350 comments were received.

Team communication systems

All staff groups were asked whether they felt they had sufficient opportunities to raise and discuss issues with colleagues on the ward.

| | Yes | No |
|---------------------------|-----|-----------|
| Nursing staff | 80 | 20 |
| Clinical staff | 89 | 11 |
| Non-Clinical staff | 91 | 9 |

In general, staff spoke highly of the supports that they received from their colleagues, as the following quote from a nurse illustrates:

"Open communication from all levels of staff. Regular staff meetings/handovers. IT communication, forum meetings, open and friendly culture. Staff very caring and approachable. Good team spirit."

One-fifth of nurses, however, answered 'no' to this question. Problems were greatest in wards for people with organic disorders, with 23% answering 'no', compared with 15% in 'functional' wards. Examination of the qualitative data revealed a number of common themes: inadequate communications systems, such as poorly attended or badly structured handovers; nursing assistants feeling that they were not being listened to by their qualified colleagues; variation in the extent to which staff were willing to support their colleagues, as one nurse described:

"On the ward there are half the staff prepared to assist while others are more than happy to pass the buck and let somebody else deal with potential risks."

All groups were then asked whether their concerns were taken seriously and acted upon.

| | Yes | No |
|---------------------------|-----|-----------|
| Nursing staff | 72 | 28 |
| Clinical staff | 85 | 15 |
| Non-Clinical staff | 88 | 12 |

Again, nursing staff were more likely than their colleagues to feel that their concerns were not being taken seriously. Sometimes, this was linked to problems amongst the members of the ward-based team, as these nurses explained:

"Orders are given and accepted"

"[This] varies greatly depending on staff in charge"

More commonly, however, this was associated with the failure on the part of the senior management teams to address problems, as these quotes explained:

"When concerns are taken further up chain it is often felt that budgetary constraints are taken into account, therefore leaving an already exhausted ward to continue to 'cope.'"

"Internally staff communicate well between themselves and feel comfortable, however I feel uncomfortable and untrusting of management."

All groups were asked about the effectiveness of the hand-over systems.

| | Yes | No |
|---------------------------|-----|-----------|
| Nursing staff | 86 | 14 |
| Clinical staff | 77 | 23 |
| Non-Clinical staff | 93 | 7 |

As previously mentioned, some wards were experiencing problems with their handover systems. Interestingly, the lowest rating came from clinicians: few comments were made, but these related to the poor structure of handovers, or variable attendance by members of the multi-disciplinary team.

Staffing on the ward

All staff groups were asked whether the staffing on the ward was appropriate to the resident population in relation to 'ratios', 'skills mix', 'gender' and 'ethnicity'.

| | Staff ratios i.e. number of staff on each shift | | Staff skill mix i.e. experience and qualifications of staff | | Gender mix of staff | | Ethnic mix of staff | |
|---------------------------|---|-----------|---|-----------|---------------------|-----------|---------------------|-----------|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| Nursing staff | 61 | 39 | 76 | 24 | 50 | 50 | 70 | 30 |
| Clinical staff | 72 | 28 | 73 | 27 | 63 | 37 | 75 | 25 |
| Non-Clinical staff | 76 | 24 | 91 | 9 | 76 | 24 | 86 | 14 |

Ratios: Perhaps not surprisingly, many nursing staff felt that the ratios of staff were not appropriate to the ward population. Many spoke of wards operating at basic staffing levels, with problems accessing additional staff if the level of patient need increased. These problems were greatest in wards for people with organic disorders, where 42% of nursing staff, 21% of clinical staff, and 27% of non-clinical staff felt this standard was not met. Some respondents described the negative impact on team working and communications associated with using bank or agency staff.

Skills mix: Interestingly, clinical staff were most likely to rate the skills mix of the ward staff as inappropriate – most particularly in 'functional' wards (38%), compared with 'organic' (23%) and 'mixed' (26%) - and though few commented directly about the problems, some inferred that some staff lacked adequate experience.

Gender: In relation to gender, overall, one-half of nursing staff felt the ratios were not appropriate to the needs of the patients. This was particularly evident in 'organic' wards, where 54% of nurses, 37% of clinical staff, and 28% of non-clinical staff felt the standard was not being met (compared with 39%, 24% and 7%, respectively, in 'functional' services). The most commonly cited request, both from the perspectives of dignity and safety, was for more male staff:

"[The ward has] not always had males on nights and its all male patients - some of them want men to wash them, understandable." (a nurse)

"I have dealt with many emergency admissions in the middle of the night when a patient has been brought in by 4 policemen and 2 ambulance crew, handcuffed, then left on the ward where 3 female staff have to deal with that patient - fear, anger, aggression, confusion, disorientation, plus supporting and safeguarding 19 other elderly vulnerable persons."
(a nurse)

In relation to whether wards were staffed according to the needs of the patients, many staff pointed towards a more fundamental problem – a mismatch between the perceived and actual needs of the resident population, as these nurses explained:

"Management [are] under the illusion that when you reach 60 years of age you become frail, weak and a loss of stamina kicks in."

"Having worked both acute and elderly, the elderly can be significantly more aggressive due to their illness, particularly dementia."

Ethnicity: Thirty percent of nursing staff and 25% of clinical staff thought that the ethnic mix of staff was inappropriate to the resident population. This was reflected in comments regarding communication problems due to language barriers between staff and patients, often in relation to bank and/or agency staff. This nurse's comment reflects the general message:

"If anything there is probably an over representation of ethnic minorities in staffing from the bank nurse side."

Access to additional resources: all groups were then asked whether they had access to additional resources when the ward had a difficult mix of patients.

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 46 | 54 |
| Clinical staff | 62 | 38 |
| Non-Clinical staff | 57 | 43 |

The results revealed a difference in experience between nursing staff, compared with other members of the clinical team. Many nurses commented upon the impact of patient mix on the ward, in general terms, but also in relation to safety in particular:

"Sometimes it seems that 'functional' patients lose out on attention from staff when there are several patients with challenging behaviours on the ward taking up considerable amounts of ward staff time per shift."

"I think we should not mix violent behaviour patients and physical frailty as this affects the physical frailty".

In relation to the availability of additional staff to support such situations, not all nurses felt they were able to access help, as this nurse described:

"If [the ward has] a difficult mix of patients, extra staff are required, but usually not available, and staff on shift just have to cope."

Some respondents explained that in their wards, replacement staff were simply not available; others spoke about the problems associated with using untrained bank and/or agency staff:

"When we do get in outside staff they are generally poorly trained and motivated." (a nurse)

Multi-disciplinary team working

Satisfaction with the provision of consensus-driven multi-disciplinary care was consistently high across all respondent groups, as these quotes illustrate:

| | Yes | No |
|---------------------------|-----------|----|
| Nursing staff | 90 | 10 |
| Clinical staff | 92 | 8 |
| Non-Clinical staff | 93 | 7 |

"Communication clear and effective between clinical staff - regular handover and MDT meetings" (a nurse)

"The ward culture and routine are flexible and geared to individuals. Communication systems appear adequate i.e. Handovers, ward diary, Multi disciplinary meetings etc." (a nurse)

Staff were then asked whether they had a say about admissions onto the ward.

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 24 | 76 |
| Clinical staff | 55 | 45 |
| Non-Clinical staff | 37 | 63 |

The results showed a difference in perspective between nurses and other members of the clinical team. Comments seemed to indicate national variations in practice, as these two contrasting quotes from nurses illustrate:

"The consultants alone make the decisions to admit patients, we have no say and they do not listen to us."

"We discuss new admissions as part of the nursing team."

Problems seemed to be biggest in wards for people with organic disorders where 79% of nurses disagreed with the statement, compared with 69% of nurses from 'functional' wards.

Concluding comments on communication and ward culture

The qualitative data suggested that there was considerable variation in the effectiveness of the communication systems that operated within wards: at one extreme, these appeared to be comprehensive and highly valued by staff; at the other, staff reported feeling unacknowledged, unvalued, and unsafe. Linked to this, there appeared to be wards where the dominant culture was supportive and nurturing, where staff felt they could rely upon their colleagues, and where learning and development was supported. There were clearly others where a combination of staff shortages, poor skills mix, inexperienced managers, unresponsive senior managers, and poor (multi-disciplinary) team working meant that staff were constantly 'fire-fighting' to maintain safety on their ward. These problems were exacerbated by the increasingly complex mix of the resident population: people with dementia being cared for alongside people with functional disorders; frail, older people being nursed with relatively fit, perhaps challenging, people. From the data, it appeared that some staff had 'given up'.

Appropriate training for staff (all staff groups)

General training

Before moving on to look at training that related specifically to the prevention and management of violence, the staff questionnaires asked a series of questions about access to general training. Over 600 individual comments were received.

Have you received any training related to the following?

| | | Yes | No |
|---|---------------------------|-----|----|
| Equal opportunities | Nursing staff | 52 | 48 |
| | Clinical staff | 55 | 45 |
| | Non-Clinical staff | 39 | 61 |
| Person-centred care and therapeutic approaches in relation to the care of older people | Nursing staff | 59 | 41 |
| | Clinical staff | 66 | 34 |
| | Non-Clinical staff | 16 | 84 |
| The 'Bournewood Ruling', especially in respect of restriction and deprivation of liberty | Nursing staff | 22 | 78 |
| | Clinical staff | 37 | 63 |
| | Non-Clinical staff | 8 | 92 |
| The Mental Capacity Act, especially in respect of the best interests and least restrictive principles | Nursing staff | 35 | 65 |
| | Clinical staff | 55 | 45 |
| | Non-Clinical staff | 15 | 85 |

Findings show that many staff, often the large majority, were not receiving this core training. When examined in relation to the wards types, some particular problem areas and anomalies appeared:

Equal opportunities: although 59% of clinical staff in 'organic' services were receiving this training, their nursing colleagues compared poorly at 46%.

Person-centred care: while 75% of clinical staff in organic services been trained, 42% of nurses had not.

Mental Capacity Act: although 63% of clinicians working on 'mixed' wards had received training, only 51% of their colleagues on 'organic' wards had.

The staff questionnaire then moved on to examine the extent to which staff were receiving the training that is specifically recommended in the 2005 Guideline.

Training related to undertaking personal searches

All staff groups were asked whether they were involved in undertaking personal searches.

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 23 | 77 |
| Clinical staff | 8 | 92 |
| Non-Clinical staff | 8 | 92 |

The respondents who answered 'yes' were then asked if they had received appropriate instruction in undertaking personal searches, which was repeated and regularly updated.

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 32 | 68 |
| Clinical staff | 56 | 44 |
| Non-Clinical staff | 71 | 29 |

Although a relatively small number of staff were involved in carrying out searches, of those, many were not receiving the appropriate instruction, particularly nursing staff. This was particularly marked in 'organic' wards, where the percentage of untrained nurses was 75%.

Training related to the management of actual incidents

Staff were asked firstly, whether they were involved in managing severely challenging/violent incidents and, if they answered 'yes', a series of follow-on questions:

| | Yes | No |
|---------------------------|-----------|----|
| Nursing staff | 79 | 21 |
| Clinical staff | 39 | 61 |
| Non-Clinical staff | 5 | 95 |

- Have you had access to training that promotes the use of non-physical interventions to recognise and prevent severely challenging/violent behaviour e.g. 'Promoting Safer and Therapeutic Services' training?
- Has your training been adequate to enable you to **minimise the risk** of a severely challenging/violent incident occurring?
- Has your training been adequate to enable you to **deal with** a severely challenging/violent incident when one occurs?
- What additional training would you like?

| | Had training | | Adequate to minimise risk | | Adequate to deal with | |
|---------------------------|--------------|----|---------------------------|----|-----------------------|----|
| | Yes | No | Yes | No | Yes | No |
| Nursing staff | 66 | 34 | 74 | 26 | 73 | 27 |
| Clinical staff | 71 | 29 | 68 | 32 | 81 | 19 |
| Non-Clinical staff | 60 | 40 | 100 | 0 | 100 | 0 |

The survey revealed that high numbers of qualified and unqualified staff did not have access to the recognised PSTS training. This was particularly common on 'mixed' wards, where 39% of nurses, 30% of clinical staff and 100% of non-clinical staff had not been trained. Interestingly, clinical staff were more likely than nurses to feel that the training did not equip them to **prevent** incidents (particularly on 'mixed' wards [no=44%]). Conversely, nurses were more likely than clinical staff to feel it did not equip them to **manage** incidents. This may reflect the relative roles and responsibilities of the two groups in relation to dealing with actual incidents. The non-clinical staff who did receive training seemed highly satisfied with its effectiveness.

All staff were then asked what additional training they would like to be given to enable them to **minimise the risk** of an incident occurring, and **enable them to deal with** an incident when one did occur. There was some degree of overlap in the answers to this two-part question. Two general themes emerged. Firstly, many staff felt that the quantity of training was inadequate. This was linked to a range of different problems: problems releasing staff from other duties to attend courses; lack of funding; poor accessibility of venues; over-

subscribed courses. Secondly, there was a strong emphasis on the need for training to be tailored to the particular needs of older people's services – recognising that in the context of the audit's participants, this might include needs associated with one or more of dementia, challenging behaviour, and physical frailty. From the descriptions offered by staff, many wards would still seem to be overly-reliant on using physical interventions and many staff emphasised the need for training in prevention and de-escalation, as one member of the clinical team explained:

"The focus on training needs to be on understanding and tracking how the environment/people contribute to escalation in violence, so that we are better able to nip it in the bud."

Other staff, however, clearly felt vulnerable and perceived that more training in the use of physical interventions would be beneficial, as this nurse explained:

"Our clientele are changing, younger and stronger, which is requiring help from the acute wards. We [are] not trained for full control and restraint, which at times can be dangerous."

Reference was also made to specific training courses that staff wanted to attend e.g. MAPA, REACT, PMVA, and others, and to skills that they would wish to develop, for example, communication, de-briefing, risk assessment and management, understanding dementia, safe holding.

Suggestions were made about different ways that training could be delivered: ward-based, with opportunities to put learning directly into practice; by reviewing and learning from actual incidents.

The management of non-violent challenging behaviour: Staff were then asked whether they had received training in managing forms of severely challenging behaviour in older people with mental health problems, other than violent behaviour, e.g. resistance to care, excessive walking.

| | Yes | No |
|---------------------------|-----|-----------|
| Nursing staff | 41 | 59 |
| Clinical staff | 37 | 63 |
| Non-Clinical staff | 16 | 84 |

The majority of staff had not received any training around managing challenging behaviour in a non-violent context. Staff commented that there was not enough training available geared towards therapeutic approaches in caring for older people, as these comments explain:

"I think the training is limited specifically in older people with dementia/challenging behaviours and therapeutic interventions." (a nurse)

"There is a lack of specific training available locally in relation to the specific needs of older people, progressive approaches to dementia care and managing challenging behaviours in this client group." (a member of the clinical staff team)

Recording incidents: Staff were asked whether they had received training in how to record any incident using the appropriate local templates.

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 63 | 37 |
| Clinical staff | 50 | 50 |
| Non-Clinical staff | 100 | 0 |

Training related to observation skills

Definition

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 nurse, which is meaningful, grounded in trust, and therapeutic for the patient.

(NICE, 2005)

All staff were asked whether they were involved in carrying out observations.

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 94 | 6 |
| Clinical staff | 35 | 65 |
| Non-Clinical staff | 11 | 89 |

Respondents who answered 'yes' were then asked whether they received ongoing competency training in observation.

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 27 | 73 |
| Clinical staff | 25 | 75 |
| Non-Clinical staff | 33 | 67 |

Although 94% of nurses indicated that they were involved in carrying out observations, only 27% of these received ongoing competency training.

Training related to the use of rapid tranquillisation

Definition

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)

All staff were asked whether they were involved in administering or prescribing rapid tranquillisation, or in monitoring patients to whom parenteral rapid tranquillisation had been administered (see table below). Overall, almost one half of nurses reported that they were. This figure was highest (53%) in services for people with functional disorders. Similarly, for other members of the clinical team, the figures were 44% and 34% for 'functional' and 'organic' services, respectively.

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 48 | 52 |
| Clinical staff | 38 | 62 |
| Non-Clinical staff | 4 | 96 |

Those that answered 'yes' were then asked a series of questions:

- Have you received training around the legal framework that authorises the use of rapid tranquillisation?
- Are you trained in the use of pulse oximeters?
- Do you receive ongoing competency training to a level of Immediate Life Support (ILS – Resuscitation Council UK)?

| | Training around the legal framework | | Trained in the use of pulse oximeters | | Ongoing competency training to a level of ILS | |
|---------------------------|-------------------------------------|----|---------------------------------------|----|---|----|
| | Yes | No | Yes | No | Yes | No |
| Nursing staff | 36 | 64 | 39 | 61 | 72 | 28 |
| Clinical staff | 53 | 47 | 61 | 39 | 76 | 24 |
| Non-Clinical staff | 50 | 50 | 25 | 75 | 25 | 75 |

Although around one-half of nurses stated that they were involved in the administration and/or care of people who had received rapid tranquillisation, the adequacy of the associated training was woefully lacking, with just over one-third being trained around the legal framework, less than 40% trained in the use of pulse oximeters, and 28% not receiving on-going ILS training. For clinical staff, the likelihood of being involved in the application of this intervention was lower, but those who were involved were considerably more likely to have received the majority of the training.

Staff were then asked whether they were involved in **administering covert medicines** with older mentally incapacitated people (see table below). Overall, the majority of nurses and clinical staff said that they were. These figures were highest in services for people with organic disorders (nurses=72%, clinicians=60%).

| | Yes | No |
|----------------------|-----------|----|
| Nursing staff | 68 | 32 |
| Clinical | 55 | 45 |
| Non-Clinical | 25 | 75 |

Those who answered 'yes' were asked: Have you received specific training in administering covert medicines with older mentally incapacitated people?

| | Yes | No |
|----------------------|-----|-----|
| Nursing staff | 36 | 64 |
| Clinical | 11 | 89 |
| Non-Clinical | 0 | 100 |

Although over two-thirds of nursing staff were involved in administering covert medication, just over one-third of these had been trained. Interestingly, although around one-half of clinical colleagues were likely to be involved in this procedure, they were even **less likely** to receive training (11%).

Training related to the use of 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:** NICE uses the term 'physical intervention'.

All staff groups were asked whether they were involved in using hands-on restraint. The service-type reporting highest usage by nursing and clinical staff was services for people with organic disorders (nurses=87%, clinical staff=29%).

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 84 | 16 |
| Clinical staff | 18 | 82 |
| Non-Clinical staff | 9 | 91 |

Those that answered 'yes' were then asked two additional questions:

- Have you received training around the legal framework that authorises the use of hands-on restraint?
- Have you been trained in Basic Life Support (BLS – Resuscitation Council UK)?

| | Training around legal framework | | Trained in BLS | |
|---------------------------|---------------------------------|----|----------------|----|
| | Yes | No | Yes | No |
| Nursing staff | 74 | 26 | 86 | 14 |
| Clinical staff | 76 | 24 | 95 | 5 |
| Non-Clinical staff | 67 | 33 | 44 | 56 |

Overall, 84% of nursing staff reported that they were involved in using hands-on restraint and the large majority had received the recommended training. Of the 84% of nursing staff, only 74% had received training on how to safely apply hands-on specifically to **older people** (see below), suggesting a need for more age-specific training.

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 74 | 26 |
| Clinical staff | 67 | 33 |
| Non-Clinical staff | 44 | 56 |

Training related to 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.

(NICE, 2005)

All staff groups were asked whether they had been directly involved in the care of a secluded patient on their ward during the last year. Not surprisingly, figures were relatively low, with the highest figure from nursing staff came from 'organic' services (19%).

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 18 | 82 |
| Clinical staff | 5 | 95 |
| Non-Clinical staff | 3 | 97 |

Those that answered 'yes' were then asked two additional questions:

- Have you received training around the legal framework that authorises the use of seclusion?
- Do you receive ongoing competency training in the use of seclusion?

| | Training around the legal framework | | Ongoing competency training | |
|---------------------------|-------------------------------------|----|-----------------------------|-----|
| | Yes | No | Yes | No |
| Nursing staff | 28 | 72 | 19 | 81 |
| Clinical staff | 33 | 67 | 0 | 100 |
| Non-Clinical staff | 33 | 67 | 0 | 100 |

Less than one-fifth of nurses were involved in the care of a secluded patient during the past year, but for those who were, access to the appropriate training was poor.

Concluding comments on appropriate training for staff

Access to training related to the prevention and management of violence in older people's services was variable, with many staff being expected to apply specialised interventions, such as rapid tranquillisation and hands-on restraint, to vulnerable patients, without any training. Where training was available, many staff reported that it was not tailored to the very particular and varying needs of the populations served. The underlying message: in the absence of adequate training, many staff (and therefore patients), were being exposed to an unreasonable level of avoidable risk.

Adequate staff supervision (all staff groups)

All staff were asked about their experiences of supervision. Almost 250 chose to comment.

All groups were asked: do you currently receive one-to-one clinical supervision?

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 56 | 44 |
| Clinical staff | 74 | 26 |
| Non-Clinical staff | 19 | 81 |

Respondents who answered 'yes' were then asked the following:

How often does supervision take place?

| | Weekly | Fortnightly | Monthly | > Monthly |
|---------------------------|--------|-------------|---------|-----------|
| Nursing staff | 6 | 5 | 59 | 31 |
| Clinical staff | 39 | 8 | 48 | 5 |
| Non-Clinical staff | 16 | 11 | 58 | 16 |

How would you rate your satisfaction with the frequency of supervision that you get?

| | Totally satisfied | Satisfied | Dissatisfied | Totally dissatisfied |
|---------------------------|-------------------|-----------|--------------|----------------------|
| Nursing staff | 24 | 63 | 11 | 3 |
| Clinical staff | 43 | 49 | 7 | 1 |
| Non-Clinical staff | 47 | 37 | 5 | 11 |

How would you rate your satisfaction with the quality of supervision that you get?

| | Totally satisfied | Satisfied | Dissatisfied | Totally dissatisfied |
|---------------------------|-------------------|-----------|--------------|----------------------|
| Nursing staff | 27 | 65 | 6 | 2 |
| Clinical staff | 39 | 55 | 6 | 0 |
| Non-Clinical staff | 39 | 50 | 0 | 11 |

Does this supervision include incidents and events relating to the prevention and management of violence?

| | Yes | No |
|---------------------------|-----|----|
| Nursing staff | 66 | 34 |
| Clinical staff | 55 | 45 |
| Non-Clinical staff | 33 | 67 |

Although the proportion of nursing and non-clinical staff receiving supervision was low, the majority of those who were getting it were satisfied with both its frequency and quality. In services for people with organic disorders, although the percentage of nurses receiving supervision were lower (51% and 67%, nurses and clinicians, respectively), their ratings of satisfaction with both frequency and quality were similar to staff from other services types. The qualitative data revealed a mix of experiences, though these were more positive than negative. Many staff described 'informal' arrangements for supervision – where they felt

able to call upon the advice or support of their colleagues or manager at any time, as this nurse explains:

"Although I don't receive lots of regular supervision per se, the way my team works enables me to access guidance and advice on an on-going basis, which I find useful to me".

Others, like this nurse, spoke of how much they valued of more formal arrangements:

"I find my supervision very useful to identify any clinical problems I may have, also it helps myself and my mentor recognise my strengths and weaknesses."

There was similar variation in the way nurses who were not receiving formal supervision felt about this: some expressed a clear desire to be supervised; others were adamant that they **would not** welcome it.

Many nurses took time to explain the reasons why supervision did not always happen. Commonly cited reasons were: competing demands on staff time; staff shortages; lack of trained/experienced supervisors.

Concluding comments on adequate staff supervision

Experiences of, and satisfaction with, supervision varied enormously. The data suggested that there is no single system that suits all needs, with some staff preferring more formal arrangements than others. What was clear, however, was that staff that are expected to deal with people who have very differing and challenging needs, and who are working in environments where the threat of being physically assaulted is high, must have ready access to advice and support from a senior colleague.

"Would be nice to have [supervision] or be asked if I wanted this after a violent incident. Had two such incidents and it was assumed that I was ok."

Supports from other colleagues on the ward (all staff groups)

Staff were asked about the supports that they received that helped them to work in environments where they were exposed to the risk of severely challenging/violent behaviour. Almost 200 people commented on these questions.

Support from colleagues

Firstly, staff were asked about their satisfaction with the support they received from staff on the ward in relation to managing severely challenging/violent behaviour.

| | Totally satisfied | Satisfied | Dissatisfied | Totally dissatisfied |
|---------------------------|-------------------|-----------|--------------|----------------------|
| Nursing staff | 27 | 63 | 7 | 2 |
| Clinical staff | 27 | 64 | 9 | 0 |
| Non-Clinical staff | 43 | 52 | 3 | 1 |

In all groups, over 90% of staff were either 'satisfied', or 'totally satisfied' with the support they received from their colleagues. Not surprisingly, their comments reflected this:

"Excellent - shifts always benefit from teamwork of a very high standard." (a nurse)

"I find the nurses helpful and supportive. They work along with me on the ward in assisting and helping patients." (a member of the non-clinical team)

"We have a good team work and when we have problems we discussed it at ward meetings." (a nurse)

Support from senior management

Next, staff were asked about the supports they received from the senior management team within their directorate.

| | Totally satisfied | Satisfied | Dissatisfied | Totally dissatisfied |
|---------------------------|-------------------|-----------|--------------|----------------------|
| Nursing staff | 12 | 56 | 25 | 7 |
| Clinical staff | 21 | 68 | 10 | 2 |
| Non-Clinical staff | 26 | 62 | 11 | 1 |

The figures show a marked difference from the way that the previous question was answered, particularly by nursing staff, with almost one-third rating themselves as either 'dissatisfied' or 'totally dissatisfied' with the support from senior managers. A number of respondents made general reference the problems:

"Senior management appear [to] have no interest in the well being of their staff." (a nurse)

One nurse's comment summarised the issues described by several:

"Senior management team offer no support at all and I couldn't even name most of them as you never see them."

The quality of leadership on the ward

Finally, they were asked how they rate their satisfaction with the quality of leadership on the ward.

| | Totally satisfied | Satisfied | Dissatisfied | Totally dissatisfied |
|---------------------------|--------------------------|------------------|---------------------|-----------------------------|
| Nursing staff | 24 | 62 | 11 | 3 |
| Clinical staff | 21 | 61 | 17 | 1 |
| Non-Clinical staff | 48 | 42 | 8 | 2 |

The results show a difference in opinion between nursing staff - who generally rated themselves as 'satisfied' or 'totally satisfied', and clinicians - who rated their satisfaction with leadership as worse than with senior management. Unfortunately, few people chose to comment on their experiences of leadership on the ward.

Concluding comments on supports from other colleagues on the ward

Both the qualitative and quantitative data suggested that most ward teams, including members of the multi-disciplinary team, were highly cohesive. There were, however, differences in some wards between people's experiences of support from other front-line colleagues, and the extent to which they, in turn, felt supported by their senior managers. The sentiments contained in numerous comments from nursing staff can be aptly summarised in this simple quote from a nurse:

"Manager here downwards fine - above that seems to be a gap, they don't really listen to what people are saying."

Being supported in relation to actual incidents

The Module 1 questionnaires asked all respondent groups about the supports they received in relation to (the risk of) actual incidents. These questions were designed to establish the extent to which organisations were putting adequate systems and supports in place to maximise safety and allow any lessons to be learned.

All non-staff groups were asked whether they had been given any **pre-emptive advice** on what to do in the event of a severely challenging/violent incident:

Has anyone given you advice on what to do if you see or hear about someone behaving in a way that is severely challenging/violent, for example, how to summon help?

| | Yes | No |
|-----------------------------|-----|-----------|
| Patient | 37 | 63 |
| Visitor | 48 | 52 |
| Carer/Next of kin | 31 | 69 |
| Third party observer | 72 | 28 |

In spite of the relatively low compliance with this safety standard, very few people chose to comment critically. Instead, they praised the sense of safety that the ward staff engendered, as illustrated in this comment from a visitor:

"The staff seem to know what to do in this respect very well. I have witnessed two incidents and was impressed how the staff regained control quickly and spent time afterwards talking to the patient."

Those that had experienced some degree of distress, threat or actual violence were asked whether staff had given them the **opportunity to talk about their experiences**.

| | Yes | No |
|-----------------------------|-----|-----------|
| Patient | 67 | 33 |
| Visitor | 71 | 29 |
| Carer/Next of kin | 75 | 25 |
| Third party observer | 85 | 15 |

Responses to this question were more favourable, with no fewer than two-thirds of respondents saying that this had happened. However, few respondents chose to comment on the nature of the support(s) (if any) that they had received.

In relation to **reporting incidents**, all staff groups were asked whether all incidents of severely challenging/violent behaviour that they had been aware of, in the past year, had been reported/recorded. The results were high and would seem to suggest that in the majority of wards, all incidents are being recorded (see table below).

| | Yes | No |
|---------------------------|-----------|----|
| Nursing staff | 88 | 12 |
| Clinical staff | 87 | 13 |
| Non-Clinical staff | 91 | 9 |

The subject of reporting was, however, a much divided one, and generated a lot of comments. **On the positive side**, many reported that their systems operated well, as these quotes describe:

"Everything gets resolved as quickly as possible and gets reported." (a member of the non-clinical team)

“Every violent behaviour is being recorded and reported through IRIS forms, followed by a staff sharing how to minimise the violent behaviour with a new care plan in place.” (a nurse)

On the negative side, the qualitative data pointed to under-reporting, which was associated with several factors. Firstly, that staff saw the violence as **‘part of the job’**, as this member of the clinical team described:

“I do feel that a lot of incidents go unrecorded, such as verbal abuse, harassment, aggression that has not resulted in injury, as all too many staff feel this is an ‘expected’ part of their job, so don’t report it.”

Linked to this, there seemed to be some confusion about **what incidents should/should not be reported**, as this nurse described:

“Most incidents reported not always worth reporting - everyone has their own interpretation e.g. raised fist worth reporting? Would be useful to have guidelines.”

Thirdly, some staff felt that it was **not worthwhile reporting** because of the relative cost/benefit associated with the time it took to complete the paperwork – particularly with patients with organic disorders, as this nurse explained:

“Some incidents are not reported because at times it feels as if writing reports on incidents involving yourself or junior staff is all you do. After an incident, it is sometimes possible to discuss the circumstances with a patient but not often. The patients on this ward generally lack insight and have memory deficits which preclude recognition of their behaviour and remembrance of its effects on others, staff or patients.”

Fourthly, some staff described how the **culture of the ward** sometimes discouraged staff from reporting incidents:

“A lot of new and junior members are being made to feel inadequate or lacking in skills if you happen to complete two incidents sometimes in one or more incident forms in a week, when the reality is there’s probably up to five or six incidents sometimes in a day.” (a nurse)

The comments from some staff highlighted the **importance of full reporting** and recording, and the implications of failure to do so:

“I feel that [the level of violence] has been grossly underestimated and therefore resources have not been provided to deal with arising occurrences adequately.”

Others spoke about the dangers associated with **focusing on the legal and paperwork-side** of reporting violent incidents and forgetting the human consequences:

“After incidents it depends on the ward staff/manager how much attention is given to individuals concerned. The Trust policy concentrates more on the legal/reporting side of incidents and leaves the dealing with the emotional side to the individual wards.” (a nurse)

They were also asked whether patients on their ward were routinely given the opportunity to discuss their experiences of being involved in severely challenging/violent incidents (either as perpetrator, victim or witness).

| | Yes | No |
|---------------------------|-----|-----------|
| Nursing staff | 65 | 35 |
| Clinical staff | 56 | 44 |
| Non-Clinical staff | 75 | 25 |

Compliance with this standard was low, particularly in services for people with organic disorders ('yes': nurses=55%; clinicians=51%; non-clinical staff=63%). Many respondents explained that this was because patients with (severe) dementia would have no recollection of the incident and would be unable to contribute to a discussion, as one member of the clinical team explained:

"Due to the nature of their illnesses it is not always possible to ensure clients talk about their experiences, so this is a very individual process. For those in the early stages of dementia, who are able to do this, opportunity is given."

A nurse explained her/his ward's alternative post-incidents management strategies:

"Due to the level and nature of their illness, it is often difficult to discuss incidents of violence with the patient. However, support and reassurance is always given to them and carers are always made aware of incidents that have occurred."

Since December 2003, all health bodies have been required by the NHS Security Management Service to provide a 'Local Security Management Specialist' whose role it is to become *"the focal point for the local delivery of professional security management work"* (see <http://www.cfsms.nhs.uk> for more details).

Staff were asked whether they knew who their Local Security Management Specialist was. As the table below indicates, even if the role is being filled, many staff are not aware of it.

| | Yes | No |
|---------------------------|-----|-----------|
| Nursing staff | 20 | 80 |
| Clinical staff | 26 | 74 |
| Non-Clinical staff | 27 | 73 |

Concluding comments on being supported in relation to actual incidents

Where problems did exist, these most commonly related to two issues: a lack of confidence in reporting systems (for the various reasons described); and lack of post-incident supports for patients. With high levels of experienced violence, neither problem can be ignored. In order to develop strategies that minimise the risk of violence, accurate data is required about actual levels of incidents. This will only be achieved if the ward culture actively encourages and supports the reporting and recording of all incidents. In wards where this is not happening, work needs to be done to address barriers to reporting, whether these are procedural, attitudinal, or cultural.

Additional comments

At the end of the Module 1 questionnaire, all respondent groups were given the opportunity to make additional comments. Over 200 comments were received. Some respondents used this as an opportunity to emphasise their key messages, others chose to comment on issues that had not been raised in the questionnaire.

Key messages

Gratitude to staff

By far the greatest numbers of comments were in praise of staff – with all non-staff groups noting, in often very moving terms, their gratitude for the job that staff do. Some typical examples:

“From my personal experience over the last year I have found the nursing and caring shown to patients by staff to be of the highest standard. Also the compassion shown to me when I’ve been at my lowest.” (a carer)

“I found the ward very friendly and relaxing. The nurses were always on hand if you needed anything.” (a patient)

“I have nothing but praise for the ward and the staff. They have treated my mother and from what I observe all the patients with a high level of respect. They care for the patients as though they were members of their own family.” (a carer)

“Neither my family or the private nursing home could contain his aggression, but they do. They are always aware of our need for safety from him and we are all happy to visit alone without fear of assault. His physical care is excellent and his basic nursing needs attended to always. Most importantly, despite his temper he is always spoken to and treated with respect and dignity. I cannot thank the staff enough for their care of him.” (a visitor)

Inadequate staffing

These comments related either to the overall staffing levels being low, or to the mix of staff not being adequate or appropriate for the resident population. Comments have been provided from a variety of respondents to illustrate their individual perspectives on the impact of poor staffing:

“Elderly mental health is very under resourced and staff do a commendable job in difficult circumstances. Staff do not feel empowered it appears and this follows in the approach to care with relatives, they can tend to isolate and disempower carers and 'blame' rather than encourage. Staff are bitter towards the cuts and morale appears very low. For the most part though, they do their best.” (a carer)

“It feels as if there is no recognition by the establishment that therapeutic interventions are just as important for older people, the message being that 'you can make do with three staff per shift'. This attitude does not take into consideration what is now required of staff, or general modern day thinking regarding the care of older people, and smacks of the old idea that carers of the elderly are glorified 'bum wipers'.” (a nurse)

“The only problem is that the staff are too busy to be there as much as you would like them to be. They do their best, but they're just too busy.” (a patient)

“I think staff try to do their best but sometimes they have too much to do and that makes it hard to watch the patients as much as they need watching.” (a carer)

“The practice can be unsafe at times due to shortage of staff or working with agency staff that do not know the unit properly.” (a nurse)

Patient mix

Respondents from all groups, though predominantly nurses, commented on problems associated with the mix of patients on old age wards, as these quotes illustrate:

"... due to the changing nature of the service [we] have a very unsuitable mix of patients. Staff are often severely stretched and do an excellent job in the light of restricted resources. With a better environment and more therapeutic interventions, the occurrence of severely challenging behaviour is likely to be reduced." (a member of the clinical team)

"I think that staff on elderly wards are expected to deal with what ever comes through the door with little thought from managers and medical staff of the implication to the staff and other patients." (a visitor)

and this plea from a nurse:

"[The] ward should only be for a particular client group. It should not be mixed with feeble continuing care patients/respite patients. One-to-one to be provided when needed. Adequate space is needed for such patients to wander about safely and away from too much stimulation. Staff [need] to be trained to deal with such behaviour and supported with adequate staff and psychologically as well."

Environments

A number of people commented on the impact of environment on the care delivery: some referred to external features such as décor, furnishings; others focused on the role of design in the provision of a safe, accessible place to stay/live. One nurse from a long-stay ward summed up the sentiments of many in her quote, where she reflected on her own ward:

"When shown the pictures of [my ward, it] looked like a prison - dark, dismal, institutionalised. These people haven't done anything wrong and deserve a better environment. This is their home."

The impact of violence

A number of respondents returned to the issue of the impact of violence on the people who live, work and spend substantial time in these wards. Firstly, a nurse commenting on the apparent lack of understanding of the problem by managers and doctors:

"Staff must calculate risk to other patients, staff and possibly visitors, of a violent and aggressive incident. My experiences this year have resulted in a deep and abiding belief that management and doctors who are not involved in these incidents, under estimate the physical and mental health consequences to their staff."

Next, from a third party observer, commenting on the plight of nursing staff:

"It is often the case that female staff are left to deal with aggressive/violent service users. I feel you can highlight problems, but not always is there a serious plan put in place or that you are listened to in ward reviews about the problems you experience, observe etc. Nurses are left to deal with everything. More notice should be given to what they report and have to deal with, as most of the time they are on the front line of aggression by service users and sometimes carers."

Other themes that were raised included the following: positive and negative experiences of cleanliness on the wards; references for the need to improve access to staff training; mixed experiences of the quality of information provision.

Additional comments

A small number of respondents commented on issues that had not been covered by the questionnaire. These ranged from patients complimenting the food, to carers complaining about the laundry service, to requests to increase central funding into older people's services. One quote that stood out amongst these that echoed the sentiments contained in many others, came from a nurse:

"The poor relation - mental illness ...Tony Blair should try working here for a day."

Module 3a: Review of violent incidents

Background

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.

Content of the audit tool

The audit tool contained a **structured checklist** and an **action plan**. The structured checklist was based upon the NICE 2005 Guideline. 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.

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.

Data management

Data collection

The data collection period began in October 2006 and continued until March 2007¹⁶. 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.

Data presentation

44 wards submitted at least one action plan, with a total of 104 completed forms. Some wards reported that they were unable to complete this component of the audit because no incidents had occurred during the data collection period. The national report was 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 related to each question asked in the action plan, broken down by working age adult's services and older people's services. Bar charts were also used to allow a clear comparison of the results.

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

¹⁶ The initial deadline of the end of February was extended at the request of many participants.

National Findings: background information (n=44)

Gender

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

Age

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

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

| | 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% |

Other (please specify)

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

Key findings

The findings from the Module 3a checklist showed an emphasised preventing and pre-empting violent incidents beforehand, as opposed to managing incidents as they happened. The following areas were commented upon most frequently:

- **Increased patient involvement:** assessing risk; discussing triggers; creating advance statements;
- **Practice changes:** debriefings for staff and patients; minimising use of bank/agency staff; flagging up good practice at senior managers meetings; increased access to therapies and activities;
- **Improved training:** reviewing number of staff trained to undertake observation; use incidents as discussion points in training;
- **Culture change:** giving clear message that 'violence is not tolerated'; Develop ethos that restraint is a 'last resort'.

Module 3b: case note/drug chart audit on the use of rapid tranquillisation

Background

The bulk of the questions within the audit tool were based upon the rapid tranquillisation section of the NICE Guideline: *Violence – the short term management of disturbed/violent in in-patient psychiatric settings and emergency departments* (2005). However, as the scope for the Guideline specifically **excluded** services for people with dementia, the audit tool for 'older people's services' was briefer than the 'working age adults' equivalent. An additional section on the use of covert medication was added to reflect management practices in older people's services; the standards for this section were drawn both from the Royal College of Psychiatrists' guidance 'College Statement on Covert Administration of Medicines (2004)', and from the NAV Steering Group.

Methods

Sampling

All wards were encouraged to take part in this part of the audit programme, although it was anticipated many wards would be unable to take part due to lack of cases. In recognition of the fact that the levels of usage of rapid tranquillisation varied considerably between subject wards, the sampling and audit methods were suitably flexible¹⁷.

A three-stage process was recommended: firstly, a census week was used to identify potential cases that might be audited; secondly, the audit sample was identified; finally, the case notes were audited against the audit checklist.

1. **Census week:** local project teams were asked to specify one week and, during this week, the Ward Manager was asked to ensure that a numbered list was compiled of all instances where a patient had received rapid tranquillisation (it was suggested that this task could be delegated to another member of the nursing team or the ward clerk, or could be compiled by the team at each handover).
2. **Sampling:** at the end of the week, teams were instructed to work through the numbered list and draw a sample from the odd numbers of a **minimum of 5** and a **maximum of 15** separate instances¹⁸.
3. **Audit of case notes/drug charts:** the following suggestions were made to local teams about who should carry out the actual audit.
 - a senior nurse
 - an SHO or SpR
 - a pharmacist
 - a member of the clinical governance/clinical audit team

¹⁷ During the Introductory Workshops that preceded the data collection, the Audit Team consulted with local teams to determine an appropriate methodology for this module of the audit.

¹⁸ If, at the end of the census week, wards that had insufficient instances to include in the audit were given two options: continue collecting the list for one (or more) additional weeks; include all instances in the sample.

Submission of data

Local teams collected their data using a simple template. This data was then entered via a web-link. The data collection period began on 9 October 2006 and continued until 9 March 2007¹⁹.

Data presentation

Nationally, data was submitted on behalf of the following:

- 37 trusts;
- 43 wards;
- 195 individual cases.

Key findings

The sampling methods for the audit, the relatively small number cases audited, and the, sometimes high, levels of missing data mean that the national results should be interpreted with caution. However, the data would seem to indicate the following:

- Rapid tranquillisation was being used in many services for older adults with mental illness.
- BNF doses were not being exceeded.
- Oral medication was being used more frequently than either intramuscular or covert medication.
- Usage of covert medication appeared rarer than intramuscular medication.
- In the minority of cases when covert medication was used: capacity was usually assessed; carers were consulted; the medication was always reviewed regularly and only included essential items.
- With intramuscular medication, only one drug of the same class was generally used.
- Vital signs were **inadequately** monitored in circumstances where they should be, due to failure to agree monitoring schedules.
- More attention was paid to assessing conscious level than airway or respiration.
- Patients were not given adequate opportunities to discuss or write about the incidents.

The full findings for Module 3b can be found at Appendix 7.

¹⁹ The original deadline of 28 February 2007 was extended at the request of many of the participating wards.

Discussion

Over recent years, political imperatives have meant that investment in older people's services has all too frequently taken second place to the development of new, community-based services. It should come as no surprise, then, that many sections of this report have made for depressing reading. The enormity of the problems they represent can be better gauged by comparing the results for older people's services, with those achieved by services for adults of working age. Appendix 9 contains a summary of the two data sets.

Key comparisons

- **Severity of violence:** nurses in older people's services (OPS) were **more likely to be physically assaulted** than their colleagues in services for working age adults (WAA).
- **Training in managing violent incidents:** in relation to many of the interventions associated with managing violence – the great majority of nurses in OPS, like their colleagues in WAA services, were being called upon to use observation, rapid tranquillisation and physical restraint. They were, however, considerably **less likely to have received the appropriate training**.
- **Environmental safety:** in relation to a number of safety features, wards for older people were rated more poorly than those for adults of working age. Specifically: the adequacy of alarm systems (including access to personal alarms), and the way that staff respond to alarm calls; sight lines; the availability of a crash bag.
- **Staffing levels:** nurses felt less 'in control' of admissions to the wards and, at the same time, less able to access additional resources when there was a difficult patient mix.

In brief, evidence from the audit suggests that many of the safety features that were recommended in the 1998 and 2005 Guidelines were woefully lacking in many services for older people. In spite of this, services for older people out-performed services for adults of working age in a number of key areas:

- **Use of physical interventions:** both patients and nurses in OPS were less likely to feel that any physical intervention was being used too quickly – in spite of the relative lack of staff training previously described.
- **Access to activities and therapies:** patient satisfaction with the provision of daytime therapies and activities was consistently higher in OPS.
- **Being treated with respect and dignity:** patients in OPS were more likely to report that they were being cared for in a dignified manner.
- **Involvement in decisions about personal care:** similarly, patients were more likely to agree that they had been involved in these decisions.

In conclusion

The picture painted by the audit findings was very mixed. On a positive note, and to the considerable credit of the staff working in older people's services, many wards were able to provide a service that offered greater dignity and choice to its patients than was evident in services for adults of working age. However, it cannot be ignored that the levels of physical assaults in many wards were unacceptably high. While this problem was often attributed to

the unintentional behaviours associated with the patients' conditions, this does not reduce the responsibility of mental health service providers to minimise risk and maximise safety on their wards.

There is considerable evidence from the audit findings that many services possessed both the knowledge and the willingness to tackle the known precipitants of violence. Indeed, it was evident that ward staff were keen to employ preventative measures, rather than waiting for incidents to escalate to a level where physical interventions were needed to bring the situation back into control. It was also clear that they were not always given the supports that they needed to do so.

Not all violence is avoidable, but through systematic planning and by listening to and supporting staff, much more can and must be done to minimise risk and to support staff when incidents do occur.

Key areas for attention

Life on the ward

- In some wards, people with functional mental health problems and dementia, or old frail people and working age adult psychiatric patients, are being nursed in the same environment. This clearly contravenes nationally recognised good practice² and should be addressed as a matter of urgency.
- Wards, by nature, are noisy places. However, more can be done to reduce avoidable noise, such as squeaky doors or equipment, loud bells, or the sound of heavy footwear.
- Boredom on wards and the associated increased risk of violent incidents is easily avoidable. Wards should review their provision of therapies and activities, particularly during evenings and weekends.
- Measures must be taken to ensure that all patients are given daily opportunities to go outside.
- The design of wards is not always appropriate to the needs of the resident population. For people with dementia, wards with long corridors and lots of doors can increase their confusion and anxiety. The introduction of simple measures e.g. use of pictures, colour-coding, signage, will help patients to remain oriented.
- Wards must examine the adequacy of their systems for sharing information with patients.

Training and support for staff

- All wards should review the training and supports that they provide relating to the prevention and management of severely challenging/violent behaviour, in particular:
 - training in person-centred care;
 - training in the prevention and management of violence that is specific to the needs of the resident population;
 - access for all staff groups to advice about the management of severely challenging/violent behaviour in patients who have complex needs;
 - access for all staff to a range of post-incident supports.

Ward staffing

- The staffing requirement of a ward will vary according to the needs of the resident population. Services must ensure that their systems for staffing their wards are sufficiently flexible to accommodate these changing needs.
- The findings suggest that the effective prevention and management of severely challenging/violent behaviour is hindered on wards where there is high usage of bank and/or agency staff. Services should develop staffing strategies that minimise dependence on bank and agency staff.

Managing and reporting incidents

- The risk of being involved in an incident of physical assault is higher on wards for older people than for adults of working age. Services must provide reliable alarm systems that meet the needs of everyone who is 'at risk'.
- If wards are to develop strategies that allow them to minimise the risk of violence, they must have access to reliable data about levels of incidence. Wards should review whether their existing incident reporting systems are generating accurate data and if not, should address any barriers to reporting.

Glossary

This glossary was adapted from the NICE Guideline, 2005.

Advance directive/statement: a document that contains the instructions of a person with mental health problems setting out their requests in the event of a relapse, an incident of disturbed/violent behaviour etc. It sets out the treatment that they do not want to receive and any treatment preferences that they may have in the event that they become violent. It also contains people who they wish to be contacted and any other personal arrangement that they wish to be made.

Aggression: a disposition, a willingness to inflict harm, regardless of whether this is behaviourally or verbally expressed and regardless of whether physical harm is sustained.

Basic Life Support: the maintenance of an airway and the support of breathing and the circulation without using equipment other than a simple airway device or protective shield.

Calming: the reduction of anxiety.

Clinical staff: any non-nursing member of the multi-disciplinary team

Crash Bag: The equipment necessary to resuscitate an individual if they suffer a cardiac arrest.

De-escalation: A complex range of skills designed to abort the assault cycle during the escalation phase, and these include both verbal and non-verbal communication skills (CRAG, 1996).

De-escalation room/area: This should be a low stimulus room, where a service user can go to calm down. It should not normally be the seclusion room, which is a specific room set aside for the purpose of seclusion, and which must meet specifications that are principled in the Mental Health Act Code of Practice. Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention; this is not the case when a service user is asked to use the de-escalation room.

Disturbed behaviour: to be experiencing emotions and exhibiting behaviours that deviate from the accepted norm as a result of mental ill-health.

Environment: the physical and therapeutic external conditions or surroundings.

Gender: Those characteristics of women and men that are **socially** determined, as opposed to 'sex' which is **biologically** determined (*Mainstreaming Gender and Women's Mental Health Implementation Guide*, 2003).

Guideline Recommendation: A systematically developed statement that is derived from the best available research evidence, using predetermined and systematic methods to identify and evaluate evidence relating to the specific condition in question.

Immediate Life Support: Basic life support and safe defibrillation (manual and/or automatic external defibrillator).

Non-clinical staff: any other staff member whose role is neither nursing nor clinical, but whose job brings them into regular contact with the ward.

Observation: a two-way relationship, established between a service user and a nurse, which is meaningful, grounded in trust, and therapeutic for the service user (UKCC, 2002).

Parenteral: Method of administering medication or nutrition other than via the digestive tract, such as intravenous, subcutaneous or intramuscular.

Patient: the term 'patient' is used, rather than 'service user' in this document and associated audit tools and guidance (except when text is quoted directly from the NICE guideline).

Physical intervention: a 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.

PICU (Psychiatric Intensive Care Unit): Psychiatric intensive care is for patients compulsorily detained usually in secure conditions, who are in an acutely disturbed/violent phase of a serious mental disorder (Department of Health, Mental Health Policy Implementation Guide, 2002).

PRN (pro re nata): medication that may be used as the occasion arises.

Rapid tranquillisation: the use of medication to calm/lightly sedate the service user, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression, thereby allowing a thorough psychiatric evaluation to take place and allowing comprehension and response to spoken messages throughout the intervention. Although not the overt intention, it is recognised that in attempting to calm/lightly sedate the service user, rapid tranquillisation may lead to deep sedation/anaesthesia.

Seclusion: the supervised confinement of a patient in a room, which may be locked to protect 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.

Seclusion Room: The seclusion room is a room which is fit for purpose as defined by the principles laid out in the Mental Health Act Code of Practice. It should only be used for the purpose of carrying out seclusion. As such, it should be distinguished from a low stimulus room, where a service user can go simply for the purpose of de-escalation.

Violence: the use of physical force which is intended to hurt or injure another person (Wright 2002).

Appendix 1 – Case Studies

Case study 1

Provided by Liz Fair, Clinical Effectiveness Manager, Sussex Partnership NHS Trust, on behalf of Rose Ward

Action point 1: through the audit of the environment, it was agreed that the ward was overcrowded, that there was insufficient space to see patients individually, and that action should be taken to reduce overcrowding and provide more therapeutic space that emphasised engagement, observation and recreation. A new unit is scheduled to be built and to be ready in 2008, but it was agreed that action was needed in the meantime. A refurbishment programme was started in mid-October 2005 and is now complete: there are now extra interview rooms available, and extra seating (via the reassignment of an old dining room into a lounge/dining room).

Action point 2: the audit highlighted concerns around the lack of meaningful activity. A basic grade OT has since been reappointed and continued attempts are being made to engage the nursing team. As of March 2006, all people being newly admitted are being assessed within 72 hours and given a full activity programme.

Case study 2

Provided by Lou Bean, Clinical Audit Manager Mental Health, East Kent NHS and Social Care Partnership Trust, on behalf of Edgehill Ward.

Edgehill Ward is a 19-bedded mixed sex acute admission ward, built in approximately 1993 with long narrow corridors, poor observation lines, limited natural daylight and ventilation. Around the same time as the ward was taking part in the audit programme, Edgehill Ward was also selected by the trust to take part in a project run by the Kings Fund - 'Enhancing the Healing Environment'. Findings from the audit were fed into plans for a series of environmental improvements.

The biggest impact was expected to result from changing the use of space by the patients within the ward: the existing dining room was not being used outside of mealtimes and patients were instead congregating in a windowless small lounge; a link was made between the resultant overcrowding and the occurrence of violent incidents – especially during summer months when temperatures rose due to the lack of ventilation. Improvements included:

- the use of calming colour schemes;
- better access to hot and cold drinks for service users;
- improved observation and greater feel of safety;
- the creation of new sitting areas;
- the introduction of artwork in communal areas.

Case study 3

Provided by Helen Bennett and Andy Morgan, Cardiff and Vale NHS Trust

Cardiff and Vale were able to produce longitudinal data over the period of the audit, relating both to the frequency and the management of challenging behaviour on three of their wards, and to corresponding staff sickness levels. The results were encouraging.

| | | June 04/ May 05 | June 05/ May 06 |
|---------------|--|----------------------------|----------------------------|
| Ward A | Number of incidents of challenging behaviour | 86 | 41 |
| | Number of incidents requiring use of restraint | 8 | 11 |
| | Staff sickness | 4.5% | 3% |
| Ward B | Number of incidents of challenging behaviour | 117 | 91 |
| | Number of incidents requiring use of restraint | 47 | 62 |
| | Staff sickness | 6.2% | 5.8% |
| Ward C | Number of incidents of challenging behaviour | 61 | 40 |
| | Number of incidents requiring use of restraint | 21 | 19 |
| | Staff sickness | 7.5% | 9.2% |

Appendix 2

National Audit of Violence 2003-5

Contribution of the findings to the development of national policy, guidance and initiatives

National Patient Safety Agency (NPSA): the topic of 'violence' was chosen as its first programme of work in mental health. The National Audit findings were one factor that influenced the decision by the NPSA to set up the "Safer Wards for Acute Psychiatry" (SWAP) initiative. Staff at the CRTU worked to ensure that the two programmes dove-tailed.

Counter Fraud and Security Management Services (CFSMS): the audit team contributed to work that the CFSMS took forward to support staff to prevent and manage violence in the workplace.

Cross-Government Group 'Management of Violence' Group. This group was set up to pull together national policy initiatives relating to the prevention and management of violence across and between public sector services. Findings from the audit were brought to the attention of this group and, in turn, the audit team was enabled to audit member trusts abreast of national policy and practice changes.

Cross-Government Group 'Management of Violence' Sub-Group: The Accreditation and Regulation of Physical Intervention Trainers and Programmes of Education and Training: the work of this sub-group was directly informed by some of the audit findings.

NIMHE's London Development Centre's 'Acute Care Collaborative' programme: as members of the Steering Group, the audit team was able to contribute both to the development of the standards, and the methods for this work.

NICE Guideline: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments:

- Reference to audit tools (Appendix D): <http://www.nice.org.uk/pdf/cg025niceguideline.pdf>
- NICE Cost impact report: <http://www.nice.org.uk/page.aspx?o=257224>

Mental Health Act Commission's Eleventh Biennial Report: the report frequently cites findings from the audit programme. <http://www.mhac.org.uk/Pages/documents/publications/MHAC%2011%20TEXT%20FA.pdf>.

NIMHE/HC handbook of standards: as part of the follow-up work from the last phase of the audit, the audit team developed an accreditation scheme for acute wards (AIMS – Accreditation for Acute In-patient Mental Health services - <http://www.rcpsych.ac.uk/aims>). When NIMHE was subsequently asked by the Healthcare Commission to develop a handbook of standards to support the latter's improvement reviews in acute psychiatric wards, the AIMS Project Team was invited to join the sub-group leading the NIMHE work. The content of the AIMS standards greatly influenced the content and process of the improvement reviews.

Appendix 3

National Audit of Violence 2006-07 Declaration of Understanding

(Name of Trust/Organisation).....
agrees to participate in the fourth wave of the **National Audit of Violence**.

This declaration lists the undertakings of the College Research and Training Unit's central project team and your trust/organisation to ensure the success of the audit, locally and nationally.

The Chief Executive will:

- offer high-level, visible support to the participating units;
- support a senior individual to work as project lead for the local project team;
- ensure that local project team members are allocated time to devote to the audit;
- ensure that local project team members have the resources to carry out programme activities, e.g. admin support, meeting rooms, access to computers and the internet;
- support the local team to develop action plans arising from the audit findings;
- create a conduit between the local project team and relevant local committees, such as the trust board (or equivalent), clinical governance committee, practice improvement groups, etc;
- monitor improvement and outcomes resulting from the audit;
- fund accommodation and travel costs for project team members to attend **one** regional introductory workshop and **one** feedback workshop.

The CRTU central project team will offer an efficient and effective service and will:

- run a regional introductory workshop event prior to data collection;
- run a regional feedback workshop at the end of the data collection period;
- develop data collection instruments, guidance, data analysis and reporting that will support evaluation against the audit standards;
- provide relevant and timely summaries of the audit findings to each participating organisation;
- support participating organisations to compare their findings with others nationally;
- encourage action planning and implementation of improvements.

Status of data derived from the audit

The data gathered during the course of the National Audit of Violence will be held by the Royal College of Psychiatrists' Research and Training Unit on behalf of the Healthcare Commission. In the normal course of events, the CRTU will provide the Healthcare Commission with a report of the results after the data have been analysed and placed in context. However, all data are subject to the Freedom of Information Act, any requests being channelled through the Healthcare Commission. In the event that a request is received for trust level data, the Healthcare Commission will consult with the trust concerned before reaching any decision on disclosure, although the final decision will remain with the Commission.

The names of our participating inpatient units are:

Acute ward

.....

Older Peoples ward

.....

Other ward (please specify e.g. PICU, Forensic, Acute)

.....

Chief Executive

Signed:

Date:

Royal College of Psychiatrists' Research and Training Unit

Signed:

Date:

Appendix 4

Contextual Data summary

| Location | | | Bed state | | | No. patients under MHA | No. consultants with allocated beds | Number qualified posts | |
|-----------------------------------|-------|-------|-----------|-----------------|-------------|------------------------|-------------------------------------|------------------------|---------|
| Mixed | Urban | Rural | Number | Number occupied | Occupancy | | | Funded | Filled |
| All wards – England (n=61) | | | | | | | | | |
| 61% | 36% | 3% | Mean=20 | Mean=17 | Median=91% | Mean=3 | Median=2 | Mean=11 | Mean=10 |
| | | | R =10-32 | R=9-35 | R=33-109% | R=0-9 | R=0-5 | R=0-19 | R=1-18 |
| All wards – Wales (n=11) | | | | | | | | | |
| 73% | 18% | 9% | Mean=17 | Mean=15 | Median=100% | Mean=2 | Median=2 | Mean=11 | Mean=10 |
| | | | R=10-24 | R= 9-24 | R=64-100 | R=0-8 | R=1-4 | R=9-15 | R=8-14 |

| Number unqualified posts | | Number unfilled advertised posts in past | | Hours admin support per week | | | | Policies and procedures % 'yes' | | | | | |
|-----------------------------------|---------|--|----------|------------------------------|------|-------|-----|---------------------------------|-----------------------------|-------------------|------------------------------------|---|--|
| Funded | Filled | 3 months | 6 months | 0 | 1-29 | 30-40 | 40+ | Risk management strategy | Risk assessment carried out | To include alarms | Alarms well maintained and checked | Doctor quickly available to attend alarms | Systems for post incident support/review |
| All wards – England (n=61) | | | | | | | | | | | | | |
| Mean=12 | Mean=11 | Mean=0.5 | Mean=0.5 | n=4 | n=40 | n=16 | n=1 | 92% | 93% | 80% | 80% | 49% | 79% |
| R=5-31 | R=0-25 | R=0-7 | R=0-7 | 7% | 66% | 26% | 2% | | | N/A=7% | N/A=5% | N/A=3% | N/A=2% |
| All wards – Wales (n=11) | | | | | | | | | | | | | |
| Mean=14 | Mean=14 | Mean=1 | Mean=1 | n=5 | n=6 | n=0 | n=0 | 91% | 100% | 55% | 55% | 55% | 55% |
| R=7-21 | R=7-21 | R=0-4 | R=0-4 | 45% | 55% | | | | | N/A=18% | N/A=27% | | |

| Groups able to access supports % 'yes' | | | | | Policies and procedures % 'yes' | | | | | | | | | | |
|--|-------------------|-------------------|----------------|------------------------|---------------------------------|-------------------|------------------------------|-----------------|---------------------------|--|---------------------------|------------------|--|---------------------------------------|--|
| Staff involved | Patients involved | Carers and family | Other patients | Visitors who witnessed | Searches of patients | Children visitors | Observing high risk patients | Safety of women | Using/recording restraint | Using/recording rapid tranquillisation | Using/recording seclusion | Locking the ward | Preventing and dealing with harassment and abuse | Supporting patients with disabilities | Training employees in short-term management of disturbed/violent behaviour |
| All wards – England (n=61) | | | | | | | | | | | | | | | |
| 84% | 61% | 61% | 41% | 44% | 77% | 90% | 93% | 46% | 85% | 72% | 36% | 72% | 92% | 66% | 92% |
| | | | | | N/A = 3% | N/A = 2% | | N/A = 10% | N/A = 10% | N/A = 18% | N/A = 57% | N/A = 15% | | | |
| All wards – Wales (n=11) | | | | | | | | | | | | | | | |
| 55% | 45% | 45% | 27% | 36% | 73% | 82% | 82% | 36% | 82% | 73% | 9% | 100% | 100% | 100% | 100% |
| | | | | | | | N/A = 9% | N/A = 18% | N/A = 9% | | N/A = 55% | | | | |

| Does the training specify: | | | | |
|---|---------------------------------|---|--|--|
| Level of training (based on risk assessment)? | How often they will be trained? | (An outline of) techniques in which they will be trained? | That training needs reviewed annually? | Protocol to ensure police and staff are aware of procedures and roles in emergency situations? |
| All wards – England (n=61) | | | | |
| 85% | 90% | 77% | 85% | 52% |
| | | | | N/A=8% |
| All wards – Wales (n=11) | | | | |
| 82% | 100% | 100% | 100% | 73% |
| | | | | N/A=18% |

Appendix 5

Ward survey results by service 'type' (n=75)

The ward

Is there enough space on the ward?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 61 | 39 | 322 | 58 | 42 | 160 | 62 | 38 | 382 |
| Clinical staff | 63 | 37 | 52 | 88 | 12 | 25 | 76 | 24 | 45 |
| Non clinical staff | 75 | 25 | 44 | 60 | 40 | 20 | 80 | 20 | 50 |
| Patient | 82 | 18 | 126 | 85 | 15 | 110 | 95 | 5 | 19 |
| Visitor | 81 | 19 | 68 | 90 | 10 | 41 | 91 | 9 | 89 |
| Carer/Next of kin | 73 | 27 | 59 | 71 | 29 | 14 | 89 | 11 | 111 |
| Third party observer | 80 | 20 | 15 | 100 | 0 | 8 | 88 | 12 | 34 |

Is the ward usually excessively noisy during the day?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 46 | 54 | 309 | 37 | 63 | 156 | 67 | 33 | 365 |
| Clinical staff | 33 | 67 | 52 | 12 | 88 | 25 | 30 | 70 | 46 |
| Non clinical staff | 29 | 71 | 45 | 30 | 70 | 20 | 38 | 63 | 48 |
| Patient | 30 | 70 | 123 | 24 | 76 | 109 | 25 | 75 | 20 |
| Visitor | 22 | 78 | 67 | 5 | 95 | 41 | 17 | 83 | 88 |
| Carer/Next of kin | 29 | 71 | 55 | 29 | 71 | 14 | 22 | 78 | 104 |
| Third party observer | 31 | 69 | 16 | 11 | 89 | 9 | 18 | 82 | 33 |

Is the ward usually excessively noisy during the night?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 16 | 84 | 300 | 7 | 93 | 153 | 22 | 78 | 345 |
| Clinical staff | 16 | 84 | 37 | 0 | 100 | 13 | 14 | 86 | 29 |
| Non clinical staff | 5 | 95 | 22 | 0 | 100 | 7 | 14 | 86 | 22 |
| Patient | 18 | 82 | 125 | 23 | 77 | 106 | 25 | 75 | 20 |

Does the temperature often feel too hot?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 55 | 45 | 320 | 63 | 38 | 160 | 58 | 42 | 369 |
| Clinical staff | 40 | 60 | 52 | 44 | 56 | 25 | 24 | 76 | 46 |
| Non clinical staff | 52 | 48 | 44 | 75 | 25 | 20 | 52 | 48 | 48 |
| Patient | 25 | 75 | 126 | 39 | 61 | 109 | 15 | 85 | 20 |
| Visitor | 32 | 68 | 66 | 38 | 62 | 42 | 26 | 74 | 89 |
| Carer/Next of kin | 34 | 66 | 58 | 14 | 86 | 14 | 19 | 81 | 109 |
| Third party observer | 0 | 100 | 16 | 11 | 89 | 9 | 18 | 82 | 34 |

Does the temperature often feel too cold?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 46 | 54 | 320 | 28 | 73 | 160 | 39 | 61 | 369 |
| Clinical staff | 22 | 78 | 51 | 13 | 88 | 24 | 21 | 79 | 42 |
| Non clinical staff | 14 | 86 | 44 | 19 | 81 | 16 | 18 | 82 | 44 |
| Patient | 22 | 78 | 125 | 29 | 71 | 104 | 22 | 78 | 18 |
| Visitor | 13 | 87 | 69 | 19 | 81 | 42 | 11 | 89 | 90 |
| Carer/Next of kin | 9 | 91 | 56 | 43 | 57 | 14 | 8 | 92 | 107 |
| Third party observer | 31 | 69 | 16 | 38 | 63 | 8 | 6 | 94 | 34 |

Is the ward homely and comfortable in respect of lighting and appropriate décor and music?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 70 | 30 | 321 | 69 | 31 | 159 | 67 | 33 | 379 |
| Clinical staff | 55 | 45 | 51 | 71 | 29 | 24 | 74 | 26 | 46 |
| Non clinical staff | 81 | 19 | 43 | 85 | 15 | 20 | 92 | 8 | 50 |
| Patient | 81 | 19 | 125 | 85 | 15 | 110 | 95 | 5 | 20 |
| Visitor | 82 | 18 | 68 | 80 | 20 | 41 | 76 | 24 | 88 |
| Carer/Next of kin | 83 | 17 | 59 | 79 | 21 | 14 | 81 | 19 | 111 |
| Third party observer | 88 | 13 | 16 | 78 | 22 | 9 | 88 | 12 | 33 |

Is open visiting encouraged?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Carer/Next of kin | 88 | 12 | 57 | 46 | 54 | 13 | 88 | 12 | 101 |
| Third party observer | 80 | 20 | 15 | 44 | 56 | 9 | 81 | 19 | 32 |

When patients have become distressed or angry, have you generally been able to access a quiet area/separate room on the ward where they can be supported by staff?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 82 | 18 | 321 | 80 | 20 | 159 | 76 | 24 | 382 |
| Clinical staff | 77 | 23 | 52 | 86 | 14 | 21 | 84 | 16 | 45 |
| Non clinical staff | 92 | 8 | 38 | 73 | 27 | 15 | 88 | 12 | 42 |

Is the emergency alarm system on the ward effective?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 81 | 19 | 320 | 68 | 32 | 158 | 74 | 26 | 376 |
| Clinical staff | 84 | 16 | 44 | 81 | 19 | 16 | 83 | 17 | 41 |
| Non clinical staff | 86 | 14 | 43 | 83 | 17 | 18 | 81 | 19 | 47 |

Is a personal safety alarm available for your use?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 54 | 46 | 317 | 62 | 38 | 159 | 57 | 43 | 378 |
| Clinical staff | 43 | 57 | 51 | 61 | 39 | 23 | 64 | 36 | 44 |
| Non clinical staff | 50 | 50 | 42 | 45 | 55 | 20 | 60 | 40 | 45 |

Does the ward have a consistent and rehearsed response to emergency alarm calls (including personal safety alarm calls)?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 65 | 35 | 314 | 61 | 39 | 158 | 59 | 41 | 369 |
| Clinical staff | 62 | 38 | 45 | 75 | 25 | 20 | 74 | 26 | 42 |
| Non clinical staff | 90 | 10 | 42 | 61 | 39 | 18 | 80 | 20 | 40 |

Do you know who your 'Local Security Management Specialist' is?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 18 | 82 | 309 | 25 | 75 | 156 | 21 | 79 | 370 |
| Clinical staff | 20 | 80 | 50 | 17 | 83 | 23 | 38 | 62 | 45 |
| Non clinical staff | 36 | 64 | 42 | 16 | 84 | 19 | 19 | 81 | 47 |

Do ward staff have a say about admissions onto the ward?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 25 | 75 | 314 | 31 | 69 | 155 | 21 | 79 | 372 |
| Clinical staff | 56 | 44 | 48 | 53 | 47 | 19 | 56 | 44 | 39 |
| Non clinical staff | 35 | 65 | 31 | 33 | 67 | 12 | 35 | 65 | 26 |

When you have a particularly difficult mix of patients, are additional resources made available to the ward?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 51 | 49 | 291 | 52 | 48 | 146 | 42 | 58 | 366 |
| Clinical staff | 58 | 42 | 45 | 63 | 38 | 16 | 70 | 30 | 40 |
| Non clinical staff | 82 | 18 | 28 | 42 | 58 | 12 | 45 | 55 | 29 |

Do you have somewhere secure to store your belongings, for example, money or jewellery?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 72 | 28 | 117 | 79 | 21 | 104 | 75 | 25 | 20 |

Can you get your belongings whenever you want?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 90 | 10 | 125 | 94 | 6 | 103 | 90 | 10 | 20 |

Do you have to share space with members of the opposite sex when you don't want to?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 14 | 86 | 127 | 20 | 80 | 109 | 11 | 89 | 18 |

Communication systems

Are you able to speak to staff when you need to, for example if you are concerned or upset?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Visitor | 97 | 3 | 69 | 98 | 2 | 41 | 97 | 3 | 87 |

Are your concerns taken seriously and acted upon?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Visitor | 91 | 9 | 65 | 98 | 2 | 42 | 99 | 1 | 83 |

Communication systems and ward culture

Do you have sufficient opportunities to raise and discuss issues and concerns with colleagues on the ward?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 82 | 18 | 320 | 85 | 15 | 162 | 77 | 23 | 379 |
| Clinical staff | 92 | 8 | 52 | 88 | 13 | 24 | 87 | 13 | 46 |
| Non clinical staff | 86 | 14 | 42 | 94 | 6 | 16 | 96 | 4 | 46 |

Are your concerns taken seriously and acted upon?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 70 | 30 | 308 | 77 | 23 | 152 | 72 | 28 | 364 |
| Clinical staff | 86 | 14 | 49 | 81 | 19 | 21 | 89 | 11 | 45 |
| Non clinical staff | 89 | 11 | 38 | 88 | 13 | 16 | 87 | 13 | 46 |

Are the handover systems on the ward effective?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 86 | 14 | 323 | 88 | 13 | 160 | 85 | 15 | 372 |
| Clinical staff | 78 | 22 | 45 | 68 | 32 | 19 | 81 | 19 | 43 |
| Non clinical staff | 83 | 17 | 23 | 100 | 0 | 10 | 97 | 3 | 29 |

Are the following appropriate to the resident population?

| | | Mixed | | | Functional | | | Organic | | |
|--|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Staff ratios i.e. number of staff on each shift | Nursing staff | 62 | 38 | 308 | 66 | 34 | 160 | 58 | 42 | 370 |
| | Clinical staff | 70 | 30 | 40 | 63 | 37 | 19 | 79 | 21 | 43 |
| | Non clinical staff | 79 | 21 | 24 | 85 | 15 | 13 | 73 | 27 | 41 |

| | | Mixed | | | Functional | | | Organic | | |
|--|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Staff skill mix i.e. experience and qualifications of staff | Nursing staff | 76 | 24 | 315 | 75 | 25 | 158 | 77 | 23 | 375 |
| | Clinical staff | 74 | 26 | 42 | 62 | 38 | 21 | 77 | 23 | 43 |
| | Non clinical staff | 88 | 12 | 25 | 100 | 0 | 13 | 89 | 11 | 38 |

| | | Mixed | | | Functional | | | Organic | | |
|----------------------------|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Gender mix of staff | Nursing staff | 50 | 50 | 319 | 61 | 39 | 160 | 46 | 54 | 375 |
| | Clinical staff | 60 | 40 | 42 | 76 | 24 | 21 | 63 | 37 | 43 |
| | Non clinical staff | 67 | 33 | 24 | 93 | 7 | 14 | 73 | 28 | 40 |

| | | Mixed | | | Functional | | | Organic | | |
|----------------------------|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Ethnic mix of staff | Nursing staff | 68 | 32 | 300 | 75 | 25 | 155 | 72 | 28 | 365 |
| | Clinical staff | 74 | 26 | 42 | 81 | 19 | 21 | 71 | 29 | 42 |
| | Non clinical staff | 69 | 31 | 26 | 100 | 0 | 13 | 93 | 8 | 40 |

Is there a multi-disciplinary consensus on the clinical care of patients?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|--------------|------|-----|-------------------|------|-----|----------------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 91 | 9 | 289 | 86 | 14 | 145 | 90 | 10 | 339 |
| Clinical staff | 93 | 7 | 46 | 100 | 0 | 21 | 88 | 12 | 41 |
| Non clinical staff | 96 | 4 | 26 | 100 | 0 | 10 | 89 | 11 | 27 |

Respect, privacy, dignity, choice

Does the ward respect patients' religious and cultural needs, e.g. religious festivals, diet?

| | Mixed | | | | Functional | | | | Organic | | | |
|-----------------------------|-------|------|------|-----|------------|-----|------|-----|---------|-----|------|----|
| | Yes % | No % | N/A% | n= | Yes % | No% | N/A% | n= | Yes% | No% | N/A% | n= |
| Patient | 67 | 6 | 28 | 127 | 59 | 3 | 38 | 106 | 50 | 10 | 40 | 20 |
| Carer/Next of kin | 52 | 4 | 44 | 52 | 55 | 9 | 36 | 11 | 59 | 2 | 39 | 96 |
| Third party observer | 73 | 7 | 20 | 15 | 100 | 0 | 0 | 9 | 63 | 3 | 34 | 32 |

Do staff treat patients with respect?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Carer/Next of kin | 100 | 0 | 58 | 100 | 0 | 13 | 98 | 2 | 108 |
| Third party observer | 100 | 0 | 16 | 100 | 0 | 9 | 100 | 0 | 33 |

Have patients been cared for in a dignified manner?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 90 | 10 | 130 | 95 | 5 | 109 | 95 | 5 | 20 |
| Carer/Next of kin | 100 | 0 | 57 | 100 | 0 | 12 | 97 | 3 | 105 |
| Third party observer | 100 | 0 | 16 | 100 | 0 | 9 | 100 | 0 | 33 |

Do you have privacy when being given medication?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 59 | 41 | 121 | 62 | 38 | 101 | 61 | 39 | 18 |

Have patients ever asked for their medication to be reviewed?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 31 | 69 | 121 | 25 | 75 | 108 | 32 | 68 | 19 |
| Carer/Next of kin | 28 | 72 | 54 | 25 | 75 | 12 | 39 | 61 | 105 |
| Third party observer | 17 | 83 | 12 | 44 | 56 | 19 | 5 | 95 | 22 |

If patients did ask for their medication to be reviewed, did it happen?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 84 | 16 | 32 | 88 | 13 | 24 | 60 | 40 | 5 |
| Carer/Next of kin | 100 | 0 | 13 | 100 | 0 | 3 | 100 | 0 | 38 |
| Third party observer | 100 | 0 | 2 | 100 | 0 | 3 | 100 | 0 | 1 |

Are patients' personal preferences respected, e.g. in relation to food and drink choices, going to bed, clothing?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 87 | 13 | 119 | 90 | 10 | 108 | 95 | 5 | 19 |
| Carer/Next of kin | 88 | 12 | 50 | 91 | 9 | 11 | 95 | 5 | 93 |
| Third party observer | 93 | 7 | 15 | 100 | 0 | 8 | 100 | 0 | 29 |

Do patients have opportunities to go outdoors/leave the ward?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 75 | 25 | 119 | 79 | 21 | 102 | 68 | 32 | 19 |
| Carer/Next of kin | 65 | 35 | 54 | 64 | 36 | 14 | 71 | 29 | 99 |
| Third party observer | 92 | 8 | 13 | 89 | 11 | 9 | 73 | 27 | 30 |

Are carers/patients able to speak to staff when they need to, for example if they are concerned or upset?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 87 | 13 | 125 | 93 | 7 | 105 | 100 | 0 | 20 |
| Carer/Next of kin | 100 | 0 | 59 | 93 | 7 | 14 | 98 | 2 | 110 |
| Third party observer | 100 | 0 | 16 | 100 | 0 | 9 | 97 | 3 | 33 |

Are carer/patients' concerns taken seriously and acted upon?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 86 | 14 | 106 | 94 | 6 | 102 | 79 | 21 | 19 |
| Carer/Next of kin | 98 | 2 | 52 | 92 | 8 | 13 | 94 | 6 | 103 |
| Third party observer | 100 | 0 | 14 | 100 | 0 | 9 | 94 | 6 | 33 |

When you were admitted to the ward, were you asked what you **would** and **would not** wish to happen if your behaviour became severely challenging/violent?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 6 | 94 | 93 | 9 | 91 | 95 | 25 | 75 | 16 |

When you were admitted to the ward, were you asked your **trigger factors** and **early warning signs** of severely challenging/violent behaviour and how these should be managed?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 9 | 91 | 82 | 11 | 89 | 90 | 31 | 69 | 16 |

Training

General Training

Have you received any training related to the following:

| | | Mixed | | | Functional | | | Organic | | |
|---------------------|--------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Equal opportunities | Nursing staff | 54 | 46 | 314 | 60 | 40 | 157 | 46 | 54 | 376 |
| | Clinical staff | 58 | 42 | 52 | 48 | 52 | 25 | 59 | 41 | 46 |
| | Non clinical staff | 44 | 56 | 36 | 44 | 56 | 18 | 31 | 69 | 45 |

| | | Mixed | | | Functional | | | Organic | | |
|--|--------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Person-centred care and therapeutic approaches in relation to the care of older people | Nursing staff | 62 | 38 | 302 | 61 | 39 | 120 | 58 | 42 | 369 |
| | Clinical staff | 64 | 36 | 47 | 55 | 45 | 22 | 75 | 25 | 44 |
| | Non clinical staff | 13 | 88 | 32 | 36 | 64 | 11 | 16 | 84 | 44 |

| | | Mixed | | | Functional | | | Organic | | |
|--|--------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| The 'Bournewood Ruling', especially in respect of restriction and deprivation of liberty | Nursing staff | 22 | 78 | 310 | 19 | 81 | 157 | 24 | 76 | 367 |
| | Clinical staff | 45 | 55 | 51 | 43 | 57 | 21 | 32 | 68 | 47 |
| | Non clinical staff | 9 | 91 | 33 | 20 | 80 | 15 | 8 | 98 | 45 |

| | | Mixed | | | Functional | | | Organic | | |
|---|--------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| The Mental Capacity Act, especially in respect of the best interests and least restrictive principles | Nursing staff | 34 | 66 | 315 | 31 | 69 | 157 | 35 | 65 | 363 |
| | Clinical staff | 63 | 37 | 52 | 55 | 45 | 22 | 51 | 49 | 47 |
| | Non clinical staff | 12 | 88 | 33 | 31 | 69 | 16 | 14 | 86 | 44 |

Undertaking personal searches

Are you involved in undertaking personal searches?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 29 | 71 | 315 | 28 | 72 | 149 | 15 | 85 | 373 |
| Clinical staff | 12 | 88 | 51 | 5 | 95 | 22 | 7 | 93 | 45 |
| Non clinical staff | 6 | 94 | 35 | 25 | 75 | 16 | 4 | 96 | 50 |

Have you received appropriate instruction in undertaking personal searches, which is repeated and regularly updated?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 38 | 62 | 87 | 28 | 72 | 39 | 25 | 75 | 56 |
| Clinical staff | 17 | 83 | 6 | 100 | 0 | 1 | 100 | 0 | 3 |
| Non clinical staff | 50 | 50 | 2 | 75 | 25 | 4 | 100 | 0 | 1 |

The management of actual incidents

Are you involved in managing severely challenging/violent incidents?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 81 | 19 | 302 | 78 | 22 | 153 | 77 | 23 | 371 |
| Clinical staff | 42 | 58 | 48 | 33 | 67 | 24 | 44 | 56 | 43 |
| Non clinical staff | 6 | 94 | 36 | 5 | 95 | 19 | 5 | 95 | 39 |

Have you had access to training that promotes the use of non-physical interventions to recognise and prevent severely challenging/violent behaviour e.g. 'Promoting Safer and Therapeutic Services' training?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 61 | 39 | 238 | 71 | 29 | 118 | 68 | 32 | 284 |
| Clinical staff | 70 | 30 | 20 | 88 | 13 | 8 | 78 | 22 | 18 |
| Non clinical staff | 0 | 100 | 2 | 100 | 0 | 1 | 100 | 0 | 2 |

Has your training been adequate to enable you to **minimise the risk** of a severely challenging/violent incident occurring?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 69 | 31 | 231 | 77 | 23 | 114 | 76 | 24 | 280 |
| Clinical staff | 56 | 44 | 18 | 88 | 13 | 8 | 88 | 12 | 17 |
| Non clinical staff | 100 | 0 | 2 | 100 | 0 | 1 | 100 | 0 | 2 |

Has your training been adequate to enable you to **deal with** a severely challenging/violent incident when one occurs?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 72 | 28 | 228 | 74 | 26 | 112 | 74 | 26 | 275 |
| Clinical staff | 56 | 44 | 16 | 100 | 0 | 8 | 94 | 6 | 17 |
| Non clinical staff | 100 | 0 | 2 | 100 | 0 | 1 | 100 | 0 | 2 |

Have you received training in how to record any incident using the appropriate local templates?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 61 | 39 | 235 | 60 | 40 | 117 | 66 | 34 | 282 |
| Clinical staff | 37 | 63 | 19 | 38 | 63 | 8 | 61 | 39 | 18 |
| Non clinical staff | 100 | 0 | 2 | 100 | 0 | 1 | 100 | 0 | 2 |

Have you received training in managing forms of severely challenging behaviour in older people with mental health problems, other than violent behaviour, e.g. resistance to care, excessive walking?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 43 | 57 | 290 | 38 | 62 | 109 | 42 | 58 | 363 |
| Clinical staff | 33 | 67 | 45 | 44 | 56 | 18 | 38 | 62 | 37 |
| Non clinical staff | 9 | 91 | 35 | 38 | 62 | 13 | 15 | 85 | 41 |

Observation

Are you involved in carrying out observations?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 96 | 4 | 316 | 95 | 5 | 153 | 92 | 8 | 376 |
| Clinical staff | 39 | 61 | 51 | 18 | 82 | 22 | 35 | 65 | 43 |
| Non clinical staff | 11 | 89 | 38 | 18 | 82 | 17 | 11 | 89 | 45 |

Do you receive ongoing competency training in observation?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 28 | 72 | 218 | 30 | 70 | 93 | 27 | 73 | 255 |
| Clinical staff | 44 | 56 | 9 | 0 | 100 | 2 | 22 | 78 | 9 |
| Non clinical staff | 50 | 50 | 2 | 0 | 100 | 2 | 33 | 67 | 3 |

Rapid Tranquillisation

Are you involved in administering or prescribing rapid tranquillisation, or in monitoring patients to whom parenteral rapid tranquillisation has been administered?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 48 | 52 | 312 | 53 | 47 | 158 | 46 | 54 | 368 |
| Clinical staff | 46 | 54 | 50 | 44 | 56 | 25 | 34 | 66 | 47 |
| Non clinical staff | 2 | 98 | 41 | 16 | 84 | 19 | 0 | 100 | 50 |

Have you received training around the legal framework that authorises the use of rapid tranquillisation?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 33 | 67 | 147 | 42 | 58 | 83 | 36 | 64 | 161 |
| Clinical staff | 52 | 48 | 23 | 82 | 18 | 11 | 44 | 56 | 16 |
| Non clinical staff | 100 | 0 | 1 | 33 | 67 | 3 | - | - | - |

Are you trained in the use of pulse oximeters?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 37 | 63 | 143 | 41 | 59 | 83 | 37 | 63 | 161 |
| Clinical staff | 55 | 45 | 22 | 73 | 27 | 11 | 56 | 44 | 16 |
| Non clinical staff | 0 | 100 | 1 | 33 | 67 | 3 | - | - | - |

Do you receive ongoing competency training to a level of Immediate Life Support (ILS - Resuscitation Council UK)?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 74 | 26 | 148 | 72 | 28 | 82 | 69 | 31 | 162 |
| Clinical staff | 87 | 13 | 23 | 45 | 55 | 11 | 88 | 13 | 16 |
| Non clinical staff | 0 | 100 | 1 | 33 | 67 | 3 | - | - | - |

Are you involved in administering covert medicines with older mentally incapacitated people?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 70 | 30 | 142 | 60 | 40 | 58 | 72 | 28 | 159 |
| Clinical staff | 47 | 53 | 19 | 56 | 44 | 9 | 60 | 40 | 15 |
| Non clinical staff | 0 | 100 | 1 | 33 | 67 | 3 | - | - | - |

Have you received specific training in administering covert medicines with older mentally incapacitated people?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 33 | 67 | 86 | 40 | 60 | 25 | 39 | 61 | 96 |
| Clinical staff | 14 | 86 | 7 | 0 | 100 | 5 | 17 | 83 | 6 |
| Non clinical staff | - | - | - | 0 | 100 | 1 | - | - | - |

Hands-on restraint

Are you involved in using hands-on restraint?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 82 | 18 | 316 | 80 | 20 | 157 | 87 | 13 | 372 |
| Clinical staff | 13 | 87 | 52 | 8 | 92 | 25 | 29 | 71 | 45 |
| Non clinical staff | 5 | 95 | 42 | 11 | 89 | 18 | 10 | 90 | 50 |

Have you received training around the legal framework that authorises the use of hands-on restraint?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 72 | 28 | 253 | 80 | 20 | 125 | 74 | 26 | 319 |
| Clinical staff | 71 | 29 | 7 | 50 | 50 | 2 | 85 | 15 | 13 |
| Non clinical staff | 50 | 50 | 2 | 50 | 50 | 2 | 80 | 20 | 5 |

Have you been trained in Basic Life Support (BLS - Resuscitation Council UK)?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 85 | 15 | 257 | 84 | 16 | 125 | 85 | 15 | 321 |
| Clinical staff | 100 | 0 | 7 | 50 | 50 | 2 | 100 | 0 | 13 |
| Non clinical staff | 50 | 50 | 2 | 50 | 50 | 2 | 40 | 60 | 5 |

Have you received training in how to safely apply hands-on restraint to older people?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 72 | 28 | 243 | 79 | 21 | 91 | 76 | 24 | 314 |
| Clinical staff | 67 | 33 | 6 | 50 | 50 | 2 | 69 | 31 | 13 |
| Non clinical staff | 50 | 50 | 2 | 0 | 100 | 2 | 60 | 40 | 5 |

Seclusion

Have you been directly involved in the care of a secluded patient on this ward during the last year?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 15 | 85 | 313 | 15 | 85 | 155 | 19 | 81 | 369 |
| Clinical staff | 6 | 94 | 51 | 4 | 96 | 25 | 4 | 96 | 46 |
| Non clinical staff | 5 | 95 | 40 | 5 | 95 | 19 | 0 | 100 | 50 |

Have you received training around the legal framework that authorises the use of seclusion?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 33 | 67 | 45 | 57 | 43 | 23 | 16 | 84 | 67 |
| Clinical staff | 33 | 67 | 3 | 100 | 0 | 1 | 0 | 100 | 2 |
| Non clinical staff | 0 | 100 | 2 | 100 | 0 | 1 | - | - | - |

Do you receive ongoing competency training in the use of seclusion?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|--------------|------|----|-------------------|------|----|----------------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 29 | 71 | 45 | 23 | 77 | 22 | 8 | 92 | 65 |
| Clinical staff | 0 | 100 | 3 | 0 | 100 | 1 | 0 | 100 | 2 |
| Non clinical staff | 0 | 100 | 2 | 0 | 100 | 1 | - | - | - |

Being given information

Have you been given enough information about why you have been admitted to the ward?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 61 | 39 | 127 | 69 | 31 | 104 | 70 | 30 | 20 |

Have you been given enough information about how the ward is run, for example visiting times, complaints procedure, ward rounds?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 68 | 32 | 127 | 75 | 25 | 107 | 75 | 25 | 20 |

Are you satisfied with your involvement in decisions about your care (e.g. treatment and medication)?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 80 | 20 | 118 | 82 | 18 | 105 | 70 | 30 | 20 |

Have you been given information about how to get advice or help from someone who does not work here, for example an advocate?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 39 | 61 | 119 | 40 | 60 | 104 | 45 | 55 | 20 |

Have you been put under close observation during your admission to this ward?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 37 | 63 | 117 | 36 | 64 | 103 | 47 | 53 | 19 |

Was the reason you were put under observation explained to you?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 88 | 12 | 34 | 77 | 23 | 31 | 83 | 17 | 6 |

Were you told how long observation was likely to be maintained?

| | Mixed | | | Functional | | | Organic | | |
|----------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 29 | 71 | 24 | 36 | 64 | 28 | 67 | 33 | 6 |

Things to do

Are there daily opportunities for group interaction and/or recreation?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 83 | 17 | 121 | 85 | 15 | 105 | 65 | 35 | 20 |
| Carer/Next of kin | 84 | 16 | 45 | 31 | 69 | 13 | 53 | 47 | 78 |
| Third party observer | 100 | 0 | 14 | 100 | 0 | 8 | 84 | 16 | 31 |

Are there daily opportunities for physical activity/exercise?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 70 | 30 | 122 | 57 | 43 | 101 | 45 | 55 | 20 |
| Carer/Next of kin | 80 | 20 | 44 | 54 | 46 | 13 | 43 | 57 | 75 |
| Third party observer | 67 | 33 | 12 | 88 | 13 | 8 | 67 | 33 | 30 |

Do you think that there is an adequate choice of **therapies** available **during the day**?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 53 | 47 | 113 | 53 | 47 | 95 | 55 | 45 | 20 |
| Carer/Next of kin | 69 | 31 | 39 | 67 | 33 | 12 | 36 | 64 | 75 |
| Third party observer | 69 | 31 | 13 | 13 | 88 | 8 | 55 | 45 | 29 |

Do you think that there is an adequate choice of **activities** available **during the day**?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 58 | 42 | 114 | 61 | 39 | 101 | 32 | 68 | 19 |
| Carer/Next of kin | 78 | 22 | 37 | 62 | 38 | 13 | 31 | 69 | 75 |
| Third party observer | 50 | 50 | 12 | 50 | 50 | 8 | 60 | 40 | 30 |

Do you think that there is an adequate choice of **activities** available in the **evenings and at weekends?**

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|--------------|------|-----|-------------------|------|-----|----------------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 32 | 68 | 108 | 38 | 62 | 102 | 21 | 79 | 19 |
| Carer/Next of kin | 38 | 62 | 37 | 8 | 92 | 13 | 26 | 74 | 68 |
| Third party observer | 36 | 64 | 11 | 29 | 71 | 7 | 59 | 41 | 27 |

Supervision

Do you currently receive one-to-one clinical supervision?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 61 | 39 | 322 | 60 | 40 | 159 | 51 | 49 | 377 |
| Clinical staff | 76 | 24 | 51 | 70 | 30 | 23 | 67 | 33 | 46 |
| Non clinical staff | 17 | 83 | 35 | 12 | 88 | 17 | 20 | 80 | 50 |

How often does the supervision take place?

| | Mixed | | | | |
|---------------------------|----------|---------------|-----------|---------------------|-----|
| | Weekly % | Fortnightly % | Monthly % | Less than monthly % | n= |
| Nursing staff | 4 | 6 | 58 | 32 | 189 |
| Clinical staff | 46 | 13 | 36 | 5 | 39 |
| Non clinical staff | 17 | 0 | 67 | 17 | 6 |

| | Functional | | | | |
|---------------------------|------------|---------------|-----------|---------------------|----|
| | Weekly % | Fortnightly % | Monthly % | Less than monthly % | n= |
| Nursing staff | 13 | 3 | 52 | 32 | 91 |
| Clinical staff | 38 | 6 | 50 | 6 | 16 |
| Non clinical staff | 0 | 0 | 100 | 0 | 2 |

| | Organic | | | | |
|---------------------------|----------|---------------|-----------|---------------------|-----|
| | Weekly % | Fortnightly % | Monthly % | Less than monthly % | n= |
| Nursing staff | 3 | 3 | 63 | 30 | 172 |
| Clinical staff | 29 | 6 | 61 | 3 | 31 |
| Non clinical staff | 20 | 10 | 50 | 20 | 10 |

How would you rate your satisfaction with the frequency of supervision that you get?

| | Mixed | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 19 | 72 | 8 | 2 | 194 |
| Clinical staff | 44 | 51 | 5 | 0 | 39 |
| Non clinical staff | 67 | 0 | 0 | 33 | 6 |

| | Functional | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 25 | 62 | 12 | 1 | 91 |
| Clinical staff | 31 | 56 | 13 | 0 | 16 |
| Non clinical staff | 100 | 0 | 0 | 0 | 2 |

| | Organic | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 30 | 54 | 12 | 4 | 182 |
| Clinical staff | 45 | 45 | 6 | 3 | 31 |
| Non clinical staff | 30 | 60 | 10 | 0 | 10 |

How would you rate your satisfaction with the quality of supervision that you get?

| | Mixed | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 22 | 71 | 6 | 2 | 194 |
| Clinical staff | 41 | 56 | 3 | 0 | 39 |
| Non clinical staff | 40 | 20 | 0 | 40 | 5 |

| | Functional | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 30 | 63 | 7 | 0 | 92 |
| Clinical staff | 31 | 63 | 6 | 0 | 16 |
| Non clinical staff | 100 | 0 | 0 | 0 | 2 |

| | Organic | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 31 | 61 | 5 | 3 | 185 |
| Clinical staff | 39 | 52 | 10 | 0 | 31 |
| Non clinical staff | 30 | 70 | 0 | 0 | 10 |

Does your supervision include incidents and events relating to the prevention and management of violence?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|--------------|------|-----|-------------------|------|----|----------------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 74 | 26 | 186 | 64 | 36 | 87 | 59 | 41 | 175 |
| Clinical staff | 62 | 38 | 39 | 44 | 56 | 16 | 55 | 45 | 31 |
| Non clinical staff | 33 | 67 | 6 | 50 | 50 | 2 | 30 | 70 | 10 |

Understanding needs of patients

On a patient's admission, were relatives/carers asked to share information on patient's likes, dislikes and fears?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Carer/Next of kin | 79 | 21 | 52 | 33 | 67 | 6 | 74 | 26 | 99 |
| Third party observer | 89 | 11 | 9 | 100 | 0 | 8 | 79 | 21 | 28 |

On a patient's admission, were relatives/carers asked to highlight patient's strengths and abilities, as well as their problems and needs?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Carer/Next of kin | 80 | 20 | 49 | 40 | 60 | 5 | 66 | 34 | 100 |
| Third party observer | 78 | 22 | 9 | 88 | 13 | 8 | 75 | 25 | 24 |

Were relatives/carers asked to provide background information to staff about patient's former occupation/s, the people they love, have loved, etc?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Carer/Next of kin | 84 | 16 | 50 | 20 | 80 | 5 | 74 | 26 | 102 |
| Third party observer | 88 | 13 | 8 | 88 | 13 | 8 | 88 | 13 | 24 |

Have you witnessed staff caring for patients in a meaningful, person-centred way?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Carer/Next of kin | 91 | 9 | 56 | 50 | 50 | 6 | 97 | 3 | 100 |
| Third party observer | 100 | 0 | 16 | 100 | 0 | 9 | 94 | 6 | 34 |

Have you been aware of staff making use of any of the information or items that relatives/carers have provided e.g. patient's favourite music, family photographs, personal items and effects etc, in caring for patients?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Carer/Next of kin | 76 | 24 | 49 | 14 | 86 | 7 | 72 | 28 | 92 |
| Third party observer | 93 | 7 | 14 | 89 | 11 | 9 | 88 | 13 | 32 |

Do staff recognise when patients are in need of help e.g. feeling hungry or thirsty, or being in discomfort or pain?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Carer/Next of kin | 94 | 6 | 51 | 75 | 25 | 4 | 94 | 6 | 98 |
| Third party observer | 100 | 0 | 16 | 100 | 0 | 9 | 94 | 6 | 32 |

Supports from other colleagues

In relation to managing severely challenging/violent behaviour, how would you rate your satisfaction with the supports that you get from **other staff on this ward?**

| | Mixed | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 26 | 66 | 7 | 2 | 320 |
| Clinical staff | 25 | 63 | 13 | 0 | 48 |
| Non clinical staff | 52 | 33 | 12 | 3 | 33 |

| | Functional | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 26 | 65 | 6 | 3 | 159 |
| Clinical staff | 20 | 80 | 0 | 0 | 20 |
| Non clinical staff | 36 | 64 | 0 | 0 | 14 |

| | Organic | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 31 | 59 | 9 | 2 | 376 |
| Clinical staff | 37 | 59 | 5 | 0 | 41 |
| Non clinical staff | 41 | 59 | 0 | 0 | 44 |

In relation to managing severely challenging/violent behaviour, how would you rate your satisfaction with the supports that you get from the **senior management team within your directorate?**

| | Mixed | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 11 | 57 | 24 | 8 | 311 |
| Clinical staff | 19 | 64 | 13 | 4 | 47 |
| Non clinical staff | 33 | 50 | 13 | 3 | 30 |

| | Functional | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 14 | 59 | 20 | 7 | 153 |
| Clinical staff | 11 | 89 | 0 | 0 | 19 |
| Non clinical staff | 21 | 71 | 7 | 0 | 14 |

| | Organic | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 13 | 54 | 28 | 5 | 368 |
| Clinical staff | 29 | 64 | 7 | 0 | 42 |
| Non clinical staff | 21 | 69 | 10 | 0 | 39 |

How would you rate your satisfaction with the quality of **leadership on the ward?**

| | Mixed | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 19 | 66 | 11 | 3 | 315 |
| Clinical staff | 25 | 63 | 13 | 0 | 48 |
| Non clinical staff | 46 | 43 | 9 | 3 | 35 |

| | Functional | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 27 | 61 | 8 | 4 | 157 |
| Clinical staff | 24 | 38 | 33 | 5 | 21 |
| Non clinical staff | 60 | 88 | 7 | 0 | 15 |

| | Organic | | | | |
|---------------------------|---------------------|-------------|----------------|------------------------|-----|
| | Totally satisfied % | Satisfied % | Dissatisfied % | Totally dissatisfied % | n= |
| Nursing staff | 27 | 60 | 11 | 2 | 373 |
| Clinical staff | 22 | 68 | 10 | 0 | 41 |
| Non clinical staff | 48 | 41 | 9 | 2 | 44 |

The way that severely challenging/violent behaviour has been dealt with on the ward

Do you think that staff deal effectively with severely challenging/violent behaviour:

| | | Mixed | | | Functional | | | Organic | | |
|-------------------------|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Between patients | Nursing staff | 95 | 5 | 319 | 88 | 12 | 156 | 90 | 10 | 372 |
| | Clinical staff | 92 | 8 | 49 | 100 | 0 | 20 | 91 | 9 | 44 |
| | Non clinical staff | 95 | 5 | 39 | 100 | 0 | 18 | 98 | 2 | 47 |
| | Patient | 89 | 11 | 96 | 96 | 4 | 82 | 100 | 0 | 16 |
| | Visitor | 93 | 7 | 58 | 96 | 4 | 28 | 93 | 7 | 73 |
| | Carer/Next of kin | 100 | 0 | 40 | 90 | 10 | 10 | 98 | 2 | 82 |
| | Third party observer | 85 | 15 | 13 | 100 | 0 | 8 | 89 | 11 | 27 |

| | | Mixed | | | Functional | | | Organic | | |
|------------------------------------|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Towards staff from patients | Nursing staff | 92 | 8 | 307 | 86 | 14 | 148 | 86 | 14 | 353 |
| | Clinical staff | 79 | 21 | 47 | 95 | 5 | 20 | 93 | 7 | 42 |
| | Non clinical staff | 97 | 3 | 35 | 94 | 6 | 17 | 100 | 0 | 45 |
| | Patient | 87 | 13 | 79 | 96 | 4 | 71 | 100 | 0 | 17 |
| | Visitor | 95 | 5 | 58 | 96 | 4 | 28 | 96 | 4 | 69 |
| | Carer/Next of kin | 100 | 0 | 34 | 100 | 0 | 8 | 97 | 3 | 75 |
| | Third party observer | 92 | 8 | 12 | 100 | 0 | 7 | 89 | 11 | 27 |

Would you feel comfortable to confidentially report an incident of staff abuse towards a patient?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 92 | 8 | 318 | 94 | 6 | 156 | 92 | 8 | 377 |
| Clinical staff | 92 | 8 | 50 | 82 | 18 | 22 | 100 | 0 | 44 |
| Non clinical staff | 85 | 15 | 41 | 89 | 11 | 19 | 90 | 10 | 49 |
| Patient | 77 | 23 | 116 | 85 | 15 | 96 | 72 | 28 | 18 |
| Visitor | 93 | 7 | 67 | 100 | 0 | 37 | 98 | 2 | 81 |
| Carer/Next of kin | 96 | 4 | 48 | 85 | 15 | 13 | 93 | 7 | 100 |
| Third party observer | 100 | 0 | 9 | 100 | 0 | 7 | 87 | 13 | 31 |

Do you think staff resort too quickly to using **medication** when managing severely challenging/violent incidents?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 11 | 89 | 323 | 14 | 86 | 158 | 17 | 83 | 374 |
| Clinical staff | 22 | 78 | 46 | 15 | 85 | 20 | 27 | 73 | 41 |
| Non clinical staff | 13 | 87 | 30 | 17 | 83 | 12 | 12 | 88 | 41 |
| Patient | 26 | 74 | 77 | 14 | 86 | 74 | 27 | 73 | 15 |
| Visitor | 18 | 82 | 56 | 4 | 96 | 27 | 8 | 92 | 59 |
| Carer/Next of kin | 15 | 85 | 33 | 0 | 100 | 6 | 9 | 91 | 65 |
| Third party observer | 9 | 97 | 11 | 14 | 86 | 7 | 4 | 96 | 26 |

Do you think staff resort too quickly to using **hands-on restraint** when managing severely challenging/violent incidents?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 8 | 92 | 322 | 8 | 92 | 154 | 11 | 89 | 375 |
| Clinical staff | 12 | 88 | 49 | 0 | 100 | 19 | 12 | 88 | 42 |
| Non clinical staff | 9 | 91 | 32 | 8 | 92 | 13 | 5 | 95 | 42 |
| Patient | 18 | 82 | 85 | 10 | 90 | 80 | 8 | 92 | 13 |
| Visitor | 8 | 92 | 62 | 4 | 96 | 28 | 8 | 92 | 63 |
| Carer/Next of kin | 6 | 94 | 34 | 0 | 100 | 4 | 3 | 97 | 69 |
| Third party observer | 8 | 92 | 12 | 14 | 86 | 7 | 7 | 93 | 28 |

Do you think staff resort too quickly to using **seclusion** when managing severely challenging/violent incidents?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 5 | 95 | 288 | 4 | 96 | 141 | 2 | 98 | 332 |
| Clinical staff | 4 | 96 | 47 | 0 | 100 | 20 | 8 | 93 | 40 |
| Non clinical staff | 11 | 89 | 28 | 8 | 92 | 13 | 5 | 95 | 37 |
| Patient | 10 | 90 | 78 | 13 | 87 | 76 | 8 | 92 | 12 |
| Visitor | 3 | 97 | 59 | 0 | 100 | 27 | 9 | 91 | 53 |
| Carer/Next of kin | 13 | 87 | 30 | 0 | 100 | 3 | 3 | 97 | 62 |
| Third party observer | 0 | 100 | 10 | 17 | 83 | 6 | 0 | 100 | 19 |

Have all incidents of severely challenging/violent behaviour that you have been aware of in the past year been reported/recorded?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|--------------|------|-----|-------------------|------|-----|----------------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 89 | 11 | 310 | 88 | 12 | 154 | 86 | 14 | 375 |
| Clinical staff | 83 | 17 | 41 | 88 | 13 | 16 | 89 | 11 | 36 |
| Non clinical staff | 92 | 8 | 26 | 86 | 14 | 14 | 93 | 7 | 41 |

Are patients routinely given the opportunity to discuss their experiences of being involved in severely challenging/violent incidents (either as perpetrator, victim or witness)?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|--------------|------|-----|-------------------|------|-----|----------------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 74 | 26 | 299 | 72 | 28 | 149 | 55 | 45 | 334 |
| Clinical staff | 62 | 38 | 39 | 69 | 31 | 13 | 51 | 49 | 35 |
| Non clinical staff | 79 | 21 | 19 | 100 | 0 | 12 | 63 | 37 | 27 |

Experiences of severely challenging/violent behaviour on the ward

Have you personally been made to feel **upset/distressed** by a patient's severely challenging/violent behaviour?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 54 | 46 | 321 | 49 | 51 | 158 | 53 | 47 | 373 |
| Clinical staff | 31 | 69 | 52 | 21 | 79 | 24 | 22 | 78 | 45 |
| Non clinical staff | 32 | 68 | 41 | 25 | 75 | 20 | 27 | 73 | 48 |
| Patient | 32 | 68 | 120 | 26 | 74 | 99 | 26 | 74 | 19 |
| Visitor | 12 | 88 | 69 | 7 | 93 | 45 | 11 | 89 | 85 |

Has your relative/friend been made to feel **upset/distressed** by another patient's severely challenging/violent behaviour?

| | Mixed | | | Functional | | | Organic | | |
|--------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Carer/next of kin | 50 | 50 | 48 | 18 | 82 | 11 | 45 | 55 | 87 |

Did you witness anyone being made to feel **upset/distressed** by a patient's severely challenging/violent behaviour?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Third party observer | 27 | 73 | 15 | 13 | 88 | 8 | 30 | 70 | 33 |

Have you personally been **threatened or made to feel unsafe**?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 61 | 39 | 320 | 64 | 36 | 160 | 69 | 31 | 375 |
| Clinical staff | 33 | 67 | 52 | 26 | 74 | 23 | 26 | 74 | 46 |
| Non clinical staff | 28 | 72 | 43 | 30 | 70 | 20 | 29 | 71 | 48 |
| Patient | 12 | 88 | 121 | 13 | 88 | 104 | 32 | 68 | 19 |
| Visitor | 9 | 91 | 69 | 4 | 96 | 45 | 13 | 88 | 88 |

Has your relative/friend been **threatened or made to feel unsafe**?

| | Mixed | | | Functional | | | Organic | | |
|--------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Carer/next of kin | 35 | 65 | 43 | 8 | 92 | 12 | 26 | 74 | 85 |

Did you witness anyone being **threatened or made to feel unsafe**?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Third party observer | 27 | 73 | 15 | 13 | 88 | 8 | 19 | 81 | 32 |

Have you personally been **physically assaulted**?

| | Mixed | | | Functional | | | Organic | | |
|---------------------------|-------|------|-----|------------|------|-----|---------|------|-----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Nursing staff | 61 | 39 | 322 | 50 | 50 | 159 | 73 | 27 | 378 |
| Clinical staff | 14 | 86 | 50 | 17 | 83 | 23 | 24 | 76 | 46 |
| Non clinical staff | 19 | 81 | 43 | 30 | 70 | 20 | 22 | 78 | 49 |
| Patient | 7 | 93 | 122 | 4 | 96 | 103 | 21 | 79 | 19 |
| Visitor | 6 | 94 | 70 | 0 | 100 | 44 | 7 | 93 | 89 |

Has your relative/friend been **physically assaulted**?

| | Mixed | | | Functional | | | Organic | | |
|--------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Carer/next of kin | 15 | 85 | 48 | 0 | 100 | 12 | 16 | 84 | 88 |

Did you witness anyone being **physically assaulted**?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Third party observer | 13 | 87 | 15 | 29 | 71 | 7 | 26 | 74 | 31 |

Did staff give the people involved the opportunity to talk about the experience?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 68 | 32 | 31 | 75 | 25 | 24 | 50 | 50 | 6 |
| Visitor | 58 | 42 | 12 | 100 | 0 | 4 | 71 | 29 | 14 |
| Carer/Next of kin | 83 | 17 | 18 | 0 | 100 | 2 | 74 | 26 | 31 |
| Third party observer | 60 | 40 | 5 | 100 | 0 | 1 | 100 | 0 | 9 |

Has anyone given you advice on what to do if you see or hear about someone behaving in a way that is severely challenging/violent, for example how to summon help?

| | Mixed | | | Functional | | | Organic | | |
|-----------------------------|-------|------|----|------------|------|----|---------|------|----|
| | Yes % | No % | n= | Yes % | No % | n= | Yes % | No % | n= |
| Patient | 22 | 78 | 81 | 48 | 52 | 91 | 40 | 60 | 15 |
| Visitor | 51 | 49 | 61 | 34 | 66 | 44 | 53 | 47 | 79 |
| Carer/Next of kin | 31 | 69 | 45 | 0 | 100 | 12 | 32 | 68 | 82 |
| Third party observer | 92 | 8 | 13 | 88 | 13 | 8 | 62 | 38 | 26 |

Appendix 6

Environmental Audit Overall National Findings (n=60)

| | Standard | Met | Not Met | N/A | PEAT |
|----|---|-----|---------|-----|------|
| 1 | All areas look clean | 66% | 12% | | 22% |
| 2 | All areas look friendly | 66% | 19% | | 16% |
| 3 | All areas smell clean | 60% | 19% | | 21% |
| 4 | There is natural daylight | 76% | 9% | | 16% |
| 5 | There is natural fresh air | 81% | 19% | | |
| 6 | There is a perception of space and overcrowding is avoided | 78% | 22% | | |
| 7 | Noise levels are adjusted to meet the needs of the people living/residing on the ward | 67% | 16% | | 17% |
| 8 | Ambient temperatures and ventilation area adequately controlled | 26% | 59% | | 16% |
| 9 | Sight-lines are unimpeded | 31% | 69% | | |
| 10 | There are good routes of entry and exit in the event of an emergency e.g. fire, disturbed/violent behaviour | 67% | 19% | | 14% |
| 11 | A crash bag is available within 3 minutes | 71% | 24% | 5% | |
| 12 | Crash bag equipment is maintained and checked weekly | 83% | 10% | 7% | |
| 13 | Provision is made for children visiting the ward | 67% | 19% | 12% | 2% |
| 14 | There are single sex toilets | 79% | 21% | | |
| 15 | There are single sex washing areas | 76% | 24% | | |
| 16 | There are single sex day areas | 26% | 57% | 9% | 9% |
| 17 | There is single sex sleeping accommodation | 81% | 5% | | 14% |
| 18 | There is a separate area to receive patients with police escorts | 31% | 36% | 33% | |
| 19 | There are adequate quiet spaces for patients for prayer and quiet reflection | 76% | 24% | | |
| 20 | Long narrow corridors and numerous doors or corridors that lead to locked doors and dead ends, are avoided | 62% | 38% | 0% | |
| 21 | Doors are colour-coded to help patients to identify rooms. There are clear and simple signs at a visible height | 40% | 60% | 0% | |
| 22 | The ward provides suitable access and facilities for people who have special needs | 76% | 24% | | |
| 23 | Internal smoking areas/rooms have powerful ventilation and are fitted with a smoke-stop door(s) | 28% | 34% | 31% | 7% |
| 24 | Patients have access to an outside area which is adequately fenced to ensure privacy and security | 76% | 24% | | |
| 25 | There is an activity room on the ward | 71% | 29% | | |

| | | | | | |
|----|--|-----|-----|-----|--|
| 26 | The ward environment helps patients become and remain oriented | 79% | 21% | 0% | |
| 27 | There is a day room with a television | 98% | 2% | | |
| 28 | There is a safe designated area or room specifically for the purpose of reducing arousal and/or agitation. This is in addition to a seclusion room | 55% | 45% | | |
| 29 | There is a designated seclusion room which is 'fit for purpose' | 7% | 9% | 84% | |
| 30 | Patients can lock their bedroom doors (with external override) | 41% | 47% | 12% | |
| 31 | Patients can lock bathroom doors (with external override) | 72% | 14% | 14% | |
| 32 | Patients can lock toilet doors (with external staff override) | 86% | 12% | 2% | |
| 33 | Personal effects are safe and accessible | 50% | 50% | | |
| 34 | Furniture is arranged so that alarms can be reached and doors are not obstructed | 78% | 22% | | |
| 35 | There are accessible alarms in interview rooms, reception areas and other areas where one patient and one staff member work together | 55% | 45% | | |
| 36 | There is a system that ensures that all alarms (for example panic buttons and personal alarms) are well maintained and checked regularly | 69% | 31% | | |
| 37 | A copy of the policy for preventing and dealing and dealing with all forms of harassment and abuse is display prominently | 59% | 41% | | |
| 38 | Meals or other foods (finger foods) are available outside of mealtimes | 93% | 7% | 0% | |

Appendix 7

Case note/drug chart audit on the use of rapid tranquillisation (n=41)

Notes

- 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%.
- Good practice has been highlighted in green on the graphs. Areas of concern have been highlighted in red.

Section 1: Carrying out rapid tranquillisation

NOTE

This section of the audit was completed by ALL respondents. The total number of cases audited by services for older people was 195 (n=195), however, the total figures in some charts do not add up to the expected number due to missing data.

1.8.4.7 Guideline recommendation

Oral medication should be offered before parenteral medication as far as possible.

1.8.4.14 Guideline recommendation

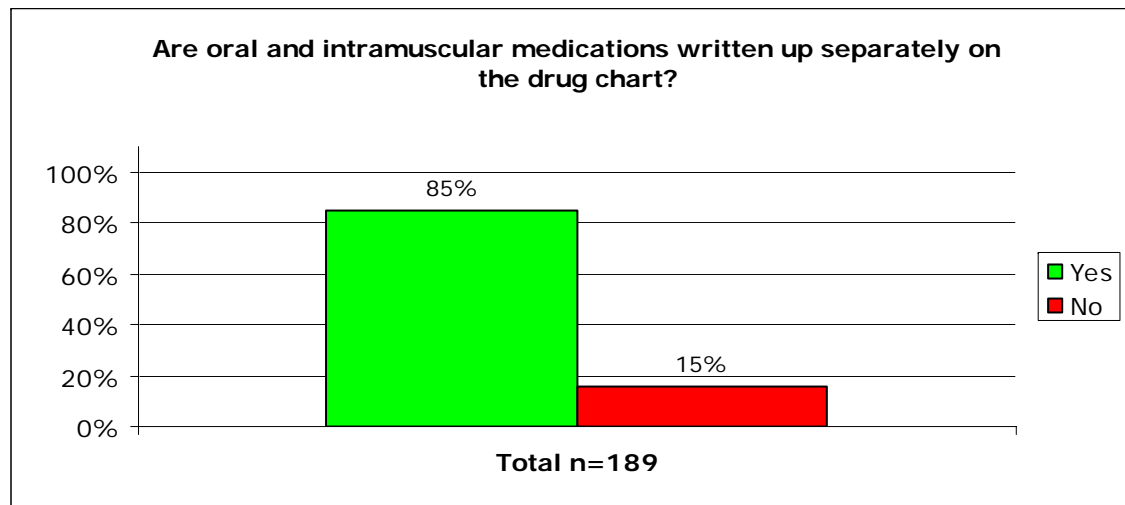
If parenteral treatment proves necessary, the intramuscular route is preferred over intravenous from a safety point of view.

Which route of administration was used?

| Oral | Covert | Intramuscular | Oral and Intramuscular | Total n |
|------|--------|---------------|------------------------|---------|
| % | % | % | % | |
| 79% | 5% | 11% | 4% | 195 |

1.8.4.9 Guideline recommendation

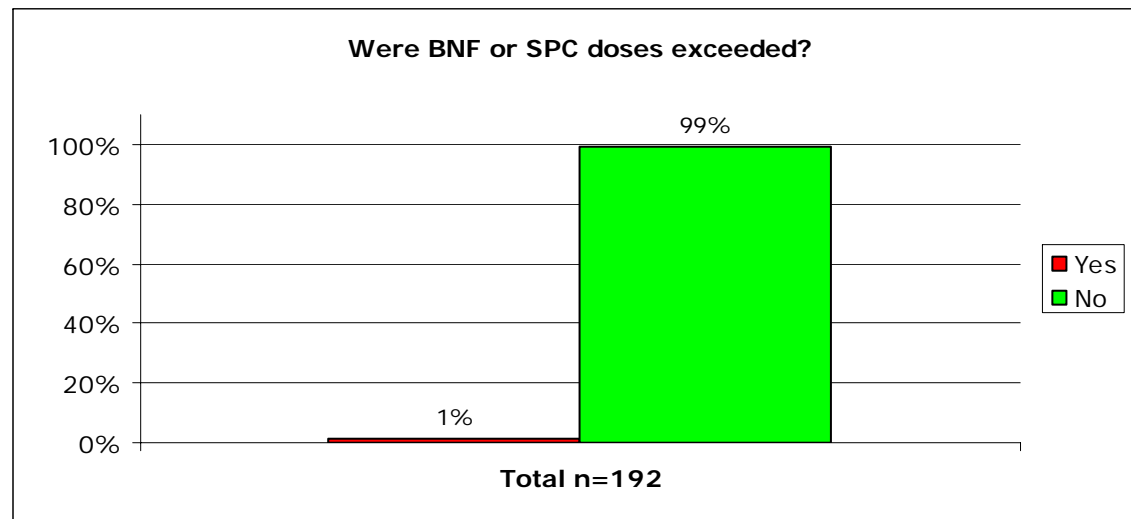
Oral and intramuscular medications should be prescribed separately and the abbreviation of o/i/m should not be used.



Prescribing levels

1.8.4.28 Guideline recommendation

When using rapid tranquillisation there may be certain circumstances in which the current BNF uses and limits and manufacturer's SPC may be knowingly exceeded. A risk-benefit analysis should be recorded in the case notes and a rationale should be recorded in the care plan.

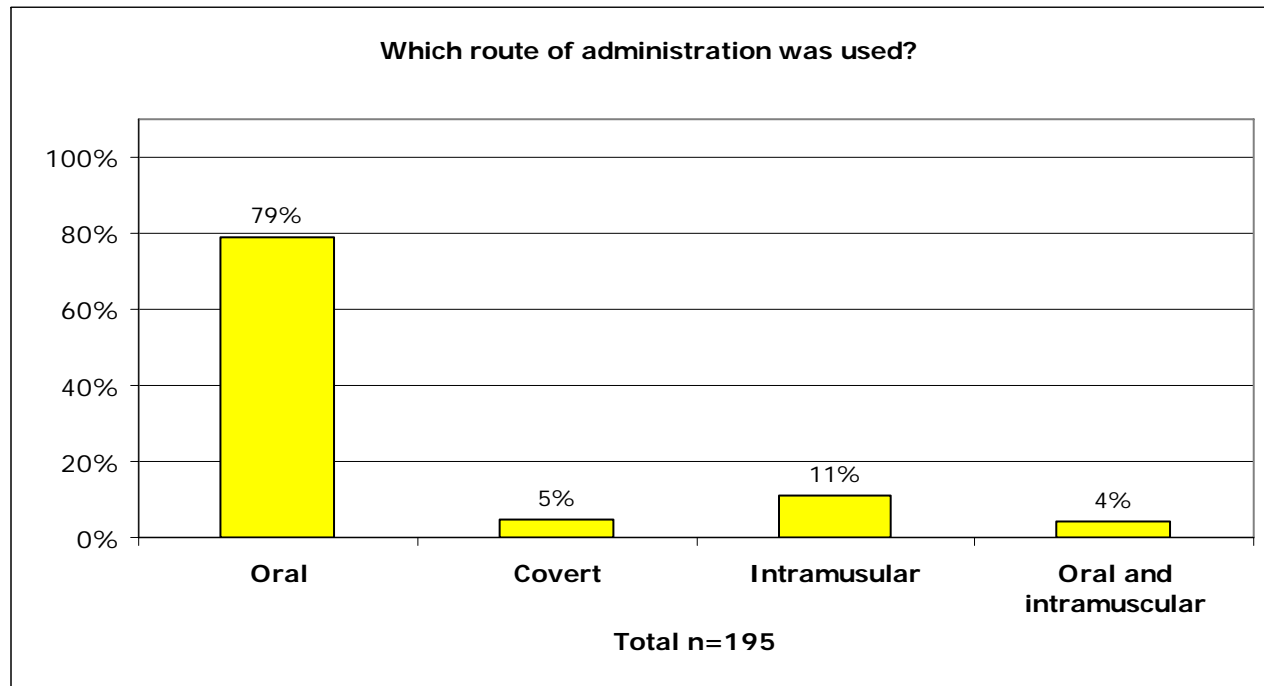


There was only **one case** where BNF or SPC does were exceeded. In this case a risk benefit analysis **was not** recorded in the notes but the rationale **was** recorded in the care plan.

Section 2: The use of oral medication

1.8.4.7 Guideline recommendation

Oral medication should be offered before parenteral medication as far as possible.



Section 3: The use of covert medication

NOTE: the respondent group for this section includes cases where covert rapid tranquillisation was administered. The total number of respondents was 10 (n=10).

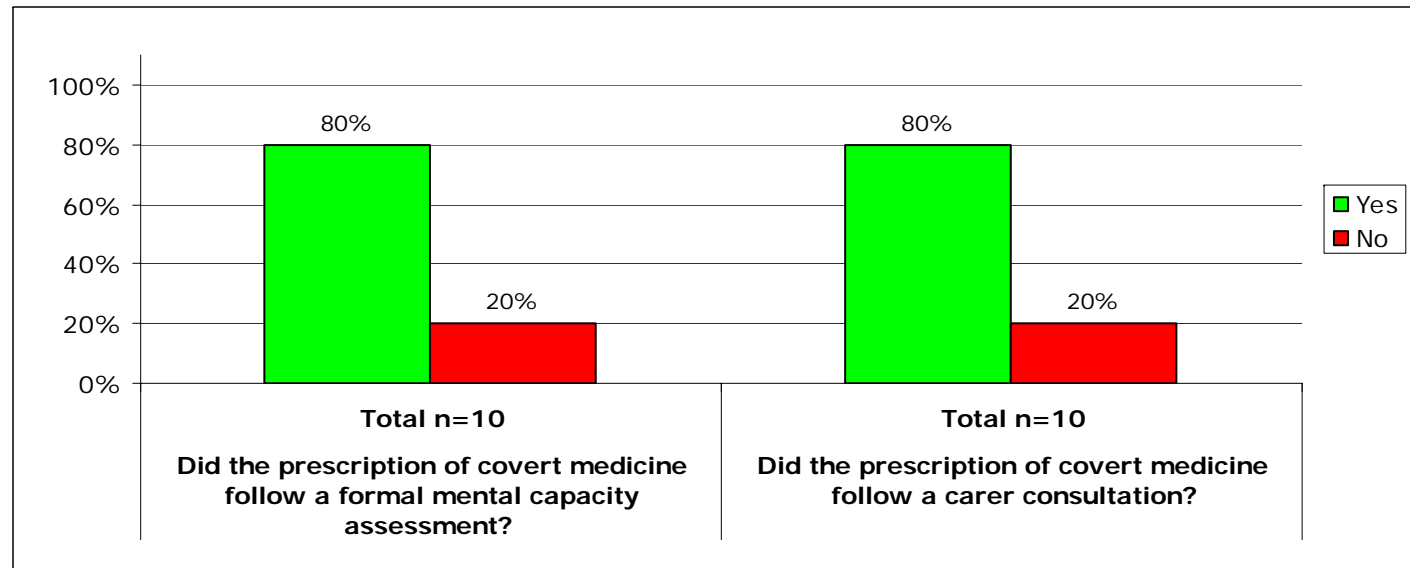
Recommendation

A record of the reasons for presuming mental incapacity (including at the time medication is administered) should be made in the clinical notes. Incapacity should be assessed as per the BMA guidelines

Recommendation

The proposed treatment plan should be discussed with a relative, carer or nominated representative unless it is clear that the patient would not have wished this.

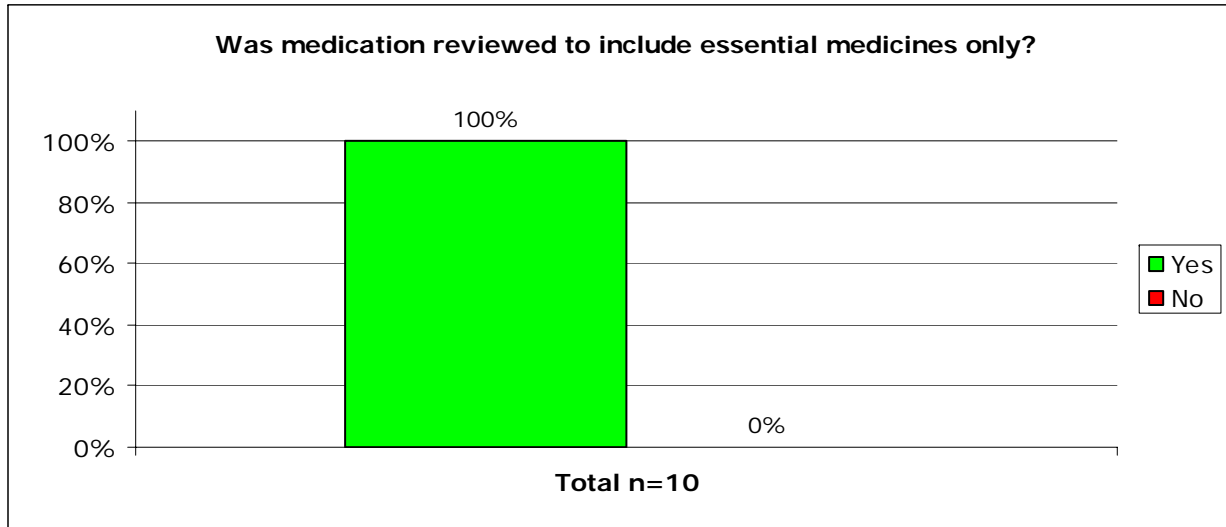
Royal College of Psychiatrists' Statement on Covert Administration of Medicines (2004)



Recommendation

Medication should be reviewed regularly to ensure inclusion of essential medicines only

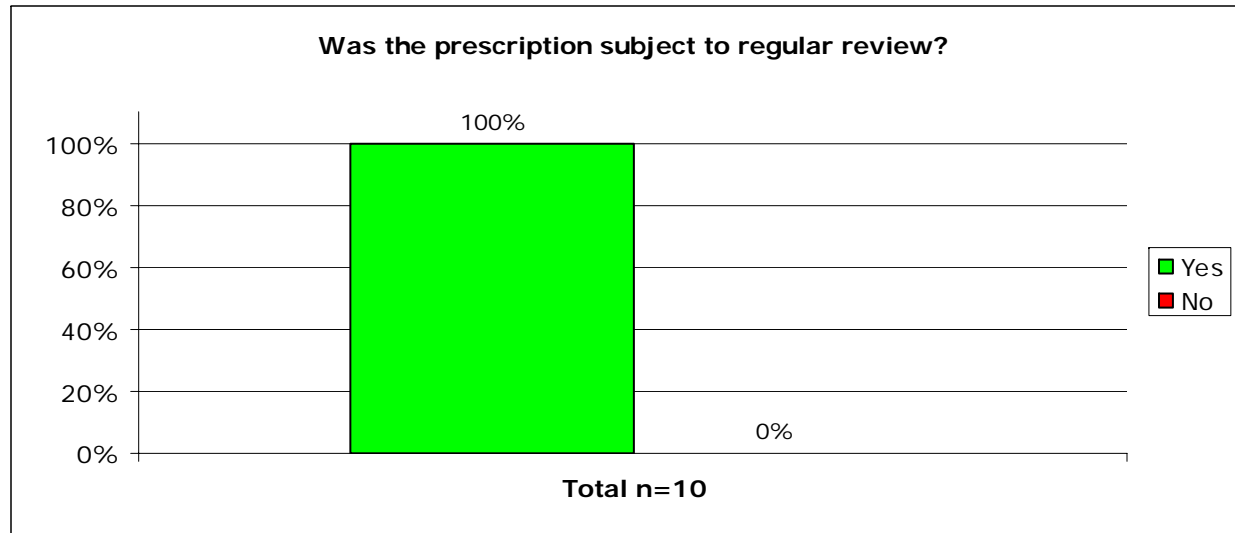
NAV Steering Group (2006)



Recommendation

The treatment plan should normally be subject to weekly review initially and if the requirement for covert medication does persist, full reviews at less frequent intervals should take place.

Royal College of Psychiatrists' Statement on Covert Administration of Medicines (2004)



Section 4: the use of intramuscular medication

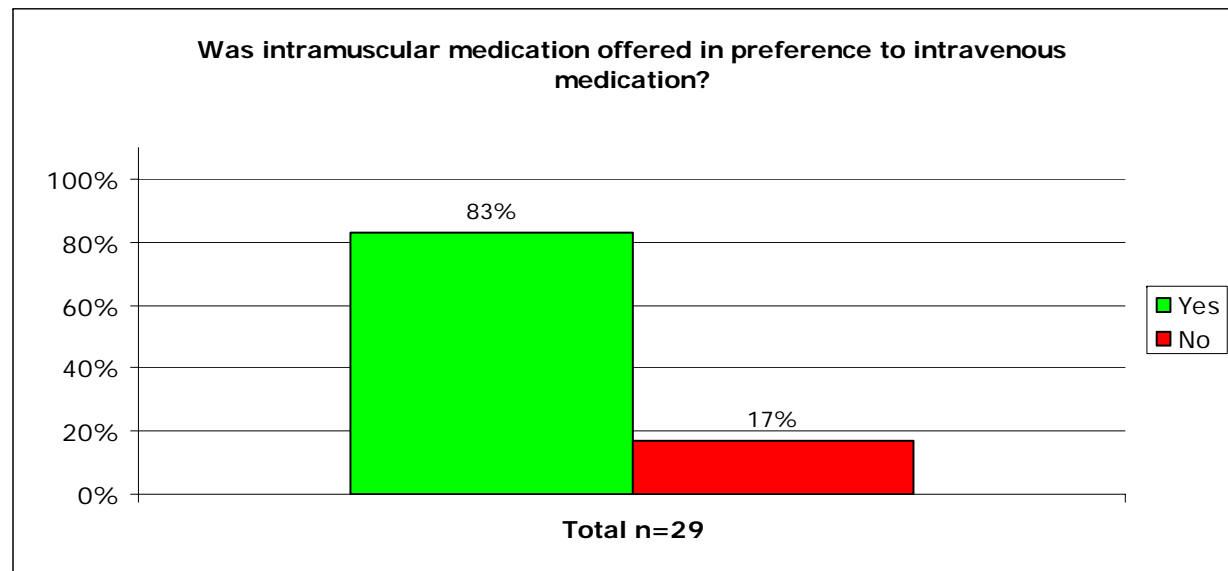
NOTE: the respondent group for this section included:

- cases where ONLY intramuscular rapid tranquillisation was administered;
- cases where oral AND intramuscular rapid tranquillisation were administered.

The total number of respondents was 30 (n=30), however, the total figures in some charts do not add up to the expected number due to missing data.

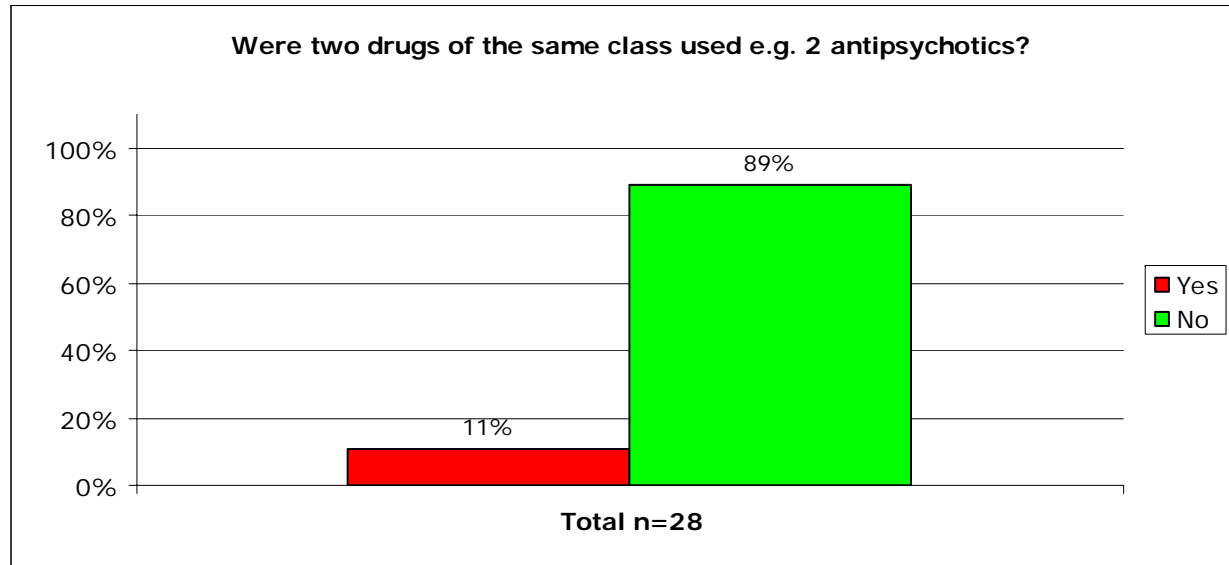
1.8.4.14 Guideline recommendation

If parenteral treatment proves necessary, the intramuscular route (i/m) is preferred over the intravenous (i/v) from a safety point of view



1.8.4.19 Guideline recommendation

The use of two drugs of the same class for the purpose of rapid tranquillisation should not occur.



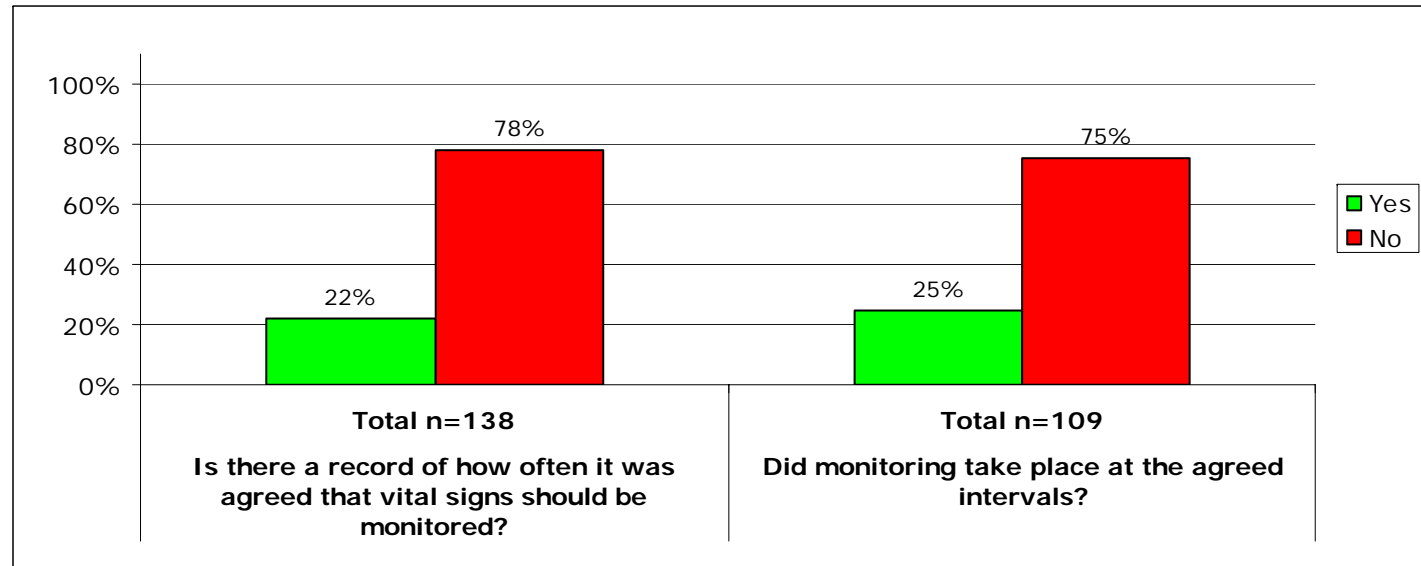
Section 5: Care after rapid tranquillisation if the patient became inactive

NOTE

This section of the audit was completed by ALL respondents. The total number of respondents was 195 (n= 195), however, the total figures in some tables/charts do not add up to the expected number due to missing data.

1.8.4.33 Guideline recommendation

After rapid tranquillisation is administered, vital signs should be monitored and pulse oximeters should be available. Blood pressure, pulse, temperature, respiratory rate and hydration should be recorded regularly, at intervals agreed by a multidisciplinary team, until the service user becomes active again.



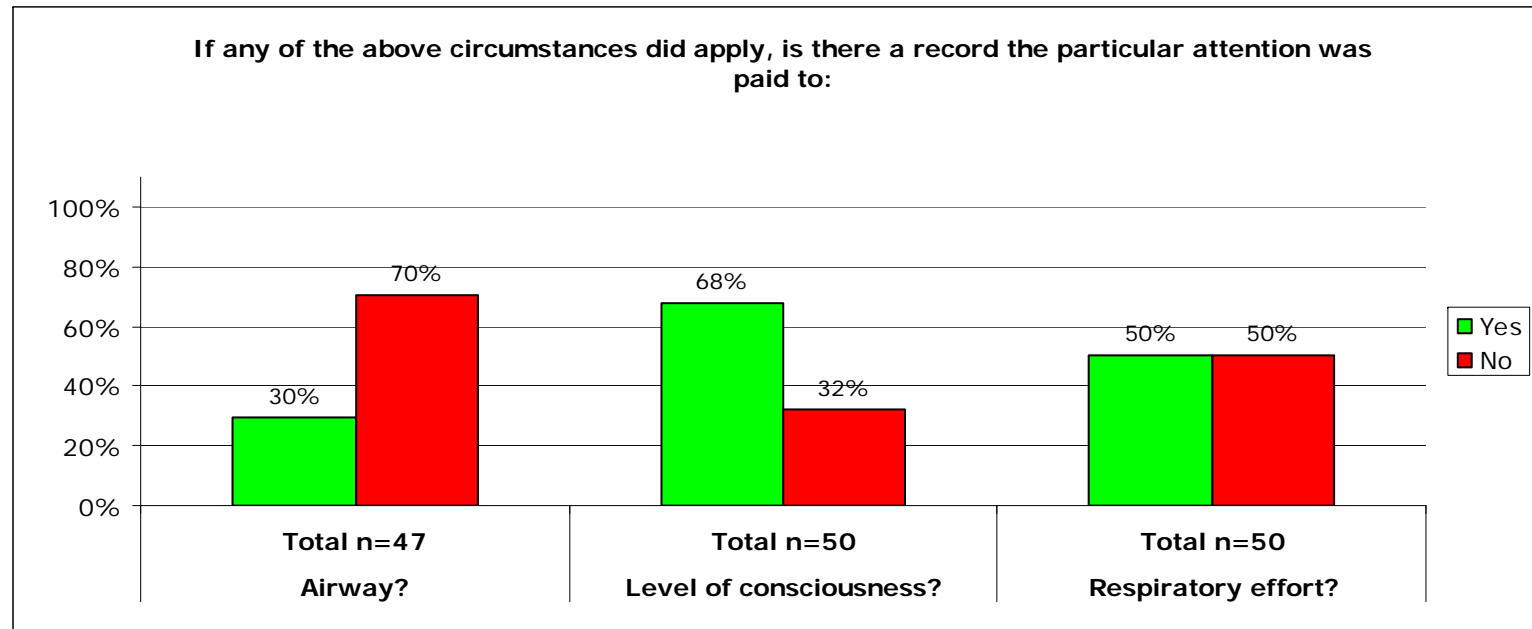
1.8.4.34 Guideline recommendation

In the following circumstances, more frequent and intensive monitoring by appropriately trained staff is required and should be recorded in the care plan. Particular attention should be paid to the service user's respiratory effort, airway, and level of consciousness:

- *If the service user appears to be or is asleep/sedated*
- *If intravenous administration has taken place*
- *If the BNF limit or SPC is exceeded*
- *In high-risk situations*
- *Where the service user has been using illicit substances or alcohol*
- *Where the service user has a relevant medical disorder or concurrently prescribed medication.*

Did any of the above circumstances apply?

| Yes | No | Total n |
|-----|-----|---------|
| % | % | |
| 32% | 68% | 163 |



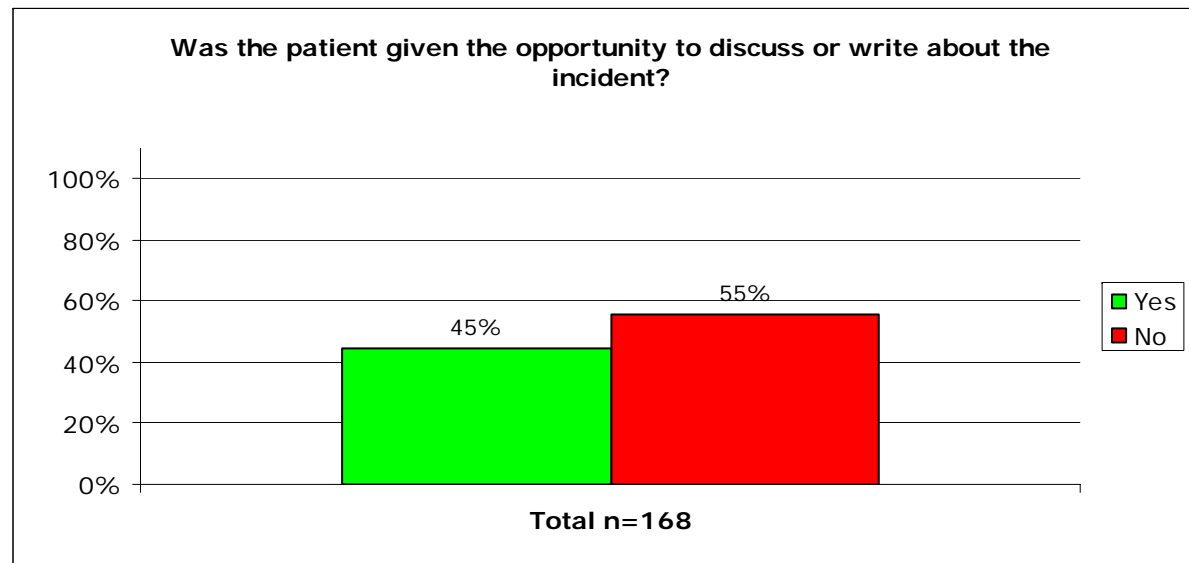
Section 6: Aftercare and support

NOTE

This section of the audit was completed by ALL respondents. The total number of respondents was 195 (n= 195), however, the total figures in some charts do not add up to the expected number due to missing data.

1.8.1.8 Guideline recommendation

After the use of rapid tranquillisation, service users should be given the opportunity to document their account of the intervention in their notes.



Appendix 8

Comparative report: key findings from older people's services, relative to services for adults of working age

Introduction

Between October 2006 to March 2007, 215 wards for adults with mental health problems in England and Wales collected various types of data relating to the prevention and management of violence. Of these, 139 wards provided services for adults of working age; the remaining 76 provided services for older people. Separate reports have been produced that detail the findings from the two service areas. This paper summarises key comparative findings between the two.

Experiences of severely challenging behaviour/violence on wards

One component of the audit surveyed the experiences of staff, patients, and visitors. Questions were asked about their exposure to different severities of violent behaviour. As the results in the table below show, although nurses working in services for working age adults (WAA) were **more likely** than colleagues in older people's services (OPS) to feel upset/distressed or threatened, they were **less likely** to experience actual physical assault. This increased risk of assault was not apparent for patients in older people's services.

| | WAA | | OPS | |
|-----------------------------------|--------|----------|--------|----------|
| | Nurses | Patients | Nurses | Patients |
| Made to feel upset/distressed | 58% | 45% | 54% | 29% |
| Threatened or made to feel unsafe | 72% | 34% | 66% | 14% |
| Physically assaulted | 46% | 18% | 64% | 6% |

Nursing staff were asked about their involvement in the various tasks and activities associated with the prevention and management of violence. Findings showed that while there was a wide disparity in the extent to which staff in OPS versus WAA were being called upon to undertake searches, this gap narrowed in relation both to involvement in seclusion, and the administration/care of someone being given rapid tranquillisation. Even more surprisingly, there was only marginal difference in the extent to which nurses from either group might be involved in undertaking observation, or in administering hands-on restraint.

| | WAA | OPS |
|-------------------------|-----|-----|
| Undertaking searches | 61% | 23% |
| Seclusion | 39% | 18% |
| Rapid tranquillisation | 66% | 48% |
| Management of incidents | 86% | 79% |
| Observation | 95% | 94% |
| Hands-on restraint | 85% | 84% |

The audit then looked at the perceptions of different respondent groups about how these incidents were being managed.

The management of severely challenging/violent incidents

When asked about whether they felt that staff dealt with violence effectively both **between patients**, and **towards staff from patients**, responses from all groups in both service areas were generally high (87% - 98%). The lowest ratings to both questions came from patients in WAA services (80% and 84%, respectively).

In relation the management of actual incidents, the questionnaires went on to ask both patients and nurses about the extent to which a range of physical interventions were being used too quickly to deal with (potentially) violent incidents. Findings indicate that this is considerably more of a problem in WAA services, as the figures below illustrate.

| | WAA | | OPS | |
|---------------------------------------|--------|----------|--------|----------|
| | Nurses | Patients | Nurses | Patients |
| Use of medication too quickly | 13% | 38% | 14% | 21% |
| Use of hands-on restraint too quickly | 8% | 30% | 9% | 14% |
| Use of seclusion too quickly | 6% | 25% | 3% | 13% |

Next, the audit examined the extent to which a range of evidence-based measures had been put in place to protect the people residing, working and spending substantial periods of time on these wards.

How organisations support people in unsafe environments

By providing a physical environment that is safe

National levels of compliance for a number of very basic safety standards in the environmental audit were alarmingly low, particularly in OPS.

| | Met | |
|--|-----|-----|
| | WAA | OPS |
| Sight lines are unimpeded | 50% | 31% |
| A crash bag is available within 3 minutes (where rapid tranquillisation, physical intervention and seclusion might be used) | 85% | 71% |
| There is a designated area or room specifically for the purpose of reducing arousal and/or agitation. This is in addition to a seclusion room. | 54% | 55% |

By providing a comfortable environment

On all standards relating to the comfort of the ward – the availability of space, temperature and noise levels, homeliness – results were similarly variable between different respondent groups for both WAA and OPS. One area of concern, particularly for wards for older people, was the lack of control over temperature and ventilation, with only 26% of OPS and 39% of WAA services meeting this standard.

By providing adequate alarm systems

A considerable **25%** of OPS nursing staff **did not** feel their alarm system was adequate (18% for WAA); only **61%** had a consistent and rehearsed response to emergency alarm calls (**83%** for WAA); only **57%** had access to a personal alarm (**86%** for WAA).

By providing adequate staffing ratios

While similar proportions of nursing staff in either service area felt that staff ratios were appropriate to the resident population (**61%** of OPS and **64%** in WAA services), only **46%** of OPS nursing staff agreed they **could** access additional resources if the ward had a difficult mix of patients, compared with **56%** in services for WAA, and **76%** of nursing staff felt that they **did not** have a say about admissions onto the ward (compared with **64%** in WAA services).

By providing adequate staff training

Older people's services: Although **79%** of nurses were involved in managing incidents, only **66%** of these had received 'Promoting Safer and Therapeutic Services' training (or equivalent) (**75%** for WAA); while **94%** were involved in carrying out observations, only **27%** of these had received training; **68%** were involved in administering covert medication but only **36%** of these had received training.

Services for adults of working age: **86%** of nurses were involved in managing incidents and of these, **75%** had received PSTS training (or equivalent), however: **21%** felt it **had not** enabled them to *minimise the risk* of an incident (**26%** in OPS); **17%** felt it **had not** enabled them to *deal with* an incident (**27%** in OPS). While **66%** of nurses were involved in rapid tranquillisation, only **53%** of these had been trained around the legal framework authorising its use, only **40%** had been trained in the use of pulse oximeters, and **31%** **did not** receive ongoing ILS training

By providing adequate access to therapies and activities

Levels of patient satisfaction with therapies and activities were similar across both groups, though access to physical activity/exercise would seem to be a problem in WAA services, and access to any activities during evenings and weekends for both groups.

| | Yes | |
|--|-----|-----|
| | WAA | OPS |
| Opportunities for group interaction and/or recreation? | 75% | 82% |
| Daily opportunities for physical activity/exercise? | 54% | 62% |
| Choice of therapies during the day? | 47% | 52% |
| Choice of activities during the day? | 52% | 56% |
| Choice of activities evenings/weekends? | 33% | 33% |

Indeed, the environmental audit revealed that **26%** of WAA and **29%** of OPS did not have an activity room on the ward.

By providing opportunities to go outside

When surveyed, an alarming **21%** (WAA) and **24%** (OPS) of patients said they did not have opportunities to go outdoors/leave the ward. These findings were backed up by the audit of the environment when **33%** of local teams in services for WAA, and **26%** in OPS said that their wards did not meet the standard that patients had access to an outside area which was adequately fenced to ensure privacy and security.

By ensuring staff are accessible

Across all respondent groups, relative to WAA services, staff in OPS felt less satisfied with opportunities to discuss issues and concerns with colleagues. Interestingly, patients in

both service areas generally felt that staff were available for them if they were concerned or upset (WAA = 88%, OPS = 91%).

By giving people information

The adequacy of the provision of information varied between service areas, depending on its type: information about why a person had been admitted was more readily available on WAA wards (WAA = 72%, OPS = 64%); information and involvement in decisions about their care was better rated by patients in OPS (WAA = 67%, OPS = 79%); information about how to access the support of an advocate was more accessible in services for WAA (WAA = 60%, OPS = 40%).

By treating people with respect and dignity

Patient satisfaction with the way religious and cultural needs were being met was higher in OPS. Similarly, 92% of patients in OPS felt they has been cared for in a dignified manner, compared with 83% in WAA services. In relation to having privacy when being given medication, however, **41%** (WAA) and **40%** (OPS) felt this standard was not being met.

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

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