

NATIONAL AUDIT OF VIOLENCE 2006/07

Working towards a safer environment on mental health inpatient units

Project Manager's Pack

Trust Name



Royal College of
Psychiatrists
Charity reg. No. 228636



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Introduction

Concern about the prevention of violence in health and social care settings and the adequacy of staff training in its containment and management is not new, and reflects wider concerns about violent crime in society in general. This has been acknowledged at a national level by the Department of Health with the introduction of 'Zero Tolerance' and targets for the reduction of violence against health and social care staff, and by an ever-growing number of national guidance and initiatives that target this area. Violent incidents result in physical, emotional and psychological damage as well as low morale for staff and service users. Improvement in the management of violent behaviour is a priority for both practitioners and service managers. The fact that your organisation has chosen to join this audit programme indicates that it shares these concerns.

The audit programme is intensive and challenging and will take you through an extended learning process. It seeks to involve a broad range of people who reside in, work in, or come into regular contact with, the participating units. Through auditing local practices, you may be able to confirm commonly held assumptions about 'what is happening'. You may also, however, be surprised by some of the results.

A key measure of the usefulness of the audit programme to your organisation will be your ability to move from learning about the problems you face, to implementing appropriate improvements.

Some of the changes identified through the audit process will relate to the behaviour of individual practitioners, others to the structure of the services within which they practice. You may be able to act on some of the findings immediately, e.g. by developing a system for recording the use of restraint. Others will require medium-term solutions, e.g. increasing staffing levels during the evenings. Others still may need long-term plans, e.g. re-building a unit. Clearly, not all changes will be welcomed and many will be resisted.

To ensure that you are able to get the most out of the audit programme it is vital that you plan ahead.

How to use the pack

This pack is designed to help you set up and run the national audit programme as a local project. The contents have been drawn largely from experiences of running national multi-centre quality improvement programmes. They are neither definitive nor exhaustive, but should highlight some of the issues you will need to address.

The pack includes the following:

- ◆ guidance material to support you to set the project up locally;
- ◆ tools and information that may help in this process;
- ◆ information about the different components of the audit programme and what each involves.

NOTE: All Appendices are at the back of the pack.

Copies of the data collection tools and supporting guidance notes for the audit programme will be sent out in accordance with the project timetable.

Summary and Recommendations from the 2003-5 Audit

Between December 2003 and March 2005, 265 mental health and learning disability wards/units took part in a national audit programme that supported them in gathering systematic data about the ways in which they maximised safety and minimised risk in relation to the prevention and management of violence. The audit focused on individual wards/units and data was gathered from the whole constituency – professions of all levels, service users and visitors. Information collected included more than 6,500 anonymised questionnaire returns, which contained over 20,000 lines of comments.

Both the factors that cause violence, and potential solutions, are highly individualised. There is no ‘magic bullet’. The audit offered participating units an insight into particular factors that either increased the likelihood that violence would happen, or meant that it would not be managed effectively if it did. Commonly, factors included one or more of the following.

- ◆ **Unsafe environments:** the design of many of the participating wards/units failed to meet many basic safety standards.
Recommendation: Systems should ensure that staff and service users are fully involved in the design process for every new mental health or learning disability residential unit. Great efforts should be made to upgrade and improve existing wards in ways that optimise safety.
- ◆ **Inadequate staffing:** nationally, many services were operating with vacancy factors. This was commonly linked to the on-going drain of experienced staff into higher paid, and often more highly-regarded, community posts. Many inpatient services were being left reliant upon inexperienced leaders. Additionally, many services were experiencing problems recruiting staff and were overly-reliant upon bank and agency staff. Under either or both of these circumstances, it can be hard to build a coherent team than can work proactively to prevent and manage violence.
Recommendation: The status of inpatient nursing should be raised to at least that of community nursing.
- ◆ **Client mix and over-crowding:** many acute mental health services were ‘fire fighting’ as they struggled to work with an increasingly unwell population, some of whom would have had a dual diagnosis. For many, faced with high bed occupancy figures and inadequate staffing, the delivery of a therapeutic service had become impossible. There are great inequities in staffing levels and skills mix across the country.
Recommendation: Action is required for both commissioners and managers to address this.
- ◆ **Substance misuse** was identified as the most common trigger for violence. The quantitative data revealed that problems associated with the use of alcohol and illegal drugs were more common in mental health services – particularly Acute, Psychiatric Intensive Care, and Forensic services (though alcohol was rated as especially problematic in Acute services).

Recommendation: More must be done to support staff teams to address the problems caused by the use of alcohol and illegal drugs in inpatient services.

- ◆ **Staff training in the prevention and management of violence:** many staff reported dissatisfaction with the timing, content, or quality of the training they received. Additionally, and perhaps of more concern, many felt unable to apply the training in real life situations.

Recommendation: Training must be tailored to individual needs and more emphasis placed on the prevention rather than the management of incidents. However, the audit findings indicated that training will only be effective if the other issues described above are also addressed.

- ◆ **High levels of boredom:** many wards/units were unable to offer service users a structured and therapeutic system of care. This was linked to low staffing levels and high volumes of paperwork. As well as the obvious link between 'boredom' and 'violence', this was seen to have an impact on recovery rates for service users, and on job satisfaction for staff.

Recommendation: Ways have to be found of supporting staff to spend more time in face-to-face contact with service users, doing the job that they were trained to do.

1. Who needs to be involved in the Audit Project?

The majority of staff feel committed to improving the quality of the services they provide. If problems identified through the audit processes are to lead to demonstrable improvements, these processes will need to be 'owned'.

- ◆ To be successful this project needs to be 'owned' by a lot of different people.
- ◆ It is vital that the people who will be **expected to have a role in or be affected by** the work of the project are involved **from the outset and throughout** the course of the project.
- ◆ Their role may be **active** (i.e. direct involvement in setting up and running the project locally) or **passive** (i.e. being consulted or receiving regular updates).

Careful thought needs to be given to **WHO** needs to be involved and **HOW**.

Attached at **Appendix 1** are some pointers around how to involve different groups of people in the audit programme. These were generated by the organisations that took part in the previous audit programmes.

2. Setting up your local Project Team

Role of the Team

You will need to establish a team of people who will lead and manage the project in your organisation or service. The role of the team will include the following:

- ◆ ensuring the project is integrated within existing quality and audit structures;
- ◆ ensuring that appropriate support/resources are available to the project ¹;
- ◆ highlighting the benefits of supporting the project;
- ◆ generating enthusiasm and motivating by example;
- ◆ monitoring adherence to local and national time-scales;
- ◆ 'trouble-shooting' when problems or delays are experienced;
- ◆ linking with the College Research and Training Unit (CRTU);
- ◆ fostering networking with other participating organisations;
- ◆ devising and overseeing a communication strategy (**see Section 3 – Developing a Communication Strategy**).

¹ An accurate assessment of the resources required in terms of manpower, time and materials is essential to ensure change is managed successfully. The project team may have all the necessary skills and abilities within it to do this. However, they may need support from management, information technology departments, or clinical audit department (Pruce and Aggarwal, 1999).

Choosing a Project Leader

It is vital that you are clear about who is in charge of the project locally. When deciding who should fulfil this role, you should consider the following:

◆ Seniority

This person will need to have the authority to 'make things happen', both in relation to getting the audit modules completed and in implementing improvements in the future.

◆ Respect, credibility and breadth

The programme necessitates the involvement of a wide section of people and your project leader will need to work effectively with all of these groups.

◆ Time available

The audit programme runs for eighteen months. Each component of the audit has a deadline for completion. The person you choose will need to be available throughout to ensure that deadlines are met.

Beyond the end of the programme, this person is likely to have a key role in ensuring that improvements identified through the audit are fully implemented.

If you choose someone who does not possess the necessary authority, the project is likely to be unsuccessful, i.e. they will be unable to motivate others to support the work and/or they will be unable to implement any improvements identified through the audit.

Choosing other Team Members

The composition of your local Project Team is extremely important. A highly committed group can influence others. This will be important when it comes to achieving broad ownership for the project, its findings, and any recommended service improvements.

Who else to involve

- ▶ Service users
- ▶ Existing groups
- ▶ Senior level staff and managers
- ▶ Respected colleagues
- ▶ Support staff, e.g. clinical audit, researchers

- ◆ **We strongly urge** that you involve service users/representatives on your team from the very beginning. This is the best way you can find out directly the best ways of winning support for the project from this group. Think about inviting at least two people so that they do not feel out-numbered by professionals (for further information, refer to **Appendices 2 and 3**).
- ◆ Avoid 're-inventing the wheel'. It may be that the membership of an existing group could be tailored to meet the needs of the project. Not only will this save time, it will mean that you have a core cohesive team to work with from the start.
- ◆ Involving senior people from within the organisation demonstrates to those inside and outside that there is commitment to the work.
- ◆ Involving individuals who are respected by their colleagues means that your team's work will have greater credibility.
- ◆ Involving clinical audit, quality, research or other support staff could give you access to specialised skills and perhaps people who can have a 'hands-on' role collecting the audit data.

Other considerations

- ◆ Are there people in your organisation who have been known to obstruct initiatives of this kind? If so, it might be better to get them actively involved from the start.
- ◆ Are there people in your organisation who are generally very supportive of initiatives of this kind? If so, it would be good to get them on the team.
- ◆ It may not be possible for senior level staff to play an active role in running your local project. Make sure that clear channels of communication are defined from the outset (**see Section 3 – Developing a Communication Strategy**).
- ◆ Stability of membership will increase the productivity of the team.

Methods of working

At the earliest point, the 'ground rules' for your team should be established. The sooner team members know what is expected of them, the more likely it is that they will work together effectively. You may wish to consider the following:

- ◆ How often will you meet?
- ◆ Where will you meet?
- ◆ When will you meet?
(NOTE: providing a sandwich lunch can enhance attendance figures)
- ◆ How long will meetings last?
- ◆ Will the meetings be formal/informal?
- ◆ How will 'actions' from the meeting be recorded and circulated?

Reviewing membership

It is important to keep checking the appropriateness of the membership of your Project Team. Often people sign up to new groups and then find that they are over-committed. If this happens, it may be appropriate to invite replacements, otherwise, you may end up with problems, for example:

- ◆ resistance from groups of people who feel their views have not been adequately represented in setting up the audit locally;
- ◆ a small group of people feeling overwhelmed trying to manage the local data collection;
- ◆ loss of momentum.

At worst, it could end up that the audit is yet another paper exercise that does not lead to any discernible improvements.

You may also consider **co-opting** people onto the team for particular parts of the audit programme, e.g. your Estates Manager or a non-executive member for Module 2.

It is likely that you will identify far more people than can reasonably be accommodated on a working group. This is when you need to consider how you will keep the less 'actively' involved people up-to-date with what is happening. You will need to plan and create a communication strategy.

3. Developing a Communication Strategy

To be successful, this project needs to be supported by a lot of different people. A communication strategy will help you to understand your audience and be clear about who will carry information and feedback about the project to the various 'stakeholder' groups.

Who to communicate with

Within the Project Team

Team members should meet regularly to report progress and to discuss solutions to potential problems that may have been encountered. This will engender co-operation between team members and a sense of individual responsibility working toward a collective goal. Your team will have a wealth of knowledge and skills and it is important to make full use of these. Ensure that all team members are able to contribute and, most importantly, are listened to by their colleagues on the team.

Within the wider organisation

Since change does not occur in a vacuum, a change in practice in one area may result in knock-on effects for other processes. For this reason, informing related groups within your organisation, or parts of your organisation, will help ensure that the activities associated with the audit programme - e.g. getting staff to fill in questionnaires - will be supported. Looked at conversely, if people hear about the work indirectly, they may feel that their contribution or involvement is not important and therefore may feel less committed to the implementation of any changes that are identified through the audit.

Secondly, quality improvement activities are often perceived as cost-cutting exercises. Keeping people informed can help dispel any fears.

Finally, this type of initiative can be seen as something 'imposed' by management, rather than as a response to a perceived issue. Telling people what is happening from the start can stop this from happening.

Within management

This audit programme generates a huge amount of information that is likely to relate not only to the units that are taking part, but also to other departments, e.g. estates, training, domestic services. The potential areas for improvement that will be identified are equally wide-ranging. Your local Project Team **MUST** have direct access to senior managers.

You should be able to expect a number of things from them:

- ◆ support around carrying out the audit;
- ◆ interest in hearing regular updates on the audit findings;

- ◆ commitment to agreeing areas for improvement;
- ◆ support in identifying appropriate action plans;
- ◆ interest in monitoring completion of action plans.

The Local Project Team **MUST** have direct access to senior managers.

The more visible the involvement of management, the better. As well as the practical supports they can provide, management endorsement will lend credibility to the improvement activities and they may stand a better chance of being accepted and implemented.

NOTE TO NHS TRUSTS

As part of its remit, it is vital that senior management ensures that the Trust board is kept regularly informed of the process and outcomes of the audit programme.

How to communicate?

Again, try to avoid re-inventing any wheels. Find out what systems are already in place and then 'hijack' them.

Some examples:

- ◆ local newsletters (Staff and User-groups);
- ◆ open meetings with senior management;
- ◆ bulletin boards, i.e. in units, canteens;
- ◆ existing meetings, e.g. management or unit meetings, CPD sessions;
- ◆ intra-net systems.

In addition, you may wish to use one or more of the following approaches:

- ◆ plan early meetings with all key stakeholders, i.e. service users, unit staff, etc. to see how you are going to involve them;
- ◆ nominate 'link people' from your Project Team who will keep specified groups informed of progress e.g. a consultant may undertake to communicate with all other staff from his/her discipline.

What to communicate?

The content of the programme

We have attached a brief **Information Sheet (Appendix 4)** that you may wish to use to give an overview of what the project will involve. As the work progresses, you may want to let people know about **key events** and **dates**. Later you will want to communicate back **key findings** from the work and **planned changes** resulting from the findings.

Hopes and fears

As indicated earlier, people may have all sorts of concerns about the impact of the project on them. It is advisable to provide a forum where these can be discussed openly.

Benefits of involvement

Try to stress the potential benefits of supporting the project. Staff are more likely to be supportive if they can see clearly the link between the project and the impact on the lives of the people who use or work in the services they provide.

Project Timetable

When?	What?
March to July 2006	<ul style="list-style-type: none"> ◆ Join and set up the project in your organisation <p><i>The amount of time available will depend on how early you sign up and how soon your team attends an Introductory Workshop.</i></p>
May to July 2006	<ul style="list-style-type: none"> ◆ Local Project Team attends one regional 'Introductory Workshop'
May to September 2006	<ul style="list-style-type: none"> ◆ Prepare for data collection (all modules) ◆ Deadline for completion of: <ul style="list-style-type: none"> ➤ Contextual Data ➤ Screening tool for Module 1 (compulsory)
August / September 2006	<ul style="list-style-type: none"> ◆ Receive report on national Contextual Data
October to December 2006	<ul style="list-style-type: none"> ◆ Data collection: Module 1
October 2006 to February 2007	<ul style="list-style-type: none"> ◆ Receive report on Module 1 Data
October 2006 to February 2007	<ul style="list-style-type: none"> ◆ Data collection: Modules 3a and 3b
January / February 2007	<ul style="list-style-type: none"> ◆ Data collection: Module 2
March / April 2007	<ul style="list-style-type: none"> ◆ Receive report on Modules 3a and 3b Data ◆ Receive report on Module 2 Data
May to July 2007	<ul style="list-style-type: none"> ◆ Local Project Team attends one regional 'Feedback Workshop'
May to July 2007	<ul style="list-style-type: none"> ◆ Prepare local action plans
July 2007	<ul style="list-style-type: none"> ◆ Deliver local action plans
October 2007	<ul style="list-style-type: none"> ◆ Publication of Final Report

Data Collection

The standards for the Audit Programme have been drawn from two sources:

- ◆ Violence: The Short-term Management of Disturbed/ Violent Behaviour in Psychiatric Inpatient Settings and Emergency Departments, NICE 2005, (www.nice.org.uk)
- ◆ Management of Imminent Violence - Clinical practice guidelines to support mental health services, Royal College of Psychiatrists 1998

1. Contextual Data	
Status	Mandatory
When?	This form will be sent to you at the beginning of June 2006. It should be completed <u>not later than the end of July 2006.</u>
Who?	On behalf of each participating unit, i.e. unit manager with the support of the Project Team.
What?	This form will provide indicators of future benchmarking partners. The types of information it asks for relate to the catchment area, number of beds and bed occupancy, staff skills mix and the presence/absence of policy and procedures relating to the management of violence.
How?	The form will be completed online through a link on the Royal College of Psychiatrists' website (link to be advised).
Reports	You will get tables of the national data, grouped according to service type, i.e. acute unit, older persons unit, etc.

2. Module 1 Screening Tool	
Status	It is mandatory that nursing staff are asked to complete the Module 1 questionnaire. However, your local team should assess the relative costs and the benefits of asking other staff groups to participate.
When?	This form will be sent to you at the beginning of June 2006. It should be completed <u>not later than the end of July, 2006.</u>
Who?	On behalf of each participating unit, i.e. unit manager.
What?	<p>This form asks units to identify staff who are 'at risk', i.e. who either spend <u>at least 16 hours per week</u> on the unit, or visit <u>at least 3 times per week</u>. Three groups of people are described:</p> <ul style="list-style-type: none"> ◆ Mandatory: nursing staff, i.e. providing (generally) 24 hour supports ◆ Optional: other clinical staff, e.g. psychiatrists, therapists, managers, pharmacists ◆ Optional: non-clinical staff, e.g. admin and reception staff, domestic staff. <p>Once total numbers for each group have been gathered, this will allow a 50% 'target' number for returned questionnaires for each group to be calculated, e.g. if there are 16 nursing staff that are defined as 'at risk', the target number of returned questionnaires for this group will be 8.</p>
How?	The screening tool will be completed online through a link on the Royal College of Psychiatrists' website (link to be advised). This will allow us to monitor when your target number of questionnaires have been completed.

Module 1

Module 1 is a survey of the people who work in, reside in and spend significant periods of time in the unit.

Module 1 questionnaire: the ways that people are supported to reduce the number of violent incidents (Part A – staff identified via screening tool)

Status	See below
When?	During a 4-week period that runs from October to November 2006. After this time it is likely that you will need to 'chase' some groups in order to meet the targets you identified using the screening tool. A month has been allowed for this. The deadline for completing questionnaires that are to be included in the national data set will be <u>the end of December 2006.</u>
Who?	All units are expected to ask nursing staff to complete this component of the programme. The inclusion of other members of the clinical team and non-clinical staff is optional (this is to be decided by the Local Project Team upon assessment of the relative costs and benefits).
What?	A brief anonymous questionnaire that allows respondents to report on how the organisation supports them to reduce the incidence of violence.
How?	The questionnaire will be completed on-line through a link on the Royal College of Psychiatrists' website (link to be advised).
Reports	<p>Local findings will be analysed and reported according to staff group membership, i.e. nursing, 'other clinical' and 'non-clinical'. You will be sent a copy of you local report soon after you complete your final questionnaire.</p> <p>A report of the quantitative data from the national findings will be sent out soon after the deadline for Module 1. A more detailed analysis of both the quantitative and qualitative data will be included in a Final Report at the end of the programme.</p>

Module 1 questionnaire: the ways that people are supported to reduce the number of violent incidents (Part B – service users)

Note: if questionnaires are not an appropriate method for gathering feedback from the people who use your service, alternative tools will be made available to you.

Status	Mandatory
When? & Who?	<p>Most units will aim for a target of 20 returned questionnaires.</p> <p>There are two ways of gathering this data:</p> <ol style="list-style-type: none"> 1. Where discharge rates from the unit are greater than 10 people per month, questionnaires can be distributed to all service users, pre-discharge, over the 3-month period that runs from the beginning of October to the end of December 2006. Once this target has been met, your organisation may decide whether or not to continue to distribute the questionnaires. 2. Where discharge rates are less than 10 people per month, the unit may use a census day approach where questionnaires are distributed to all service users that are on the unit on the chosen day (which will fall within the period from the beginning of October to the end of December 2006).
What?	A brief questionnaire that allows a range of people who have used the unit to report on how the organisation supported them to reduce the incidence of violence. The questionnaires will be anonymous.
How?	<p>Two options exist</p> <ol style="list-style-type: none"> 1. The questionnaire can be completed on-line through a link on the Royal College of Psychiatrists' website (link to be advised). 2. A paper-based questionnaire can be completed and returned in a freepost envelope to the CRTU.
Reports	As for Part A (page 17).

Module 1 questionnaire: the ways that people are supported to reduce the number of violent incidents (Part C – visitors)

Status	Optional (this is to be decided by the Local Project Team upon assessment of the relative costs and benefits).
When? & Who?	Over a 3-month period that runs from the beginning of October to the end of December 2006, questionnaires will be distributed to all visitors who spent significant periods of time on the unit.
What?	A brief questionnaire that allows a range of people who have visited the unit to report on how the organisation supported them to reduce the incidence of violence. The questionnaires will be anonymous.
How?	<p>Two options exist</p> <ol style="list-style-type: none"> 1. The questionnaire can be completed on-line through a link on the Royal College of Psychiatrists' website (link to be advised). 2. A paper-based questionnaire can be completed and returned in a freepost envelope to the CRTU.
Reports	As for Part A (page 17).

Module 2

Environmental audit

Status	<u>Mandatory</u>
When?	To be carried out between the beginning of January and the end of February 2007.
Who?	On behalf of each participating unit.
What?	<p>This will involve 2 local teams, each of between 4 and 6 members:</p> <ol style="list-style-type: none"> 1. one made up of key staff from the participating unit; 2. one team made up of 'non-staff' i.e. user representatives, members of the CHC, advocates, non-executive members. <p>Each team will be encouraged to carry out pre-visits to another unit that is taking part in the national audit. They will then carry out an audit of the environment against a structured checklist. Once both teams have carried out the audit, they will be brought together and facilitated to agree a consensus rating for each item in the checklist, and to discuss possible changes.</p>
How?	The checklist will be completed on-line through a link on the Royal College of Psychiatrists' website (link to be advised).
Findings	National findings will be based on the final, consensually agreed checklist and will be presented according to service type. Service units will also be asked to provide information about exceptions and any ideas for improvement, and these additional qualitative findings will be collated and presented in a national report.

Module 3a

Review of violent incidents

Status	<u>Mandatory</u>
When?	To be carried out from the start of the data collection period at the beginning of October, but to be completed by <u>the end of February 2007.</u>
Who?	On behalf of each participating unit.
What?	A sample of 3 violent incidents will be drawn. The teams involved in each incident will be brought together to go through a structured framework that asks them to compare their management of the incident, relative to the good practice described in the Guideline.
How?	The audit return form will be completed on-line through a link on the College's website.
Findings	Service units will be asked to complete a form that asks them to provide information about the learning and changes that resulted from taking part in the process.

Module 3b

Case note audit: the use of rapid tranquillisation in the management of violence

Status	Mandatory
When?	To be carried out from the start of the data collection period at the beginning of October, but to be completed by <u>the end of February 2007.</u>
Who?	On behalf of each participating unit.
What?	A stratified sample of case notes of people who have been given rapid tranquillisation to manage their violent behaviour. The content of each set of records will be audited against a series of 'good practice' standards.
How?	The audit return form will be completed on-line through a link on the Royal College of Psychiatrists' website (link to be advised).
Findings	Local findings will be analysed and reported according to compliance with each standard. You will be sent a copy of your local report soon after you return your data to us. A report of the national findings will be sent out soon after the deadline for Modules 3a and b.

Should you have any queries, please contact the Audit Team on 0207 977 6646/6645 or email audit-of-violence@cru.rcpsych.ac.uk

Appendix 1. Involving Service Users and Staff

Involving service users					
What information do service users want?	<ul style="list-style-type: none"> ◆ Aims and objectives of the project ◆ Potential benefits to them as individuals in terms of tangible outcomes ◆ Time-scales and what will be involved ◆ Assurances of confidentiality and non-blaming ◆ A named contact person <p style="color: #4a4a9a; font-style: italic; margin-top: 5px;"><i>NOTE: membership on the Project Team should be on an 'equal partnership' basis: think about inviting 2 user representatives</i></p>				
What format and by whom?	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #4a4a9a; color: white;"> <th style="width: 50%; padding: 5px;">Written</th> <th style="width: 50%; padding: 5px;">Verbal</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;"> <ul style="list-style-type: none"> ➤ Clear, concise and jargon-free ➤ Initially a news-sheet </td> <td style="padding: 5px;"> <p style="color: #4a4a9a; font-style: italic; margin: 0;"><i>Local groups</i></p> <ul style="list-style-type: none"> ➤ Provide opportunities for people to talk with one or more of the members of your local Project Team ➤ Hold workshops </td> </tr> </tbody> </table> <p style="color: #4a4a9a; font-style: italic; margin-top: 5px;"><i>NOTE: be aware of potential language or cognitive barriers</i></p>	Written	Verbal	<ul style="list-style-type: none"> ➤ Clear, concise and jargon-free ➤ Initially a news-sheet 	<p style="color: #4a4a9a; font-style: italic; margin: 0;"><i>Local groups</i></p> <ul style="list-style-type: none"> ➤ Provide opportunities for people to talk with one or more of the members of your local Project Team ➤ Hold workshops
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Who should oversee this?	<ul style="list-style-type: none"> ◆ User Groups, e.g. MIND, Rethink, UKAN, advocacy services. ◆ Locality manager or a non-clinical member of the Project Team ◆ Someone with time 				
Incentives?	<p style="background-color: #4a4a9a; color: white; padding: 2px 5px; margin: 0;">Individual</p> <ul style="list-style-type: none"> ◆ Food e.g. lunch time meetings ◆ Expenses/sessional payments ◆ Therapeutic value 				
Potential supports?	<ul style="list-style-type: none"> ◆ Local Project Team members ◆ Knowledge of culture ◆ Positive attitude of staff ◆ Have a good 'communication strategy' ◆ Involve everyone from the start ◆ Provide training and information for service users 				
Potential barriers?	<ul style="list-style-type: none"> ◆ Selection of user groups ◆ Getting user groups 'on board' ◆ Lack of interest, apathy, lack of empowerment ◆ Turnover of staff and service users ◆ Poor communication ◆ Insufficient resources e.g. to pay service users for their time ◆ Different expectations ◆ Antagonism e.g. attitudes of staff, hidden agendas ◆ Historical factors e.g. dynamics between local personalities 				

Involving Nursing Staff		
What information do nursing staff want?	<ul style="list-style-type: none"> ◆ Aims and objectives of the project ◆ Potential benefits to them as individuals in terms of tangible outcomes ◆ Time-scales and what will be involved ◆ Assurances of confidentiality and non-blaming ◆ A named contact person ◆ Visible top-level commitment ◆ A view of 'the bigger picture' 	
What format and by whom?	Written	Verbal
	<ul style="list-style-type: none"> ➤ Handouts 	<ul style="list-style-type: none"> ➤ Workshop presentations by people with credibility/Ward Manager/Project Team ➤ Teaching sessions
<i>NOTE: use existing networks and structures</i>		
Who should oversee this?	<ul style="list-style-type: none"> ◆ Clinical nurse specialist/clinical practitioner/senior nurse ◆ Someone who can be 'trusted' (this will vary) ◆ Recognised 'change agents' 	
Incentives?	Individual	Collective
	<ul style="list-style-type: none"> ➤ Food e.g. lunch time meetings ➤ Personal development ➤ 'Being heard' ➤ Networking ➤ Being released from duty to carry out work 	<ul style="list-style-type: none"> ➤ Improved job satisfaction ➤ Improvements to working environment ➤ Reduction of 'blame' culture ➤ Reduction in 'fear'
Potential supports?	<ul style="list-style-type: none"> ◆ Management: stress the benefits, e.g. recruitment and retention of staff; creating 'models of understanding' ◆ Visible commitment: involve influential people within the trust; all disciplines; Clinical Audit Department; Quality Team; Occupational Health (counselling); H&S Team ◆ Feedback findings on an on-going basis and if outcome is negative, explain 'why'. 	
Potential barriers?	<ul style="list-style-type: none"> ◆ Insufficient resources: lack of time, staff shortages, lack of admin support ◆ Staff turn-over ◆ Defensiveness, i.e. associated with fear of criticism, lack of knowledge/trust ◆ Historical factors, e.g. past events ◆ Unrealistic expectations ◆ Lack of organisational strategy ◆ Low morale ◆ Poor communication, e.g. mixed messages ◆ Resistance to change 	

Involving other Clinical Staff		
What information do clinical staff want?	<ul style="list-style-type: none"> ◆ Aims and objectives of the project ◆ Potential benefits to them as individuals in terms of tangible outcomes ◆ Time-scales and what will be involved ◆ Assurances of confidentiality and non-blaming ◆ A named contact person ◆ Stress national, multi-disciplinary context ◆ Describe the resources available to support the programme ◆ Trust Board: time and (potential) money implications 	
What format and by whom?	Written	Verbal
	<ul style="list-style-type: none"> ➤ Information sheets, existing communication structures, e.g. newsletters ➤ Set up a dedicated file ➤ E-mail 	<ul style="list-style-type: none"> ➤ Face-to-face ➤ Tailor-made meetings
	<i>NOTE: present an objective, lateral view</i>	
Who should oversee this?	<ul style="list-style-type: none"> ◆ Clinical Audit Department ◆ A member of the Project Team i.e. members link to specific groups, e.g. psychiatrists; social workers 	
Incentives	Individual	
	<ul style="list-style-type: none"> ◆ Food e.g. lunch time meetings ◆ Recognition for the CEO and Chairman ◆ CPD points and other professional practice development systems 	
Potential supports	<ul style="list-style-type: none"> ◆ Visible top-level commitment ◆ Communicate positive results from previous initiatives ◆ Be flexible within methods being used ◆ Clinical Audit Department ◆ Local admin supports ◆ Drug companies (free lunches) 	
Potential barriers?	<ul style="list-style-type: none"> ◆ Attitudes, e.g. 'just another form' ◆ Time-scales ◆ Money: need ring-fenced budget 	

Involving Non-Clinical Staff					
What information do non-clinical staff want?	<ul style="list-style-type: none"> ◆ Aims and objectives of the project ◆ Potential benefits to them as individuals in terms of tangible outcomes ◆ Time-scales and what will be involved ◆ Assurances of confidentiality and non-blaming ◆ A named contact person 				
What format and by whom?	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #4b0082; color: white;">Written</th> <th style="background-color: #4b0082; color: white;">Verbal</th> </tr> </thead> <tbody> <tr> <td style="vertical-align: top;"> <ul style="list-style-type: none"> ➤ Newsletters ➤ Notice-boards </td> <td style="vertical-align: top;"> <ul style="list-style-type: none"> ➤ Workshops ➤ The 'grape-vine' ➤ Presentations as part of the ward-based team (where applicable) or by own managers (if not) </td> </tr> </tbody> </table>	Written	Verbal	<ul style="list-style-type: none"> ➤ Newsletters ➤ Notice-boards 	<ul style="list-style-type: none"> ➤ Workshops ➤ The 'grape-vine' ➤ Presentations as part of the ward-based team (where applicable) or by own managers (if not)
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<ul style="list-style-type: none"> ➤ Newsletters ➤ Notice-boards 	<ul style="list-style-type: none"> ➤ Workshops ➤ The 'grape-vine' ➤ Presentations as part of the ward-based team (where applicable) or by own managers (if not) 				
	<i>NOTE: provide relevant information only; offer participation as an invitation, not a mandate</i>				
Who should oversee this?	<ul style="list-style-type: none"> ◆ Service managers ◆ Trade union representatives 				
Incentives?	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #4b0082; color: white;">Individual</th> </tr> </thead> <tbody> <tr> <td style="vertical-align: top;"> <ul style="list-style-type: none"> ◆ Food, e.g. lunch-time meetings ◆ A sense of being included, 'belonging' ◆ Acceptance of the validity of individual opinions </td> </tr> </tbody> </table>	Individual	<ul style="list-style-type: none"> ◆ Food, e.g. lunch-time meetings ◆ A sense of being included, 'belonging' ◆ Acceptance of the validity of individual opinions 		
Individual					
<ul style="list-style-type: none"> ◆ Food, e.g. lunch-time meetings ◆ A sense of being included, 'belonging' ◆ Acceptance of the validity of individual opinions 					
Potential supports?	<ul style="list-style-type: none"> ◆ Updates and feedback ◆ Time and support from managers ◆ Opportunities for questions ◆ Acknowledgement of involvement ◆ Need for visible, Trust-wide support and involvement 				
Potential barriers?	<ul style="list-style-type: none"> ◆ Contracted staff feeling isolated ◆ Individual perceptions of violence: raising awareness may increase fear ◆ Criminal versus clinical perspectives ◆ Cynicism; lack of motivation ◆ Lack of information ◆ Seen as extra work 				

Appendix 2

Ten ways for mental health workers to impede user participation in planning and managing mental health services

By Vivien Lindow

Introduction

I am introducing this subject in a contrary way. I am going to tell workers how to stop us from getting involved in service planning and management. All these things have happened to me in trying to take part in psychiatric service planning, as someone who has used the services. At the same time, I must acknowledge the very great help that professional people have given to me and other service users in helping us to be involved in trying to improve services.

1. Do not give resources

If you want to prevent user involvement, never give service users the money they need to meet and discuss policy matters. Do not offer money for training in committee skills. After all, you do not want them to get the hang of how the power system works.

2. Take charge

Secondly; take charge. When asked to be treasurer or chairperson by a user group where the members lack confidence; feel flattered, accept the job and wonder why the users will not take responsibility.

3. Sow doubts

The third way you can prevent user participation is to express doubt about the group's ability to be autonomous. Ask: "What if the chairperson becomes manic?" What happens when any chairperson is unable to fulfil that function? User groups are no different.

4. Not representative

Suggest to colleagues that the service users who are making representations are not representative because they are articulate. "Real" psychiatric patients are not articulate. If they were, they would have been given drugs to stop them speaking out. **How representative are you?**

5. Choose someone compliant

Invite a service user of your choice on to your committee rather than inviting a user group to send representatives. Then you can be sure to hear what you want to hear-not what psychiatric patients have to say.

6. Tokenism: outnumber them

My next two points are about tokenism. Invite just one service user representative on to a committee comprised of professionals. The user will probably not be confident enough to present other users' views unsupported. If the person is confident, he or she will be so heavily outnumbered that you will not have to change anything.

7. Tokenism: ignore them

The next form of tokenism is to consult widely; but exclude service users from the decision-making structures of your organisation. Then you can say that you have asked the service users, but will not have to act on what they have told you.

8. Embarrass them

The eighth idea to exclude service users is to embarrass them. For example, if a service user representative starts by making remarks that do not conform to your agenda, ensure that an awkward silence is followed by ignoring the content of what is said.

9. Exploit them

Never pay service users. Expect them to attend regularly as the only unpaid people in the roomful of salaried people. Then they will stop embarrassing you with their presence; and you'll have satisfied your conscience by inviting them.

10. Suggest that you are as powerless as service users

The tenth way to exclude psychiatric patients is to suggest that you are as powerless as they are. Mental health workers have the power to recommend children being taken away; to order compulsory admission to hospital; to remove access to desired services; to release grants of money and give access to housing of various sorts. You have a salary and probably a secure home. You do not carry a diagnosis that invalidates what you say.

The ideas in this paper have been published in 'Just Lip-Service' by Vivien Lindow in the Nursing Times (UK), 2 December 1992.

Appendix 3

Some things to check if inviting service users to a meeting of mostly workers

Membership

- ◆ Service user representatives should be service users and ex-users. Carers and people from the voluntary sector should be represented if appropriate, to speak about their own needs.

Support

- ◆ User attendance at meetings should be funded with meeting attendance payments. Such pay should take into account amounts allowed by benefits.
- ◆ Travel costs should be paid on the day of the meeting.
- ◆ Find out what support the service users need to feed back issues from the committee to other survivors, and to consult with them.
- ◆ Produce papers, including the agenda, soon after the meeting so that representatives can consult other people.
- ◆ Avoid unnecessary paperwork.

Power and decision making

- ◆ Make the committee purpose and limits clear.
- ◆ Make it clear where the power and decision-making lies.
- ◆ Do not assume there are areas where service users are not competent to take part.
- ◆ Do not pass the buck of difficult decisions to service users.
- ◆ Invite service user items for the agenda; don't place them near the end.

At the meeting

- ◆ Avoid jargon: challenge each other, as well as being open to users' challenges.
- ◆ Make statements about the equality of everyone's contribution to the meeting.
- ◆ Be clear about issues of confidentiality.
- ◆ Be clear to staff and service users that no-one will be victimised in their use of services for taking part in consultation and representation: this fear can sometimes prevent open criticism by users.
- ◆ Provide liquids: many psychoactive drugs dry the mouth.
- ◆ Be prepared for meetings to take longer sometimes.
- ◆ Be prepared for strong emotional expression, including anger. Do not regard this as a symptom.
- ◆ Provide breaks and a place for smoking.
- ◆ Let individuals and groups know you appreciate their input.

Access

- ◆ Hold meetings in user-friendly and public transport accessible places: ask people about this.
- ◆ Don't assume that mental health service users don't have physical impairments: make your meetings accessible in this sense too.

**From: Changing Practice: Mental Health Nursing and User Empowerment.
Peter Campbell and Vivien Lindow, 31 December 1997,
Royal College of Nursing and Mind Publications.**

Appendix 4. Information Sheet

Concerns about the prevention of violence in health and social care settings, and the adequacy of staff training in its containment and management are not new, and reflect wider concerns about violent crime in society in general. This has been acknowledged at a national level by the Department of Health with the introduction of 'Zero Tolerance' and targets for the reduction of violence against health and social care staff. The College Research and Training Unit has developed an approach to auditing violence that has proven popular and feasible with services. A new phase began in spring 2006 and will run for eighteen months.

Who is organising the programme?

The Healthcare Commission is providing funding for three wards from every NHS and independent sector provider of mental health services in England and Wales to take part.

The programme is being run by the Royal College of Psychiatrists' Research and Training Unit (also known as 'the College Research and Training Unit' or 'CRTU').

Who is taking part?

This phase of the audit is targeting two mental health specialities:

- ◆ Acute psychiatry
- ◆ Old age

A range of other units for adults with mental health problems will also be taking part.

Where do the audit standards come from?

- ◆ In 1998, the College Research and Training Unit published the first guideline on the subject ¹
- ◆ In 2005, the National Institute for Clinical Excellence published a guideline on the subject ²

¹ 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.

² Violence - The short-term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments, NICE 2005.

- ◆ The CRTU has already used standards from the first Guideline as the basis for four national audit programmes.

What audit data will you have to collect?

Contextual information: e.g. skills mix, and information about existing systems and procedures relating to the reporting of violent incidents. This will provide a framework for bench-marking and exchanging information and ideas.

Module 1: a survey involving people who reside in, work in, or come into regular contact with areas where violent incidents are known to occur, examining the supports that they receive to increase safety, and to reduce the likelihood that a violent incident will occur.

Module 2: an environmental audit where staff and non-staff teams will rate the environment against a set of evidence-based standards and work towards ideas for improvement.

Module 3a: a review of a series of violent incidents where staff groups work through a 'good practice' framework and agree an action plan for improving the management of adverse incidents.

Module 3b: a case note audit of the care and supports offered to people who have been given rapid tranquillisation to manage their violent behaviour.

What feedback will you get?

You will receive local and national feedback at the end of each part of the programme. A final report showing overall national findings will be produced at the end of the eighteen-month period.

What other supports will you get?

- ◆ A Project Management Pack: this pack provides advice and tools to help you set up the project locally.
- ◆ Introductory Event: your local Project Team will attend a regional workshop before data collection begins.
- ◆ Copies of all audit tools with detailed guidance on their use.
- ◆ Data analysis: all data will be returned to the CRTU for central analysis and reporting.
- ◆ Regular newsletters.
- ◆ Facilitated networking and benchmarking with other participating trusts/organisations.
- ◆ Feedback Event: your local Project Team will attend a regional workshop at the end of the data collection period.

Your local Project Team

Who is leading the project in your trust/organisation?

Which wards/units are taking part?

Who else is on the Project Team?

What are the key milestones?

What?	When?
Introductory Event	
Module 1 data collection	
Module 2 data collection	
Module 3a data collection	
Module 3b data collection	
Feedback Event	

For more information, contact