



Module 3a Audit Tool

(Older people's services)

Review of severely challenging/violent incidents

Data collection commences 1 October and ends
February 2007

BACKGROUND INFORMATION

Please tick which of the following occurred during this incident:

• Raised voices/verbal aggression/threats	<input type="checkbox"/>	• Pushing	<input type="checkbox"/>
• Hitting another person	<input type="checkbox"/>	• Throwing, striking or damaging objects/ furnishings/fittings	<input type="checkbox"/>
• Spitting at a person	<input type="checkbox"/>	• Use of a weapon or object to threaten	<input type="checkbox"/>
• Use of a weapon or object to attack a person	<input type="checkbox"/>	• Injury which required treatment	<input type="checkbox"/>
• Resisting restraint or forced treatment	<input type="checkbox"/>	• Other (<i>please specify</i>):	

How old is the person involved (i.e. the subject of this review)?

What is the gender of the person involved?

What is the ethnic group of the person involved? (please circle)

White British	White and Black Caribbean	Indian	Black Caribbean
Other white	White and Black African	Pakistani	Black African
Chinese	White and Asian	Bangladeshi	Other Black
Other Ethnic Group	Other Mixed	Other Asian	Other (<i>please specify</i>):

Please give a brief description of the incident:

SECTION 1: ASSESSING AND MANAGING RISK

Severely challenging/violent behaviour can never be predicted with 100% accuracy. Since the components of risk are dynamic and may change according to circumstance, risk assessment (of the environment and the patient) should be ongoing and care plans based on an accurate and thorough risk assessment.

1. Was the patient considered to be a high risk of violence? <i>(refer to text box on the right)</i>	YES/NO	<p style="text-align: center;">RISK ASSESSMENT</p> <p>The following lists are not intended to be exhaustive and these risk factors should be considered on an individual basis.</p> <p>Demographic or personal history including the following features:</p> <ul style="list-style-type: none"> • History of severely challenging/violent behaviour • History of misuse of substances or alcohol • Carers reporting patient's previous anger or violent feelings • Previous expression of intent to harm others • Evidence of rootlessness or 'social restlessness' • Previous use of weapons • Previous dangerous impulsive acts • Denial of previous established dangerous acts • Severity of previous acts • Known personal trigger factors • Verbal threat of violence • Evidence of recent severe stress, particularly loss event or threat of loss • One or more of the above in combination with any of the following: <ul style="list-style-type: none"> - Cruelty to animals - Reckless driving - History of bed-wetting - Loss of parent before the age of 8 years <p>Clinical variables, including the following features:</p> <ul style="list-style-type: none"> • Misuse of substances and/or alcohol • Drug effects (disinhibition, akathisia) • Active symptoms of schizophrenia or mania, in particular delusions or hallucinations focused on a particular person • Command hallucinations • Preoccupation with violent fantasy • Delusions of control (especially with violent theme) • Agitation, excitement or impulsive personality traits or disorder • Organic dysfunction <p style="text-align: right;">(continues on next page)</p>
2. Was the patient asked about their trigger factors, early warning signs of severely challenging/violent behaviour and other vulnerabilities, and the management of these?	YES/NO	
3. Were there specific interventions for the short-term management of severely challenging/violent behaviour?	YES/NO	
4. Were actuarial tools and structured clinical judgement used to assist in the risk assessment?	YES/NO	
5. Was the risk assessment multidisciplinary?	YES/NO	
6. Were the findings of the risk assessment communicated to all who needed to know (allowing for patient confidentiality)?	YES/NO	
7. Was an advance directive made about choice between rapid tranquillisation, restraint or seclusion, should they become severely challenging/violent?	YES/NO	
8. If the patient was found to be at high risk of violence, was there an effective plan to manage this risk?	YES/NO	

<p>9. Were the staff adequately trained in assessment and management of risk?</p>	<p>YES/NO</p>	<p>Situational variables, including the following features:</p> <ul style="list-style-type: none"> • Extent of local support • Immediate availability of a potential weapon • Relationship to potential victim (for example, difficulties in relationship are known) • Access to potential victim <p>The following additional factors need to be considered for people with dementia who develop behaviour that severely challenges:</p> <ul style="list-style-type: none"> • The person's physical health • The presence of undetected pain and discomfort • The presence of hallucinations, paranoid symptoms or mood disorder • Side effects of medication • Physical environmental factors • Pre-morbid personality and personal preferences/dislikes
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Comments and points for discussion

PLEASE NOTE: THIS PART OF THE CHECKLIST IS FOR LOCAL USE ONLY

SECTION 2: ANTECEDENTS/WARNING SIGNS

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

1. Were any antecedents evident during the days, hours or minutes leading up to the incident?	YES/NO	Antecedents and warning signs <ul style="list-style-type: none">• Facial expressions tense and angry• Increased or prolonged restlessness, body tension, pacing• General over-arousal of body systems (increased breathing and heart rate, muscle twitching, dilating pupils)• Increased volume of speech, erratic movements• Prolonged eye contact• Discontentment, refusal to communicate, withdrawal, fear, irritation• Thought processes unclear, poor concentration• Delusions or hallucinations with severely challenging/violent content• Verbal threats or gestures• Replicating, or behaviour similar to that which preceded, earlier severely challenging/violent episodes• Reporting anger or violent feelings• Blocking escape routes
2. Were there any specific 'triggers' to the incident? (refer to text box on the right)	YES/NO	
3. Were the staff adequately trained in recognising antecedents/warning signs?	YES/NO	
4. Did staff know the individual well enough to recognise these signs?	YES/NO	

Comments and points for discussion

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SECTION 3: THE USE OF OBSERVATION FOR THE SHORT-TERM MANAGEMENT OF VIOLENCE

The primary aim of observation should be to engage positively with the patient. This involves a two-way relationship, established between a patient and a staff member, which is meaningful, grounded in trust, and therapeutic for the patient¹. Observation is an intervention that is used both for the short-term management of severely challenging/violent behaviour and to prevent self-harm. The recommendations and good practice points below are specifically directed towards the use of observation as an intervention for the short-term management of severely challenging/violent behaviour.

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

1. Was the patient subject to the least intrusive level of observation?	YES/NO
2. Was the patient involved in the decision about the observation level?	YES/NO
3. Was the multidisciplinary team in agreement about observation levels?	YES/NO
4. Was it agreed <u>who</u> was going to review observation levels and <u>when</u> ?	YES/NO
5. Was the nurse undertaking the observation: <ul style="list-style-type: none"> • able to take an active role in engaging positively with the patient? • appropriately briefed about the patient's history, background, specific risk factors and particular needs? <p style="margin-left: 40px;">familiar with the ward, the ward policy for emergency procedures, and potential risks in the environment?</p>	YES/NO
6. Was an individual staff member asked to undertake a continuous period of observation above the general level for longer than 2 hours?	YES/NO

Comments and points for discussion

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¹ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (2002) *The Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care*. London.

SECTION 4: THE USE OF DE-ESCALATION TACTICS

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

1. Did one member of staff assume control of the situation?	YES/NO	<p>De-escalation tactics</p> <ul style="list-style-type: none"> • Manage others in the environment, for example removing other patients from the area, enlisting the help of colleagues and creating space • Explain to the patient and others in the immediate vicinity what you intend to do • Give clear, brief, assertive instructions • Move towards a safe place and avoid being trapped in a corner • Attempt to establish a rapport and emphasise cooperation • Offer and negotiate realistic options and avoid threats • Ask open questions and inquire about the reason for the patient's anger, for example 'What has caused you to feel upset/angry?' • Show concern and attentiveness through non-verbal and verbal responses • Listen carefully and show empathy, acknowledging any grievances, concerns or frustrations, and not being patronising or minimising patient concerns • If potential weapons are involved, relocate the severely challenging/violent person to a safer environment • If a weapon is involved ask for the weapon to be placed in a neutral location rather than handed over • Consider asking the patient to make use of the designated area or room specifically for the purpose of reducing arousal and/or agitation to help them calm down
2. Were all relevant tactics used? (refer to text box on the right)	YES/NO	
3. Were staff able to summon help?	YES/NO	
4. Was the patient given the opportunity to remove themselves to a safe and quiet designated area?	YES/NO	
5. Was medication offered voluntarily?	YES/NO	
6. Were the staff involved adequately trained in de-escalation?	YES/NO	

Comments and points for discussion

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SECTION 5: THE USE OF OTHER INTERVENTIONS

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

1. Were all staff aware of the legal framework that authorised the use of any other intervention other than de-escalation that was employed to manage this incident?	YES/NO
2. Was the use of each additional intervention recorded at that time, using a local template?	YES/NO
3. If the incident involved physical assault, was it reported to the NHS Security Management Service (SMS) as per Secretary of State directive November 2003?	YES/NO

Comments and points for discussion

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A: THE USE OF PHYSICAL INTERVENTIONS (HANDS-ON RESTRAINT)

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

(NICE, 2005)

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

1. Had contraindications to the use of hands-on restraints been assessed?	YES/NO	<p>Risk factors to justify the use of physical interventions</p> <ul style="list-style-type: none"> • A serious degree of urgency and danger • As a last resort when less restrictive methods have failed • A significant risk of physical attack • Significant threats or attempts at self-injury • Serious property destruction • Prolonged <u>and</u> serious verbal abuse, threats, or disruption to the ward • Prolonged over-activity, with risk of exhaustion to the patient • Risk of serious accident to the patient or others <p>The use of hands-on restraint: patient concerns</p> <ul style="list-style-type: none"> • Self-respect, dignity and privacy • Cultural values, e.g. sex of restrainer • Monitoring for signs of physiological distress <p>The deliberate application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, patients and/or others.</p> <p>Older people should require minimal hands-on restraint and never be taken to the floor.</p>
2. Were sufficient risk factors present to justify the use of hands-on restraint to manage the situation? (<i>refer to text box on the right</i>)	YES/NO	
3. During the hands-on restraint, was one team member responsible for protecting and supporting the head and neck, where required?	YES/NO	
4. During hands-on restraint, was the overall <u>physical wellbeing</u> of the patients continuously monitored, i.e. ensuring that the airway and breathing were not compromised and that vital signs were monitored?	YES/NO	
5. During hands-on restraint, was the overall <u>psychological well being</u> of the patient continuously monitored?	YES/NO	
6. <u>During the act of restraining</u> , was adequate consideration given to the patient's concerns? (<i>refer to text box on the right</i>)	YES/NO	
7. Was the level of force applied justifiable, appropriate, reasonable and proportionate to the specific situation, and was it applied for the minimum possible amount of time?	YES/NO	
8. Was every effort made to utilise skills and techniques that did not use the deliberate application of pain? (<i>refer to text box on the right</i>)	YES/NO	
9. After the incident, did someone talk to <u>everyone</u> who had been involved or witnessed the incident about what had happened?	YES/NO	
10. Had all of the staff responsible for applying the hands-on restraint received training in those that were used?	YES/NO	

Comments and points for discussion

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B: THE USE OF RAPID TRANQUILLISATION

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

(NICE, 2005)

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

Note: The NICE Guideline (2005) explicitly excludes services for people with dementia, hence, in relation to Older People's Services, the National Audit of Violence Steering Group cannot recommend usage of medication in accordance with the algorithm provided for use in services for adults of working age. Please refer to your local policy, or you may wish to consider the following guidance: 'Psychiatric Services to Accident and Emergency departments'. Council report CR118, February 2004. Published by the Royal College of Psychiatrists and British Association for Accident and Emergency Medicine.

(NAV Steering Group, September 2006)

1. Prior to the administration of medication , were the appropriate precautions taken? (<i>refer to text box on the right</i>)	YES/NO	<p>Please refer to appendix two for further information.</p> <p>Precautions prior to administration</p> <ul style="list-style-type: none"> • A history/mental state examination • A physical examination (if possible) • Establishment of a provisional diagnosis and legal status • A multi-disciplinary discussion as to whether rapid tranquillisation is safe and appropriate <p>Risks associated with the use of rapid tranquillisation</p> <p>Medication for rapid tranquillisation, particularly in the context of physical intervention, should be used with caution owing to the following risks:</p> <ul style="list-style-type: none"> • Loss of consciousness instead of tranquillisation • Sedation with loss of alertness • Loss of airway • Cardiovascular and respiratory collapse • Interaction with medicines already prescribed or illicit substances taken (can cause side effects such as akathisia, disinhibition) • Possible damage to patient-staff relationship • Underlying coincidental physical disorders <p>Risk factors for the use of rapid tranquillisation</p> <ul style="list-style-type: none"> • Intoxication with drugs or alcohol • Failure to monitor vital signs • Poor access to resuscitation equipment and drugs, including flumazenil • Use of seclusion <p style="text-align: right;">(continues on next page)</p>
2. Were staff trained in the use of resuscitation equipment?	YES/NO	
3. Was oral medication offered before parenteral medication?	YES/NO	
4. Was sufficient time allowed for clinical response between oral doses of medication for rapid tranquillisation? (see chart for rapid tranquillisation)	YES/NO	
5. Was sufficient time allowed for clinical response between intramuscular (i/m) doses of medications for rapid tranquillisation?	YES/NO	
6. Did dosage exceed the BNF/SPC limits?	YES/NO	
7. <i>If the answer to question 6 is 'YES'</i> , was a risk-benefit analysis recorded in the case note, and the rationale recorded in the care plan?	YES/NO	
8. Was a specialist mental health pharmacist involved in deciding the RT regime?	YES/NO	
9. During the rapid tranquillisation , was adequate consideration given to any risk factors? (<i>refer to text box on the right</i>)	YES/NO	

10. Was the patient able to respond to communication throughout the period of rapid tranquillisation?	YES/NO	<p>On occasion, rapid tranquillisation with mentally incapacitated adults may need to be administered covertly, i.e. delivered in patients food and drink. The following precautions may apply:</p> <ul style="list-style-type: none"> • Prescription of covert medicines should follow a formal mental capacity assessment and carer consultation regarding best interests. • Medication should be reviewed regularly to include essential medicines only. • Consultation with mental health pharmacists should be undertaken regarding the safety of medication after it has been mixed with food and drink. • Close observation should be maintained to ensure medication is taken by the patient and eliminate the risk of other patients ingesting it. • The prescription should be subject to daily review. • Covert medications should be prescribed with caution as this may make the patient paranoid about eating and drinking. Oral intake and hydration should be closely monitored and if necessary another route of administration considered. • Covert medication may reinforce pre-existing delusional beliefs and therefore maybe counter-therapeutic.
11. After rapid tranquillisation was administered (and until the patient became active again): (a) Were blood pressure, pulse, temperature, respiratory rate and hydration recorded?	YES/NO	
(b) Were the intervals between recordings agreed between doctor and nurses?	YES/NO	
12. Were the context, actions taken and outcome documented, and were subsequent revisions made to the management plan?	YES/ NO	
13. Was the patient given the opportunity to talk about the incident and write about it in their notes?	YES/ NO	

Comments and points for discussion

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C: THE USE OF SECLUSION

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

(NICE, 2005)

Note: The NICE Guideline (2005) explicitly excludes services for people with dementia, hence, in relation to Older People's Services, the National Audit of Violence Steering Group cannot recommend usage of seclusion in accordance with the Guideline. However, occurrence of its use with Older People's Services does need to be monitored to assist in recommending future guidance if necessary.

(NAV Steering Group, September 2006)

1. Were the reasons and likely outcome explained to the patient and repeated during seclusion?	YES/NO
2. Was an observation schedule specified?	YES/NO
3. Was the use of seclusion recorded in accordance with the guidance in the Mental Health Act Code of Practice?	YES/NO
4. Was seclusion used for the shortest time possible?	YES/NO
5. Was the use of seclusion reviewed at least every 2 hours in accordance with the guidance in the Mental Health Act Code of Practice?	YES/NO
6. Was the patient made aware that reviews would take place at least every 2 hours?	YES/NO
7. Was the patient allowed to retain their clothing (assuming it did not compromise their safety and the safety of others)?	YES/NO
8. Was the patient allowed to keep personal items including those of religious or cultural significance (such as some items of jewellery, assuming they did not compromise their safety or the safety of others)?	YES/NO
9. Was a nurse in sight or sound throughout the period of seclusion (and present if the patient was subject to rapid tranquillisation)?	YES/NO
10. Was a doctor present within the first few minutes of seclusion?	YES/NO
11. Was the patient given the opportunity to talk about the incident and write about it in their notes?	YES/NO

Comments and points for discussion

PLEASE NOTE THIS PART OF THE CHECKLIST IS FOR LOCAL USE ONLY

D: THE USE OF RAPID TRANQUILLISATION AND SECLUSION

Note: The NICE Guideline (2005) explicitly excludes services for people with dementia, hence, in relation to Older People's Services, the National Audit of Violence Steering Group cannot recommend the combined usage of rapid tranquillisation and seclusion in accordance with the Guideline. However, occurrence of its use with Older People's Services does need to be monitored to assist in recommending future guidance if necessary.

(NAV Steering Group, September 2006)

1. Was the patient monitored by 'within eyesight' observation by an appropriately trained individual?	YES/NO
2. Once rapid tranquillisation had taken effect, was seclusion terminated?	YES/NO

Comments and points for discussion

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E: THE USE OF MECHANICAL RESTRAINT

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

Discuss the mechanical restraint that was applied and whether it followed principles of best practice/least restrictive practice.

Comments and points for discussion

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SECTION 6: POST-INCIDENT

1. Was every opportunity taken to establish whether the patient understood why the intervention(s) had been used?	YES/NO
2. Did a post-incident review take place as soon after the incident as possible, but in any event within 72 hours of the incident ending?	YES/NO

Comments and points for discussion

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Appendix 1

Suggested ground rules for the review meetings

- One person speaks at a time.
- It should be clear who is chairing/facilitating the meeting. They should have the necessary skills and training.
- Every contribution is valued – no one is right and no one is wrong.
- Strong views can be expressed, but not in a way that would cause offence to other people who are present or absent. The meeting is not an arena for personal vendettas.
- What is said in the group will not be discussed outside of the group.
- Aim to reach consensus whenever possible.
- Work together to create a shared 'action plan'.
- It is clear who is responsible to deliver the actions generated in the 'action plan'.

Appendix 2

Medication guidelines

Definition:

All medication given in the short-term management of severely challenging/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)

Note: The NICE Guideline (2005) explicitly excludes services for people with dementia, hence, in relation to Older People's Services, the National Audit of Violence Steering Group cannot recommend usage of medication in accordance with the algorithm provided for use in services for adults of working age. Please refer to your local policy or you may wish to consider the following guidance:

'Psychiatric Services to Accident and Emergency departments'. Council report CR118, February 2004. Published by the Royal College of Psychiatrists and British Association for Accident and Emergency Medicine.

In addition, the following modified guidance is provided for your consideration.

(NAV Steering Group, September 2006)

Principles

(These points were drawn from the NICE Guideline, with additions from the Steering Group marked in *emboldened italics*)

- Aim for reduction in agitation or aggression rather than sedation
- Consider advance directives and issues of consent
- Patients should be able to respond to communication throughout
- Use the lowest effective dose: ***'start low, go slow'***
- Prescribe oral and intramuscular doses separately (don't prescribe O/IM)
- Keep within BNF limits except in exceptional circumstances
- Vital signs must be monitored after parenteral treatment (blood pressure, pulse and temperature) until the patient becomes active again. ***Consider the use of 1:1 nurse specialising if parenteral treatment is used.***
- Pulse oximeters should be available

Potential risks

(These points were drawn from the NICE Guideline, with additions from the Steering Group marked in *emboldened italics*)

- Oversedation causing loss of consciousness
- Loss of airway
- Cardiovascular and respiratory collapse
- Interaction with prescribed or illicit drugs
- Damage to therapeutic relationship

- Underlying coincidental physical disorders
- ***Reduced hydration and nutrition***
- ***Skincare: care to pressure areas when patient is undergoing long periods of immobility***

Additional guidance from the National Audit of Violence Steering Group.

For people with dementia where there is significant risk of harm because of behaviour that severely challenges, the immediate management should be conducted by staff with specialist training who should follow the NICE Guideline (2005), with due consideration for dosage adjustments because of age and the presence of dementia. Once the immediate risk has been reduced, a comprehensive assessment and review of treatment options should be carried out.

Antipsychotic drugs may be considered and used for people with dementia with severe behaviour that challenges when the following conditions have been met:

- Cardiovascular risk factors have been assessed and discussed with the person and/or their carers – particularly the risk of stroke/TIA
- Target symptoms are identified, quantified and documented and any changes assessed and documented at regular intervals
- The choice of antipsychotic is made after an initial risk-benefit analysis
- Starting dose is low and titrated upwards
- Treatment time is limited and regularly reviewed
- For people with Dementia with Lewy Bodies (DLB), clinicians should avoid the use of neuroleptics where possible. However, in severe cases when use of these drugs is necessary, clinicians should monitor carefully for the emergence of severe adverse reaction (such as extrapyramidal effects).

PART B: ACTION PLAN

To be completed for each of the THREE incidents, between 1 October and 28 February 2007, and entered online at www.rcpsych.ac.uk/nav-data

Should you have any problems please do not hesitate to contact the Audit team on 0207 977 6645/6 or audit-of-violence@cru.rcpsych.ac.uk

Name of Trust/Organisation:	
Ward:	

BACKGROUND INFORMATION

1. Please tick which of the following occurred during this incident:

- | | |
|---|--|
| • Raised voices/verbal aggression/threats | |
| • Pushing | |
| • Hitting another person | |
| • Throwing, striking or damaging objects/furnishings | |
| • Spitting at a person | |
| • Use of a weapon or object to <u>threaten</u> | |
| • Use of a weapon or object to <u>attack</u> a person | |
| • Injury which required treatment | |
| • Resisting restraint or forced treatment | |
| • Other (<i>please specify</i>): | |

2. How old is the person involved (i.e. the subject of this review)?

3. What is the gender of the person involved?

4. What is the ethnic group of the person involved? (please circle)

White British	White and Black Caribbean	Indian	Black Caribbean
Other white	White and Black African	Pakistani	Black African
Chinese	White and Asian	Bangladeshi	Other Black
Other Ethnic Group	Other Mixed	Other Asian	Other (<i>please specify</i>):

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

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

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