



Module 3a Audit Tool

(Working age adult services)

Review of severely challenging/violent incidents

NOTE: This tool does not apply to older people's services

Data collection commences 1 October and ends
28 February 2007

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/fittings	
• Spitting at a person		• Use of a weapon or object to threaten	
• Use of a weapon or object to attack a person		• Injury which required treatment	
• Resisting restraint or forced treatment		• Other (<i>please specify</i>):	

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

3. What is the gender of the person involved?

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

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

5. 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?	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>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
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	
9. Were the staff adequately trained in assessment and management of risk?	YES/NO	

Comments and points for discussion (box continues on next page)

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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, minutes or hours 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?	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 who was going to review observation levels and when?	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?• familiar with the ward, the ward policy for emergency procedures and potential risks in the environment?	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

Action plans should be developed at a local level which detail how to call for help in an emergency. 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 they 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?	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. Was there an advance directive from the patient about what type of intervention they would prefer in the event of their own severely disturbed behaviour?	YES/NO
2. 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
3. Was the use of each additional intervention recorded at that time, using a local template?	YES/NO
4. If the incident involved physical assault was it reported to the NHS Security Management Service (SMS) as per Secretary of State directives November 2003?	YES/NO

Comments and points for discussion

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

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. During the hands-on restraint was one team member responsible for protecting and supporting the head and neck, where required?	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>
2. During hands-on restraint was the overall physical well-being of the patient continuously monitored, i.e. ensuring that the airway and breathing were not compromised and that vital signs were monitored?	YES/NO	
3. During hands-on restraint was the overall psychological well-being of the patient continuously monitored?	YES/NO	
4. Had contraindications to the use of hands-on restraint, been assessed?	YES/NO	
5. Were sufficient risk factors present to justify the use of hands-on restraint to manage the situation?	YES/NO	
6. Had all of the staff responsible for applying the hands-on restraint received training in those that were used?	YES/NO	
7. <u>During the act of restraining</u> , was adequate consideration given to the patient's distress and concerns?	YES/NO	
8. After the incident, did someone talk to <u>everyone</u> who had been involved or witnessed the incident about what had happened?	YES/NO	
9. 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	
10. Was every effort made to utilise skills and techniques that did not use the deliberate application of pain?	YES/NO	

Comments and points for discussion

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B: THE USE OF RAPID TRANQUILLISATION

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. **Please refer to Appendix 2 for medication guidelines.**

All medication given in the short-term management of severely challenging/violent behaviour should be considered as part of rapid tranquillisation (including pro re nata [PRN] medication taken from an agreed rapid tranquillisation protocol or as part of an advance directive).

1. <u>Prior to the administration of medication</u> , were the appropriate precautions taken?	YES/NO	<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 (please refer to Appendix 2)</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
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', was a risk-benefit analysis recorded in the case note and rationale recorded in the care plan?</i>	YES/NO	
8. Was a specialist mental health pharmacist involved in deciding the RT regime?	YES/NO	
9. <u>During the rapid tranquillisation</u> , was adequate consideration given to any risk factors?	YES/NO	
10. Was the patient able to respond to communication throughout the period of rapid tranquillisation?	YES/NO	
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 (box continues on next page)

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C: THE USE OF SECLUSION

Patients generally dislike seclusion, even when it is carried out properly, but some accept that it can be necessary, as a last resort, and then for the shortest period possible.

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 (box continues on next page)

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D: THE USE OF RAPID TRANQUILLISATION AND SECLUSION

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 acute 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

Guidance for the use of Rapid Tranquillisation

(Based on NICE Management of Violence Guideline 2005)

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)

Principles

- 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
- 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
- Pulse oximeters should be available

Potential risks

- 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

Drugs **not** recommended for rapid tranquillisation

Chlorpromazine either orally or i/m

Diazepam i/m

Depot antipsychotics

Thioridazine (withdrawn)

Droperidol (withdrawn)

Risperidone / olanzapine **not recommended** for patients with dementia

Zuclopentixol acetate (acuphase) **only recommended if** previous good response to it or history of repeated parenteral administration, prolonged disturbance or indicated by advance directive.

Do not prescribe to patients who have not previously received antipsychotics.

Drugs recommended for rapid tranquillisation

Route of administration	Drugs	Comments
1. Oral (preferred route)	<ul style="list-style-type: none"> • Non psychotic context, consider oral lorazepam • Psychotic context consider oral lorazepam + oral antipsychotic 	
2. Intramuscular (i/m) Consider if: <ul style="list-style-type: none"> • Oral therapy is refused or has failed • Oral therapy is not indicated by a previous clinical response • Allow sufficient time after an oral dose if given 	<ul style="list-style-type: none"> • Non Psychotic context consider i/m lorazepam • Psychotic Context consider i/m lorazepam + i/m haloperidol, • May also consider i/m olanzapine for moderate disturbance • If using i/m olanzapine, don't give i/m lorazepam within an hour and use oral lorazepam with caution 	<ul style="list-style-type: none"> • When using haloperidol, benztropine or procyclidine should be immediately available • If verbal response is lost, use the level of care appropriate to general anaesthesia
3. Intravenous (i/v) To be used in exceptional circumstances only where immediate tranquillisation is essential	<ul style="list-style-type: none"> • Consider i/v benzodiazepines or haloperidol • Decision is not to be made by junior staff in isolation 	<ul style="list-style-type: none"> • Crash bag to be available in 3 minutes • Staff trained to Immediate Life Support • Never leave patient unattended • If verbal response is lost, use the level of care appropriate to general anaesthesia

PART B: ACTION PLAN

Review of severely challenging/violent incidents

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 020 7977 6645/6 or email 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:

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

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

3. What is the gender of the person involved?

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

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

	Action(s) required	Person responsible	To be completed by (date)	Completed (date)
<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>				