Charity reg. No. 228636

National Audit of Violence

Standards for Adult In-patient Mental Health Services

Edited by Leanne Shinkwin, Maureen McGeorge and Graham Hinchcliffe.
March 2007.

A manual of standards written primarily for:
Adult in-patient mental health services

Also of interest to:
Patients
Commissioners
Policy makers
Researchers

Edition March 2007

Correspondence:
Maureen McGeorge
Programme Manager, National Audit of Violence
Royal College of Psychiatrists' Centre for Quality Improvement
Tel: 020 7977 6646,
Fax: 020 7481 4831
E Mail: mmcgeorge@cru.rcpsych.ac.uk

This document can be downloaded, free of charge, from:
http://www.rcpsych.ac.uk/nav

With thanks to our funders, the Healthcare Commission.

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

Foreword

Disturbed or violent behaviour by an individual in an adult in-patient psychiatric setting poses a serious risk to that individual, other patients and staff. In 1998/99, an NHS Executive survey found that there were approximately 65,000 violent incidents against staff across the NHS. The average number of incidents in mental health trusts was more than three times the average for all trusts (NOTE: the data included learning disability trusts). The standards for the National Audit of Violence cover a broad range of areas relating to both the maximisation of safety/minimisation of risk, and also to the ways in which challenging/violent incidents are managed when they do occur.

The 2006/07 phase of the audit is working with approximately 80% of eligible mental health service providers in the NHS and independent sector in England and Wales.

The methodologies that participating wards are being asked to apply in order to measure their compliance with the standards are both varied and challenging.

- **Module 1**: an anonymised survey of staff, patients and visitors to the wards. The questionnaires[1] examine the supports that each group receives to maximise safety and minimise risk that a violent incident will occur. Each questionnaire contains a mixture of closed 'yes/no' questions, and free text boxes for comments. Local project teams were guided to aim for a response rate of at least 50% of staff, and 20 questionnaire returns from patients[2].
- **Module 2**: an environmental audit where staff and non-staff teams rate the ward environment against a set of standards and agree ideas for improvement.
- **Module 3a**: a review of a series of severely challenging/violent incidents, where staff groups work through a 'good practice' framework and agree an action plan for improving the future management of incidents.
- **Module 3b**: a case note/drug chart audit of the use of rapid tranquillisation.

The qualitative and quantitative data generated by the audit will allow participants to deepen their understanding of the problems they experience in relation to the prevention and management of violence. The opportunities that the project offers for national benchmarking and shared learning further increase the likelihood that individual wards and trusts will be able to establish plans to address some of these problems.

[1] Additional data collection methods, tools and guidance were developed for services for people with dementia, i.e. a carer questionnaire and a framework for third-party observation.

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

Contents

Introduction v
Acknowledgements vi
Key vii
Glossary viii

STANDARDS:

SECTION 1: Environment 1
- 1.1 Safety and security
- 1.2 Activities and external areas
- 1.3 Patient concerns
- 1.4 Alarms
- 1.5 Clinical environment
- 1.6 Leadership and supervision
- 1.7 Interagency working
- 1.8 Specific issues - older people's services

SECTION 2: Prediction 4
- 2.1 Policy
- 2.2 Risk Assessment
- 2.3 Antecedents and warning signs
- 2.4 Risk Factors
- 2.5 Specific issues dementia services

SECTION 3: Training 7
- 3.1 Policy
- 3.2 Specific staff training needs
- 3.3 Specific issues older people's services
- 3.4 Incident reporting

SECTION 4: Working with patients 9
- 4.1 Creating a feeling of safety and understanding
- 4.2 Specific issues - older people's services
- 4.3 Patients with disabilities

SECTION 5: Searching 10
SECTION 6: De-escalation techniques 11
- 6.1 General
- 6.2 De-escalation techniques

SECTION 7: Observation and engagement 12
- 7.1 Policy
- 7.2 Carrying out observation
- 7.3 Patient needs

SECTION 8: Other interventions 13
- 8.1 Overarching recommendations
- 8.2 Physical interventions
- 8.3 Seclusion
- 8.4 Rapid tranquillisation and seclusion
- 8.5 Rapid tranquillisation
- 8.6 Covert medication

SECTION 9: Incident reporting and post incident reviews 19
- 9.1 Incident reporting
- 9.2 Post-incident reviews

Introduction

The standards for the National Audit of Violence have been largely drawn from two sources:

- the recent NICE guideline, 'Violence: The Short-term Management of Disturbed/Violent Behaviour in Psychiatric In-patient Settings and Emergency Departments' (2005), and;
- the earlier Royal College of Psychiatrists' guideline on the subject, 'The Management of Imminent Violence - Clinical practice guidelines to support mental health services' (1998).

Note: the NICE 2005 guideline **specifically excludes** services for people with dementia. The Steering Group for the audit carefully considered the relevance of each standard to older people's services in general, and services for people with dementia more specifically:

- some standards relating the management of violent or disturbed behaviour were **excluded** in the audit tools for older people's services;
- additional standards specific to older people's services were added.

The additional standards were drawn from a number of sources, as advised by the expert members of our Steering Group.

Where a standard **does not refer to both adults of working age and older people**, the box is shaded. A full listing of the sources, and the abbreviations used to refer to each of the standards, is included on page vii.

A full copy of this document is available on our website at: www.rcpsych.ac.uk/nav.

Acknowledgements

Consultation and support

Special thanks are expressed to the following people for their continued advice and support in compiling the standards and audit tools:

Ms Helen Bennett	Cardiff and Vale NHS Trust
Dr Rob Chaplin	Royal College of Psychiatrists' Research and Training Unit
Ms Marion Janner	Patient representative (Bright)
Ms Sarah King	Patient representative (Impact)
Dr Paul Lelliott	Royal College of Psychiatrists' Research and Training Unit
Dr Simon O'Donovan	Cardiff and Vale NHS Trust
Dr Alan Swann	Northumberland, Tyne and Wear NHS Trust
Mr Rick Tucker	NHS Counter Fraud and Security Management Service

Key

Full listing of sources for standards and their abbreviations

Literature source	
CT	College Statement on Covert Administration of Medicines, Royal College of Psychiatrists (2004).
DAB:TBS	Delirious about dementia, towards better services for patients with cognitive impairment by geriatricians, Dementia Link Faculty (2005).
MIV	Management of Imminent Violence, Clinical Practice Guidelines to support mental health services, Royal College of Psychiatrists (1998).
NICE	Violence: The Short-term Management of Disturbed/Violent Behaviour in Psychiatric In-patient Settings and Emergency Departments, National Institute for Clinical Excellence (2005).
Other source	
CFSMS	NHS Counter Fraud and Security Management Service
NAV SG 1999	National Audit of Violence Steering Group (1999)
NAV SG 2006	National Audit of Violence Steering Group (2006)

Abbreviations for audit modules in which each standard is reviewed

CI	Contextual Information Checklist
1	Module 1: Ward survey of staff, patients and visitors
2	Module 2: Environmental audit
3a	Module 3a: Review of severely challenging/violent incidents
3b	Module 3b: Case note/drug chart audit of the use of rapid tranquillisation

Where applicable, the standards have also been mapped across to the Healthcare Commission's 'Standards for Better Health' and this had been noted in the right-hand column, e.g. 'HC C20a'.

General glossary

This glossary was adapted from the NICE Guideline, 2005.

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

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

Antecedents: warning signs that indicate a patient is escalating towards a violent act.

Antipsychotics: a class of prescription medications used to treat psychotic conditions.

Benzodiazepines: refers to any of several similar lipophilicamines used as tranquillisers, sedatives, hypnotics or muscle relaxants.

Calming: reduction of anxiety/agitation.

Cardiovascular compromise: failure of the heart and circulatory system to produce adequate blood flow to the vital organs leading to collapse and often to death.

Cardiopulmonary resuscitation: combined artificial ventilation and cardiac massage technique for reviving a person whose heart and breathing have stopped and who is unconscious.

Crash bag: the equipment necessary to resuscitate an individual if they suffer a cardiac arrest.

David Bennett Inquiry: public inquiry into the death of David Bennett, a 38-year-old black man, who died while being restrained in a medium secure unit in the early hours of Saturday 31 October 1998.

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

Dystonia: a slow movement or extended spasm in a group of muscles.

Environment: the physical and therapeutic external conditions or surroundings.

Exceptional circumstances: those circumstances that cannot reasonably be foreseen and as a consequence cannot be planned for.

Gender: those characteristics of women and men that are socially determined, as opposed to 'sex' which is biologically determined (*Mainstreaming gender and women's mental health implementation guide 2003*).

Mania: an irrational but irresistible motive for a belief or action. It can also be used to refer to a mood disorder and an affective disorder in which the victim tends to respond excessively and sometimes violently.

Mechanical restraint: a method of physical restraint involving the use of authorised equipment applied in a skilled manner by designated health care professionals. Its purpose is to safely immobilise or restrict movement of part(s) of the body of the individual concerned.

NHS Security Management Service (SMS), also known as the Counter Fraud and Security Management Service: a special health authority which has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption and the management of security in the National Health Service (http://www.cfsms.nhs.uk/).

Observation: a two-way relationship, established between a patient and a nurse, which is meaningful, grounded in trust, and therapeutic for the patient (*The recognition, prevention and therapeutic management of violence in mental health care,* (2002) London: United Kingdom Central Council for Nursing, Midwifery and Mental Health Visiting).

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

Patient: the term 'patient' is used, rather than 'service user' in this document and all associated audit tools and guidance.

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

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

Psychiatric in-patient settings: any care setting in which psychiatric treatment is given to in-patients.

Psychosocial interventions: the term is used to refer to a range of social, educational, occupational, behavioural, and cognitive interventions. Within the short-term management of disturbed/violent behaviour, the two main psychosocial interventions are de-escalation and observation.

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

Seclusion: the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed/violent 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; where there is any risk of suicide or self-harm. Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention.

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

Sleep: a condition of body and mind such as that which normally recurs for several hours every night, in which the nervous system is inactive, the eyes closed, the postural muscles relaxed, and consciousness practically suspended (Oxford English Dictionary).

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

NUMBER	MODULE	STANDARD	SOURCE/ LINK
SECTION 1: ENVIRONMENT			
1.1		**Safety and security**	
1.1.1	1 and 2	All services should provide a designated area or room that staff may consider using, with the patient's agreement, specifically for the purpose of reducing arousal and/or agitation. In services where seclusion is practised, this area should be in addition to a seclusion room.	NICE HC C20a
1.1.2	2	In services in which seclusion is practised there should be a designated seclusion room fit for purpose. This room should allow clear observation, be well insulated and ventilated, have access to toilet/washing facilities and be able to withstand attack/damage. **The NICE Guideline specifically 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.**	NICE HC C20a
1.1.3	2	There should be secure, lockable access to a patient's room, bathroom and toilet area, with external staff override. ***Service discretion: older people's wards were given the option of scoring this standard 'not applicable'.***	NICE HC C20a/b
1.1.4	2	The internal design of the ward should be arranged to facilitate observation, and sight lines should be unimpeded (for example, not obstructed by the opening of doors). Measures should be taken to address blind spots within the facility, including consideration of the use of CCTV and parabolic mirrors.	NICE HC C20a
1.1.5	2	Facilities should ensure routes of safe entry and exit in the event of an emergency related to disturbed/violent behaviour.	NICE HC C20a
1.1.6	2	There should be a separate area to receive patients with police escorts. ***Service discretion: older people's wards were given the option of scoring this standard 'not applicable'.***	NICE HC C20b
1.1.7	2	Provisions should be in place for children visiting the ward.	NAV SG 1999 HC C2
1.1.8	1	Trained and accredited Local Security Management Specialists (LSMS) should take the lead in security management work.	CFSMS HC C1a
1.2		**Activities and external areas**	
1.2.1	2	Services should be able to accommodate patients' needs for engaging in activities and individual choice – there should be an activity room and a dayroom with a television, as boredom can lead to disturbed/violent behaviour.	NICE HC D11b
1.2.2	1 and 2	Patients should have single sex toilets, washing facilities, day areas and sleeping accommodation.	NICE HC C20b
1.2.3	2	There should be a space set aside for prayer and quiet reflection.	NICE HC D2b

1.2.4	1	There should be daily opportunities for patients to engage in physical exercise, group interaction, therapy and recreation.	NICE HC C21
1.2.5	2	Patients should be able to have easy access to fresh air and natural daylight.	NICE HC C21
1.2.6	2	Where practicable, access to an external area should be via the unit and where necessary, appropriate standards of fencing should be provided.	NICE HC C21
1.2.7	1	Patients should have opportunities to go outdoors/leave the ward.	NAV SG 2006 HC C21
1.3		**Patient concerns**	
1.3.1	1 and 2	Facilities should have adequate means of controlling light, temperature, ventilation and noise.	NICE HC C21
1.3.2	1 and 2	There should be perception of space on the ward.	MIV HC C21
1.3.3	1 and 2	Patients’ personal effects should be kept safely and be easily accessible.	MIV HC C20a
1.3.4	2	All areas should look friendly.	MIV HC C21
1.3.5	1	The ward should be homely and comfortable in respect of lighting and age appropriate décor and music.	NAV SG 2006 HC C21
1.3.6	2	Toilet and bathing facilities should be clearly labelled in a way that can be understood by people from ethnic minority groups and those with visual or cognitive impairments.	NAV SG 1999 HC C21
1.3.7	1	Patients’ personal preferences should be respected, e.g. in relation to food and drink choices, going to bed, clothing.	NAV SG 2006 HC C15a
1.3.8	1	Procedures should be in place to ensure alcohol/illegal drugs are not brought onto the ward. ***Not applicable in older people’s services***	NAV SG 1999 HC D1
1.3.9	1	Patients and visitors to the ward should feel able to confidentially report an incident of staff abuse towards a patient, should they witness one.	NAV SG 2006 HC C14a/b/c
1.3.10	1	Protection from intimidation and violence should be ensured.	MIV HC D1
1.3.11	2	Suitable access facilities should be provided for people who have problems with mobility, orientation, visual or hearing impairment, or other special needs.	NICE HC D12
1.3.12	2	All areas should look and smell clean.	NICE HC C21
1.3.13	2	Internal smoking areas/rooms should have powerful ventilation and be fitted with smoke-stop door(s).	NICE HC C21
1.4		**Alarms**	
1.4.1	CI and 1	Each service should have a local policy on alarms and determine the need for alarms according to a comprehensive risk assessment of the clinical	NICE HC C1b

		environment, patients and staff. The policy should be disseminated, and staff made familiar with its contents.	
1.4.2	1	Comprehensive risk assessment of the clinical environment should be used to determine whether supplementary personal alarms should be issued to individual staff members and vulnerable patients.	NICE HC C7c
1.4.3	1	Collective responses to alarm calls should be agreed before incidents occur. These should be consistently applied and rehearsed.	NICE HC C1b
1.4.4	2	Furniture should be arranged so that alarms can be reached and doors are not obstructed.	NICE HC C20a
1.4.5	2	Alarms should be accessible in interview rooms, reception areas and other areas where one patient and one staff member work together.	NICE HC C20a
1.4.6	CI and 2	All alarms (for example, panic buttons and personal alarms) should be well maintained and checked regularly.	NICE HC C1b
1.5		**Clinical environment**	
1.5.1	CI	There should be a regular and comprehensive general risk assessment to ensure the safety of the clinical environment.	NICE HC C7c
1.5.2	1	Bed occupancy should be decided at a local level and this level should not be exceeded, because overcrowding leads to tension, frustration and overstretched staff.	NICE HC C1b
1.6		**Leadership and supervision**	
1.6.1	1	There should be policies available regarding staff management issues, including regular monitoring of staff training and development, morale, multi-disciplinary working, specification of responsibilities, appraisal of performance.	MIV HC C5b/c
1.6.2	1	There should be clear leadership based on regularly updated management policies.	MIV HC C5b
1.6.3	1	In relation to the management of severely challenging/ violent behaviour, staff should be supported by the senior management team.	NAV SG 2006 HC C5b
1.6.4	1	There should be adequate handover between clinical teams for continuity.	MIV HC C5b
1.6.5	1	The gender and ethnic mix of staff should be appropriate to the patient population.	MIV HC D5a
1.6.6	1	There should be a multi-disciplinary consensus on clinical care.	MIV HC C5b
1.6.7	1	The ratio and staff mix should be appropriate to the patient population, i.e. numbers of staff on shift, experience and qualifications of staff.	MIV HC D5a
1.6.8	1	Staff should have the opportunity to raise and discuss issues.	MIV HC C7b
1.7		**Interagency working**	
1.7.1	CI	Local protocols should be developed to ensure that the police and staff are aware of the procedures and ascribed roles in an emergency, in order to prevent	NICE HC C1b

		misunderstanding between different agencies. Such policies should set out what constitutes an emergency requiring police intervention.	
1.8		**Specific issues – older people's services**	
1.8.1	2	The ward environment should help patients become and remain orientated.	NAV SG 2006 HC D12b
1.8.2	2	Long, narrow corridors, numerous doors or corridors that lead to locked doors and dead ends, should be avoided.	NAV SG 2006 HC D12b
1.8.3	2	Doors should be colour-coded to help patients to identify rooms. There should be clear and simple signs at a visible height.	NAV SG 2006 HC D12b
1.8.4	1	Open visiting should be encouraged.	DAB:TBS
SECTION 2: PREDICTION			
2.1		**Policy**	
2.1.1	CI	Measures to reduce disturbed/violent behaviour should be based on comprehensive risk assessment and risk management. Therefore, mental health service providers should ensure that there is a full risk management strategy for all their services.	NICE HC C1a
2.2		**Risk assessment**	
2.2.1	3a	Risk assessment should be used to establish whether a care plan should include specific interventions for the short-term management of disturbed/violent behaviour.	NICE HC C7a and C1a
2.2.2	3a	Actuarial tools and structured clinical judgement should be used in a consistent way to assist in risk assessment, although no 'gold standard' tool can be recommended.	NICE HC C7a and C1a
2.2.3	3a	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 accurate and thorough risk assessment.	NICE HC C7a and C1a
2.2.4	1 and 3a	The approach to risk assessment should be multidisciplinary and reflective of the care setting in which it is undertaken. The findings of the risk assessment should be communicated across relevant agencies and care settings, in accordance with the law relating to patient confidentiality.	NICE HC C7a and C1a
2.3		**Antecedents and warning signs**	
2.3.1	3a	Certain features can serve as warning signs to indicate that a patient may be escalating towards physically violent behaviour. The following list is not intended to be exhaustive, and these warning signs should be considered on an individual basis: • 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 violent contents.	NICE HC C1a

		• Verbal threats or gestures. • Replicating or behaviour similar to that which preceded earlier disturbed/violent episodes. • Reporting anger or violent feelings. • Blocking escape routes.	
2.4		**Risk factors**	
2.4.1	3a	***Demographic or personal history*** should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features: • History of disturbed/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: - cruelty to animals; - reckless driving; - history of bed wetting; - loss of parent before the age of 8 years.	NICE HC C1a
2.4.2	3a	***Clinical variables*** should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features: • 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 a violent theme); - agitation, excitement, overt hostility or suspiciousness. • Poor collaboration with suggested treatments. • Agitation, excitement or impulsive personality traits or disorder. • Organic dysfunction.	NICE HC C1a
2.4.3	3a	***Situational variables*** should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features: • Extent of social support. • Immediate availability of a potential weapon. • Relationship to potential victim (for example, difficulties in relationship are known). • Access to potential victim. • Limit setting (for example, staff members setting parameters for activities, choices etc).	NICE HC C1a

		• Staff attitudes.	
2.5		**Specific issues - dementia services**	
2.5.1	3a	The following additional factors need to be considered for people with dementia who develop behaviour that severely challenges: • 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.	HC C1a
SECTION 3: TRAINING			
3.1		**Policy**	
3.1.1	CI	All service providers should have a policy for training employees and staff-in-training in relation to the short-term management of disturbed/violent behaviour. This policy should specify who will receive what level of training (based on risk assessment), how often they will be trained, and also outline the techniques in which they will be trained.	NICE HC C11b/c
3.2		**Specific staff training needs**	
3.2.1	1	Appropriate staff should have access to training related to the following: • Equal opportunities. • The 'Bournewood Ruling' (especially in respect of restriction and deprivation of liberty). • The Mental Capacity Act (especially in respect of the best interests and least restrictive principles).	NAV SG 2006 HC C11b/c
3.2.2	1	All staff involved in carrying out risk assessment should receive training in the assessment and management of risk.	NAV SG 2006 HC C11b/c
3.2.3	1	There should be an ongoing programme of training for all staff in racial, cultural, spiritual, social and special needs issues to ensure that staff are aware of and know how to work with diverse populations and do not perpetuate stereotypes. Such courses should also cover any special populations, such as migrant populations and asylum seekers that are relevant to the locality.	NICE HC C11b/c
3.2.4	3a	All staff whose need is determined by risk assessment should receive ongoing competency training to recognise anger, potential aggression, antecedents and risk factors of disturbed/violent behaviour and to monitor their own verbal and non-verbal behaviour. Training should include methods on anticipating, de-escalating or coping with disturbed/violent behaviour.	NICE HC C11b/c
3.2.5	1	Staff members are responsible for carrying out observation and engagement should receive ongoing competency training in observation so that they are equipped with the skills and confidence to engage with patients.	NICE HC C11b/c
3.2.6	1	All staff involved in administering or prescribing rapid tranquillisation, or monitoring patients to whom parenteral rapid tranquillisation has been administered, should receive ongoing competency training to a minimum of Immediate Life Support (ILS –	NICE HC C11b/c

		Resuscitation Council UK) (covers airway, cardiopulmonary resuscitation (CPR) and use of defibrillators).	
3.2.7	1	Staff who employ physical intervention or seclusion should as a minimum be training to Basic Life Support (BLS – Resuscitation Council UK).	NICE HC C11b/c
3.2.8	1	All staff whose level of need is determined by risk assessment should receive ongoing competency training in the use of seclusion. Training should include appropriate monitoring arrangements for patients placed in seclusion. **The NICE Guideline specifically excludes services for people with dementia, hence, in relation to older people's services, the National Audit of Violence Steering Group <u>cannot</u> recommend usage of seclusion in accordance with the Guideline.**	NICE HC C11b/c
3.2.9	1	All staff involved in rapid tranquillisation should be trained in the use of pulse oximeters.	NICE HC C11b/c
3.2.10	1	All staff are involved in undertaking of searches should receive appropriate instruction which is repeated and regularly updated.	NICE HC C11b/c
3.2.11	1	Staff should have access to training that promotes the use of non-physical interventions to recognise and prevent severely challenging/violent behaviour, e.g. 'Promoting Safer and Therapeutic Services' training.	CFSMS HC C11b/c
3.3		**Specific training - older people's services**	
3.3.1	1	All staff working in older people's services should receive training relating to person-centred care and therapeutic approaches in relation to the care of older people.	NAV SG 2006 HC C11b/c
3.3.2	1	Staff involved in using physical intervention should receive training in how to safely apply hands on restraint to older people.	NAV SG 2006 HC C11b/c
3.3.3	1	All staff working in older people's services should receive training in managing forms of severely challenging behaviour in older people with mental health problems, other than violent behaviour, e.g. resistance to care, excessive walking.	NAV SG 2006 HC C11b/c
3.3.4	1	Staff involved in administering covert medicines with older mentally incapacitated people should receive specific training in administering covert medicines.	NAV SG 2006 HC C11b/c
3.4		**Incident reporting**	
3.4.1	1	Training should be given to all appropriate staff to ensure that they are aware of how to correctly record any incident using the appropriate local templates.	NICE HC C11b/c
SECTION 4: WORKING WITH PATIENTS			
4.1		**Creating a feeling of safety and understanding**	
4.1.1	1	All patients, regardless of culture, gender, diagnosis, sexual orientation, disability, ethnicity or religious/spiritual beliefs should be treated with dignity and respect.	NICE HC C13a
4.1.2	1	Patients should have access to information about the following in a suitable format:	NICE

		• Which staff member has been assigned to them and how and when they can be contacted. • Why they have been admitted (and if detained, the reason for detention, the powers used and their extent, and rights of appeal). • What their rights are with regard to consent to treatments, complaints. • Procedures, and access to independent help and advocacy. • What may happen if they become disturbed/violent. This information needs to be provided at each admission, repeated as necessary and recorded in the notes.	HC C16
4.1.3	1	An effective and fair complaints procedure should be put in place.	NICE HC C14
4.1.4	1	Patients identified to be at risk of disturbed/violent behaviour should be given the opportunity to have their needs and wishes recorded in the form of an advance directive. This should fit within the context of their overall care and should clearly state what intervention(s) they would and would not wish to receive. This document should be subject to periodic review.	NICE HC D9a/b
4.1.5	1 and 3a	During the staff/patient risk assessment interview, where a risk of disturbed/violent behaviour is discussed or identified as a possibility, intervention and management strategies (and the patient's preferences regarding these) should be recorded in the patient's care plan and healthcare record. Efforts should be made to ascertain the patient's own views about their trigger factors, early warning signs of disturbed/violent behaviour and other vulnerabilities, and the management of these. The patient should be given a copy of the care plan and, subject to their agreement, a copy should be given to their carer.	NICE HC D9a
4.1.6	3a	Following any intervention for the short-term management of disturbed/violent behaviour, every opportunity should be taken to establish whether the patient understands why this has happened. Where possible, this should be carried out by a staff member not directly involved in the intervention. This should be documented in the patient's notes.	NICE HC D9
4.1.7	CI and 2	All services should have a policy for preventing and dealing with all forms of harassment and abuse. Notification of this policy should be disseminated to all staff and displayed prominently in all clinical and public areas.	NICE HC C8a
4.1.8	1	During the administration or supply of medicines to patients, confidentiality should be ensured.	NICE HC C13c
4.1.9	1	Prescribers should be available for and responsive to requests from the patient for medication review.	NICE HC D9
4.1.10	1	A member of staff should be available for patients to talk to when feeling distressed.	MIV
4.1.11	1	Patients reporting angry feelings should not be 'threatened' or 'punished' with the use of interventions such as medication or seclusion.	MIV

4.2		**Specific issues - older people's services**	
4.2.1	1	On a patient's admission, carers/next of kin should be asked: • To share personal information on the patient's likes and dislikes. • To highlight the patient's strengths and abilities, as well as their problems and needs. • To provide background information about the patient's former occupation(s), the people they love, have loved etc.	NAV SG 2006 HC D9
4.2.2	1	Staff should ensure patients are cared for in a meaningful person-centred way, using information and items provided by their carer/next of kin, e.g. favourite music, family photographs, personal items and effects.	NAV SG 2006 HC D9
4.2.3	1	Staff should be able to recognise when patients are in need of help, e.g. feeling hungry or thirsty or in discomfort or pain.	NAV SG 2006 HC C5c
4.2.4	2	Meals or other foods (finger foods) should be available outside of mealtimes	NAV SG 2006 HC C15b
4.3		**Patients with disabilities**	
4.3.1	CI	Each service should have a policy that outlines the procedures for dealing with patients who have disabilities, including those with physical or sensory impairment and/or other communication difficulties.	NICE HC D12
SECTION 5: SEARCHING			
5.1.1	CI	All facilities should have an operational policy on the searching of patients, their belongings and the environment in which they are accommodated, and also the searching of visitors. Where necessary the policy should refer to related policies such as those for substance misuse and police liaison. The searching policy should be in place in order to ensure the creation and maintenance of a safe and therapeutic environment for patients, staff and visitors.	NICE
SECTION 6: DE-ESCALATION TECHNIQUES			
6.1		**General**	
6.1.1	3a	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.	NICE HC C3
6.2		**De-escalation techniques**	
6.2.1	3a	One staff member should assume control of a potentially disturbed/violent situation.	NICE HC C3
6.2.2	3a	The staff member who has taken control should: • Consider which de-escalation techniques are appropriate for the situation. • 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.	NICE HC C3
6.2.3	3a	The staff member who has taken control should ask for facts about the problem and encourage reasoning. This	NICE

		will involve: • Attempting to establish a rapport and emphasising cooperation. • Offering and negotiating realistic options and avoiding threats. • Asking open questions and inquiring about the reason for the patient's anger, for example 'What has caused you to feel upset/angry?' • Showing concern and attentiveness through non-verbal and verbal responses. • Listening carefully and showing empathy, acknowledging any grievances, concerns or frustrations, and not being patronising or minimising patient concerns.	HC C3
6.2.4	3a	Staff should 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. In services where seclusion is practised, the seclusion room should not routinely be used for this purpose (see recommendation 1.1.2).	NICE HC C3
6.2.5	3a	Staff should be in a position to summon help should it be required.	NAV SG 2006 HC C3
6.2.6	3a	The patient should be offered voluntary medication during the de-escalation process.	NAV SG 2006 HC D9
SECTION 7: OBSERVATION AND ENGAGEMENT			
7.1		**Policy**	
7.1.1	CI	Each service should have a policy on observation and engagement that adheres to contemporary NICE terminology and definitions. This policy should include: • Who can instigate observation above a general level. • Who can increase or decrease the level of observation. • Who should review the level of observation. • When reviews should take place (at least every shift). • How patients' perspectives will be taken into account. • A process through which a review by a full clinical team will take place if observation above a general level continues for more than 1 week.	NICE HC C3
7.2		**Carrying out observation**	
7.2.1	3a	Designated levels of observation should only be implemented after positive engagement with the patient has failed to dissipate the potential for disturbed/violent behaviour.	NICE HC C3
7.2.2	3a	The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to a patient's dignity and privacy whilst maintaining the safety of those around them.	NICE HC C3
7.2.3	3a	Nurses and other staff undertaking observation: • Should take an active role in engaging positively with the patient. • Should be appropriately briefed about the patient's	NICE HC C3

		history, background, specific risk factors and particular needs. • Should be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment. • Should be able to increase or decrease the level of engagement with the patient as the level of observation changes. • Should be approachable, listen to the patient, know when self-disclosure and the therapeutic use of silence are appropriate and be able to convey to the patient that they are valued.	
7.2.4	3a	An individual staff member should not undertake a continuous period of observation above the general level for longer than 2 hours.	NICE HC C3
7.2.5	1 and 3a	The patient should be involved in the decision about observation levels	NAV SG 2006 HC D9
7.2.6	3a	The multi-disciplinary team should be in agreement about observation levels	NAV SG 2006 HC C5b
7.2.7	3a	It should be agreed who was going to review observation levels and when.	NAV SG 2006 HC C5b
7.3		**Patient needs**	
7.3.1	1	The patient should be provided with information about why they are under observation, the aims of observation and how long it is likely to be maintained.	NICE HC C16
SECTION 8: OTHER INTERVENTIONS			
8.1		**Overarching recommendations**	
8.1.1	2	***Equipment*** A crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line resuscitation medications) should be available within 3 minutes in healthcare settings where rapid tranquillisation, physical intervention and seclusion might be used. This equipment should be maintained and checked weekly.	NICE HC C3
8.1.2	CI and 3a	***Personnel*** At all times, a doctor should be quickly available to attend an alert by staff members when rapid tranquillisation, physical intervention and/or seclusion are implemented. ***Note: The Bennett report recommended that a doctor should be available within 20 minutes. The [NICE] Guideline Development Group considered quick attendance to mean within 30 minutes of an alert.***	NICE HC C3
8.1.3	1	***Legal concerns*** All staff need to be aware of the legal framework that authorises the use of rapid tranquillisation, physical intervention and seclusion. The guidance of the Mental Health Act Code of Practice (chapter 19) should be followed, with any departures from that guidance clearly recorded and justified as being in the patient's best interest.	NICE HC C11C
8.1.4	3a	***Patient concerns*** When using interventions such as rapid tranquillisation, physical intervention or seclusion, steps should be	NICE HC C13a

		taken to try to ensure that the patient does not feel humiliated (such as respecting a patient's need for dignity and privacy commensurate with the needs of administering the intervention).	
8.1.5	3a	The reasons for using rapid tranquillisation, physical intervention or seclusion should be explained and the likely outcome specified to the patient at the earliest opportunity.	NICE/MIV HC C16
8.1.6	3a	Patients should be given the opportunity to document their account of the intervention in their notes.	NICE HC D9
8.2		**Physical interventions**	
8.2.1	3a	Older people should require minimal hands-on restraint and should never be taken to the floor. ***Applicable in older people's services only***	NAV SG 2006
8.2.2	3a	***Carrying out physical intervention*** There are real dangers with continuous physical intervention 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.	NICE HC C3
8.2.3	3a	During physical intervention, one team member should be responsible for protecting and supporting the head and neck, where required. The team member who is responsible for supporting the head and neck should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.	NICE HC C3
8.2.4	3a	During physical intervention, under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. The overall physical and psychological well-being of the patient should be continuously monitored throughout the process.	NICE HC C3
8.2.5	3a	The level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible amount of time.	NICE HC C3
8.2.6	3a	Every effort should be made to utilise skills and techniques that do not use the deliberate application of pain.	NICE HC C3
8.2.7	3a	The deliberate application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, patients and/or others.	NICE HC C3
8.2.8	3a	Mechanical restraints are not a first-line response or standard means of managing disturbed/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.	NICE HC C3
8.2.9	3a	Reasons for using restraint: • Serious degree of urgency and danger. • As a last resort when less restrictive methods have	MIV HC C3

		failed. • Significant risk of physical attack. • Significant threats or attempts and self-injury. • Serious property destruction. • Prolonged and serious verbal abuse, threats, or disruption to the ward. • Prolonged over-activity, with risk of exhaustion to patient. • Risk of serious accident to patient or others.	
8.3		**Seclusion**	
		Older people's services The NICE Guideline specifically 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 in Older people's Services does need to be monitored to assist in recommending future guidance, if necessary.	
8.3.1	3a	***Carrying out seclusion*** The use of seclusion should be recorded in accordance with the guidance in the Mental Health Act Code of Practice.	NICE HC C3
8.3.2	3a	Seclusion should be for the shortest time possible and should be reviewed at least every 2 hours and in accordance with the guidance in the Mental Health Act Code of Practice. The patient should be made aware that reviews will take place at least every 2 hours.	NICE HC C3
8.3.3	3a	If seclusion is used, an observation schedule should be specified.	NICE HC C3
8.3.4	3a	A patient in seclusion should retain their clothing, as long as it does not compromise their safety and the safety of others.	NICE HC C3
8.3.5	3a	Patients in seclusion should be allowed to keep personal items including those of religious or cultural significance (such as some items of jewellery) as long as they do not compromise their safety or the safety of others.	NICE HC C3
8.3.6	3a	A nurse must be in sight or sound throughout the period of seclusion (and present if the patient was subject to rapid tranquillisation).	MIV HC C3
8.3.7	3a	A doctor must be present within the first few minutes of seclusion.	MIV HC C3
8.4		**Rapid tranquillisation and seclusion**	
		Older people's services The NICE Guideline specifically 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 rapid tranquillisation and seclusion in accordance with the Guideline. However, occurrence of its use in Older people's Services does need to be monitored to assist in recommending future guidance, if necessary.	
8.4.1	3a	The patient should be monitored by 'within eyesight' observation by an appropriately trained individual.	NICE HC C3
8.4.2	3a	Once rapid tranquillisation has taken effect, seclusion	NICE

		should be terminated.	HC C3
8.5		**Rapid Tranquillisation**	
		Older people's services The NICE Guideline specifically 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 rapid tranquillisation in accordance with the algorithm provided for use in services for adults of working age.	
8.5.1	3a	***Rapid tranquillisation and associated risks*** Medication for rapid tranquillisation, particularly in the context of physical intervention, should be used with caution owing to the following risks: • 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.	NICE HC C3
8.5.2	CI	***Policy*** Local protocols should be produced that cover all aspects of rapid tranquillisation. Such protocols should be in accordance with legal requirements (especially in respect of detained patients, the consent to treatment, and the emergency treatment powers and duties under the Mental Health Act) and relevant NICE guidance, and should be subject to review.	NICE HC C3
8.5.3	3a	***Precautions to consider before rapid tranquillisation*** • Take a history: where possible, collect information from the patient and those who know the patient. • Do a mental state examination and attempt a physical examination. • Establish a provisional diagnosis. • Establish legal status. • Conduct a multi-disciplinary discussion as to whether or not rapid tranquillisation is safe and appropriate.	MIV HC C3
8.5.4	3a	***Carrying out rapid tranquillisation*** The patient should be able to respond to communication throughout the period of rapid tranquillisation/sedation.	NICE HC C3
8.5.5	3a	The aim of rapid tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the patient or to others.	NICE HC C3
8.5.6	3a and 3b	***Oral therapy for rapid tranquillisation*** Oral medication should be offered before parenteral medication as far as possible.	NICE HC C3
8.5.7	3a and 3b	All medication given in the short-term management of disturbed/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).	NICE HC C3
8.5.8	3b	Oral and intramuscular medications should be prescribed separately and the abbreviation of o/i/m	NICE

		should not be used.	HC C3
8.5.9	3b	When the behavioural disturbance occurs in a non-psychotic context it is preferable to initially use oral lorazepam alone, or intramuscularly if necessary.	NICE HC C3
8.5.10	3b	When the behavioural disturbance occurs in the context of psychosis, to achieve early onset of calming/sedation, or to achieve a lower dose of antipsychotic, an oral antipsychotic in combination with oral lorazepam, should be considered in the first instance (see chart for rapid tranquillisation at end of section).	NICE HC C3
8.5.11	3a and 3b	Sufficient time should be allowed for clinical response between oral doses of medication for rapid tranquillisation (see chart for rapid tranquillisation).	NICE HC C3
8.5.12	3b	***Parenteral therapy for rapid tranquillisation*** If parenteral treatment proves necessary, the intramuscular route (i/m) is preferred over intravenous (i/v) from a safety point of view. The patient should be transferred to oral routes of administration at the earliest opportunity.	NICE HC C3
8.5.13	3b	Where rapid tranquillisation through oral therapy is refused, is not indicated by previous clinical response, is not a proportionate response, or is ineffective, a combination of an intramuscular antipsychotic and an intramuscular benzodiazepine (i/m haloperidol and i/m lorazepam) is recommended.	NICE HC C3
8.5.14	3b	In the event of moderate disturbance in patients with psychosis, i/m olanzapine may also be considered. Intramuscular lorazepam should not be given within 1 hour of i/m olanzapine. Oral lorazepam should be used with caution.	NICE HC C3
8.5.15	3a and 3b	Sufficient time should be allowed for clinical response between intramuscular (i/m) doses of medications for rapid tranquillisation.	NICE HC C3
8.5.16	3b	The use of two drugs of the same class for the purpose of rapid tranquillisation should not occur.	NICE HC C3
8.5.17	3b	Intravenous administration of benzodiazepines or haloperidol should not normally be used except in very exceptional circumstances, which should be specified and recorded. This decision should not be made by junior medical staff in isolation.	NICE HC C3
8.5.18	3b	If immediate tranquillisation is essential then intravenous administration may be necessary. If it is used, staff should be appropriately trained to recognize symptoms of respiratory depression, dystonia or cardiovascular compromise (such as palpitations, significant changes in blood pressure, or collapse).	NICE HC C3
8.5.19	3b	***Medications not normally used for rapid tranquillisation*** Zuclopenthixol acetate injection is not recommended for rapid tranquillisation due to long onset and duration of action. However, zuclopenthixol acetate injection may be considered as an option for rapid tranquillisation when: • It is clearly expected that the patient will be disturbed/violent over an extended period of time. • A patient has a past history of good and timely response to zuclopenthixol acetate injection.	NICE HC C3

		• A patient has a past history of repeated parenteral administration. • An advance directive has been made indicating that this is a treatment of choice. It should never be administered to those without any previous exposure to antipsychotic medication. The *British National Formulary* and manufacturer's Summary of Product Characteristics (SPC) should be consulted regarding its use.	
8.5.20	3b	***Medications not recommended for rapid tranquillisation*** The following medications are not recommended for rapid tranquillisation: • Intramuscular or oral chlorpromazine or oral (a local irritant if given intramuscularly; risk of cardiovascular complications; causes hypotension due to α-adrenergic receptor blocking effects, especially in the doses required for rapid tranquillisation; is erratically absorbed; its effect on QTc intervals suggests that it is unsuitable for use in rapid tranquillisation). • Intramuscular diazepam. • Thioridazine. • Intramuscular depot antipsychotics. • **Olanzapine or risperidone should not be used for the management of disturbed/violent behaviour in patients with dementia**.	NICE HC C3
8.5.21	3b	***Doses for rapid tranquillisation*** When using rapid tranquillisation there may be certain circumstances in which the current *BNF* uses and limits and SPC may be knowingly exceeded (for example, for lorazepam). This decision should not be taken lightly and the risks should not be underestimated. A risk–benefit analysis should be recorded in the case notes and a rationale should be recorded in the care plan. Where the risk–benefit is unclear, advice may be sought from clinicians not directly involved in the patient's care.	NICE HC C3
8.5.22	3a	***Care after rapid tranquillisation*** After rapid tranquillisation is administered, vital signs should be monitored and pulse oximeters should be available. Blood pressure, pulse, temperature, respiratory rate and hydration should be recorded regularly, at intervals agreed by a multidisciplinary team, until the patient becomes active again.	NICE HC C3
8.5.23	3b	In the following circumstances, more frequent and intensive monitoring by appropriately trained staff is required and should be recorded in the care plan. Particular attention should be paid to the patient's respiratory effort, airway, and level of consciousness: • If the patient appears to be or is asleep/sedated. • If intravenous administration has taken place. • If the *BNF* limit or SPC is exceeded. • In high-risk situations. • Where the patient has been using illicit substances or alcohol. • Where the patient has a relevant medical disorder or concurrently prescribed medication.	NICE HC C3

8.6		**Covert Medication**	
8.6.1	3a and 3b	**Applicable in older people's services only** On occasion rapid tranquillisation with mentally incapacitated adults may need to be administered covertly, i.e. delivered in patient's food and drink. The following precautions apply: • 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.	CT HC C4d
8.6.2	3b	The treatment plan should normally be subject to weekly review initially and if the requirement for covert medication does persist, full reviews at less frequent intervals should take place.	CT HC C4d
SECTION 9: INCIDENT REPORTING AND POST-INCIDENT REVIEWS			
9.1		**Incident reporting**	
9.1.1	1	All incidents of severely challenging/violent behaviour should be recorded/reported.	NAV SG 1999 HC C1a
9.1.2	3a	Any incident requiring rapid tranquillisation, physical intervention or seclusion should be recorded contemporaneously, using a local template. The incident should be documented clearly and fully outlining the context, i.e. precipitants, victim, weapon, severity, actions taken, outcome, subsequent revisions to management plan.	NICE/ MIV HC C1a
9.1.3	3a	Incidents of physical assault should be reported to the NHS Security Management Service (SMS) as per Secretary of State directives November 2003.	NICE HC C1a
9.2		**Post-incident reviews**	
9.2.1	3a	A post-incident review should take place as soon after the incident as possible, but in any event within 72 hours of the incident ending.	NICE HC C1a
9.2.2	CI and 1 and 3a and 3b	Mental health service providers should have systems in place with appropriately skilled staff to ensure that a range of options of post-incident support and review mechanisms are available and take place within a culture of learning lessons. The following groups should be considered: - staff involved in the incidents; - patients;	NICE HC C1a

		- carers and family where appropriate; - other patients who witnessed the incident; - visitors who witnessed the incident; - independent advocates; - Local Security Management Specialist (SMS).	

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