Document Control

Title			
Violence & Aggression Policy			
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Directorate Nursing Quality and Workforce		**Department** Compliance Team, Corporate Governance	
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0.2	Nov 2005	Draft	Revisions made in response to Occupational Safety Health Advisers Group. Submitted to Health and Safety Committee for comment.
0.3	Dec 2005	Draft	Submitted to Crime and Disorder Co-ordination Group.
0.4	Sep 2006	Draft	Sent to Northern Devon Healthcare NHS Trust Legal Department for comment.
0.5	Oct 2007	Draft	Sent to Clinical Services Executive Committee
0.6	Mar 2008	Draft	Revisions made in response to CSEC and NHSLA comments. Re-submitted to Health and Safety Committee, Crime and Disorder Co-ordination Group and CSEC.
0.7	Apr 2008	Draft	Ratified by Trust Board 1/04/08 subject to minor amendments.
1.0	Apr 2008	Final	Submitted to Task and Finish Group following group's recommendations.
1.1	Jul 2008	Revision	Submitted to Health & Safety Committee following amendments.
1.2	Nov 2008	Revision	Checked for compliance with NHS Litigation Authority level 1 assessment. No amends necessary.
1.3	Dec 2008	Revision	Final proof-check to ensure corporate requirements.
1.4	Dec 2011	Revision	Harmonised & revised policy as a result of merging of Northern Devon Healthcare NHS Trust and NHS Devon community services. A summary of key issues and differences is on page 3. The monitoring section has been strengthened as a result of revised NHSLA requirements. Minor amendments by Corporate Governance to document control report, formatting, headers and footers, automated table of contents, hyperlinks to appendices and sections. Addition of appendices C and E.
2.0	Feb 2012	Final	Approved by Health and Safety Committee on 2nd February 2012 following consultation.

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2.2	Apr 2015	Revision	Three year revision:
3.0	Sep 15	Final	Approved at CSEC and Published on Bob
4.0	Dec 17	Final	Roles & Responsibilities amended. Training information updated. Reference to NHS Protect removed. Reference to NICE guideline NG10 added. 24/7 Security officer arrangements at NDDH added. Occupational Health responsibilities added. For approval at Health and Safety Committee

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Superseded Documents
NDHT Managing Violence & Aggression policy (v1.3 2008)
NHS Devon / Devon Provider Services Preventing Violence & Aggression and Lone Worker policy (v3.0 2010)

Issue Date	Review Date	Review Cycle
January 2018	January 2021	Three years

Consulted with the following stakeholders:

- Clinical Matron Unscheduled Care
- Community Nurse Team Manager
- Consultant Emergency Medicine
- Deputy Director of Nursing and Head of Professional Practice
- Divisional Nurse Planned Care
- Divisional Nurse Unscheduled Care
- Head of Clinical Site Services
- Head of Therapy Services, Trust Falls Lead
- Health and Safety Committee Members
- Health and Social Care Cluster Manager
- Modern Matron
- Non-Executive Director
- Outpatients Service Manager
- Occupational Health Department
- Quality Improvement Facilitator (Patient Safety)
- Rapid Intervention, Urgent Care Nursing & Care Home Team Manager
- Safeguarding Adult Lead
- Safeguarding Children's Lead
- Security Management Director (Director of Nursing, Quality and Workforce)

Approval and Review Process

- Health and Safety Committee

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CONTENTS

1. Introduction

This document sets out Northern Devon Healthcare NHS Trust's system for managing violence and aggression. It provides a robust framework to ensure a consistent approach across the whole organisation, and supports our statutory duties as set out in the NHS Constitution which outline staff rights regards healthy and safe working conditions and an environment free from harassment, bullying or violence.

The policy is designed to ensure that the delivery of healthcare takes place in a safe and secure environment, free from the risks of crime which may arise when providing a public service.

The Trust recognises enforcing zero tolerance towards individuals for acts of violence and aggression is not achievable due to the occasions when there will be violent and abusive incidents when the person exhibiting challenging behaviour is unable to control their actions due to medical factors.

This policy will provide guidance to the Trust to pro-actively manage intentional violent and aggressive behaviour and challenging behaviour due to medical factors on the most effective interventions required to minimise risk to staff, patients and visitors.

2. Purpose

The purpose of this policy is to ensure that staff working in healthcare are provided with an environment that is safe and secure and that minimises the risk of violence and aggression, in line with health and safety legislation and requirements to manage violence and aggression such as but not limited to:

- Secretary of State for Health Directions on NHS Security Management Measures (as amended 2006)
- Secretary of State's Directions on work to tackle violence against staff and professionals who work or provide services for the NHS (2003)
- Health & Safety at Work Act 1974
- The Management of Health and Safety at Work Regulations 1999
- NICE Guideline NG10 Violence and Aggression: short-term management in mental health, health and community settings
- The NHS Constitution for England
- Care Quality Commission Fundamental Standards (safety)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Reg 12 Safe Care and Treatment)

Violence anti-social behaviour by staff is unacceptable behaviour and may constitute a criminal or civil offence. Instances will be dealt with through the Trust's Disciplinary Policy and may be referred to the Police and relevant professional bodies as appropriate.

This policy will also raise awareness of behaviours that are unacceptable and of the sanctions available in the face of such behaviours. It includes a mechanism whereby

patients, visitors or other users who are extreme or persistent in their unacceptable behaviour can be dealt with by partnership arrangements.

Where it is suspected unlawful acts have occurred which are in contravention of criminally enforceable law, incidents (with disclosure of personal details) may be referred to Devon and Cornwall Police subject to the incident and seriousness / nature of the suspected offence.

Implementation of this policy will ensure that:

- Current legislation is complied with.
- The Trust ensures as far as reasonable practicable a safe working environment for staff.
- Direct action is taken against those who are abusive, violent or display inappropriate behaviour without reasonable excuse.
- A framework is provided for the reduction of incidents involving violence and aggression; and
- Staff understand their responsibility to report all incidents.

The Trust's commitment to the prevention and management of unacceptable behaviour is outlined below. The Trust:

- Recognises that the prevention and management of challenging behaviour in health care settings and service users' homes is a complex issue and that unacceptable behaviour resulting from a clinical condition needs to be linked to other relevant policies covering individualised care, positive behavioural support, patient safeguarding and the use of restrictive interventions.
- Accepts that verbal abuse and physical violence may be symptoms of an underlying mental health problem, illness or adverse reaction to medication whilst recognising that staff should not accept such behaviour as inevitable.
- Recognises that the level of risk varies in different areas of the organisation and for particular groups of staff (e.g. those that are ward based, lone workers or where there are small staff numbers in an area at night).
- Will provide all front line staff with conflict resolution training.
- Will provide breakaway training suitable for patient facing staff working in acute and community settings. This training supplements current in house dementia training.
- Will provide physical interventions training suitable for staff working in clinical situations where physical restraint may be required to manage challenging behaviour. (Physical interventions are used as a last resort when all other therapeutic behaviour management methods have failed).
- Recognises the impact of patient mix and staffing levels on the ability of front line staff to defuse and deal with violence and aggression.
- Recognises that everyone needs to be aware of how their personal behaviour might be perceived by others.
- Recognises the rights of staff to use such force which is reasonable to protect themselves from an attack or threatened attack. This principle is extended by Section 3 (1) of the Criminal Law Act 1967 to stop a person committing a crime.

- Supports staff and will consider pressing charges against the perpetrator of a violent attack upon a member of staff when it is legally permissible and appropriate to do so.

This policy applies to all staff, and includes all people who are on Trust premises or where staff are undertaking a Trust activity, including working in service users' homes. This includes service users, employees, visitors, and people working on our behalf, contractors, trainees and members of the public, including volunteers.

Matters concerning the management of violence and aggression are reported to the Health and Safety Committee under routine reports such as Quarterly Incident Reports.

3. Definitions

3.1. Physical Assault

Physical assault is defined as: "the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort."

(Secretary of State Directions, Department of Health. 2003).

3.2. Non Physical Assault

Non Physical assault is defined as: "the use of inappropriate words or behaviour causing distress and/or constituting harassment."

(Secretary of State Directions, Department of Health. 2003).

Examples of physical and non-physical assault including harassment, unacceptable behaviour both verbal & written can be found in Appendix A.

4. Responsibilities

The overall organisational strategy to tackle violence and aggression is the responsibility of the Chief Executive, Trust Board and Security Management Director in liaison with the Local Security Management Specialist and risk, health and safety and line managers.

This strategy takes into account NICE Guideline NG10 Violence and Aggression: short-term management in mental health, health and community settings and the health & Safety at Work Act 1974 and The Management of Health and Safety at Work Regulations 1999.

4.1. Role of the Chief Executive

The Chief Executive has the overall responsibility for all matters of health and safety and for ensuring mechanisms are in place for the overall implementation, maintenance, monitoring and revision of this Policy. The Chief Executive has nominated the Director of Nursing, Quality and Safety as the Security Management Director.

4.2. Role of the Director of Nursing, Quality and Workforce

The Director of Nursing, Quality and Workforce is nominated as the Security Management Director as required by the Secretary of State's Directions to NHS bodies to tackle violence and aggression and the creation of a pro-security culture

throughout the organisation. The Security Management Director shall be in a position to advise both the Chief Executive Officer and the Trust Board on security related matters and policy effectiveness.

In order to create a pro-security culture the Security Management Director shall be integral in ensuring and maintaining a good working relationship with external agencies such as:

- Local Police
- Crown Prosecution Service
- NHS Counter Fraud Authority
- Local Councils (via community safety partnerships)

In consultation with the Local Security Management Specialist, the Security Management Director will notify the Chief Executive of all exclusions from Trust sites and of any high level incidents that require any further actions.

The Security Management Director shall act as the communication link to the Trust Board on Violence and Aggression related issues and shall monitor and review this policy to ensure that resources are made available as required.

4.3. Role of the Non-Executive Director for Security

The Non-Executive Director for Security is responsible for promoting security provision within the Trust, and also where necessary, challenging security issues at Trust Board level including violence and aggression.

4.4. Role of the Executive Directors

It is the responsibility of Executive Directors to:

- Disseminate the policy within their area of responsibility.
- Ensure the implementation of the policy within their area of responsibility by providing support and advice to their managers.
- Monitor the implementation of the policy across the Trust.

4.5. Role of Head of Compliance

The Head of Compliance, Corporate Governance is the nominated line manager for the Trust Health and Safety Manager and Local Security Management Specialist.

4.6. Role of the Local Security Management Specialist

The Local Security Management Specialist is trained and accredited and will take the lead in all Violence and Aggression management work. The Local Security Management Specialist's work takes place within a clear legal framework set out in the Secretary of State Directions issued by the Department of Health to relevant health bodies.

The Local Security Management Specialist will follow the duties and functions:

- Promote a pro-security culture throughout the Trust by using all available means, such as courses, road shows, bulletins and regular updates to manage Violence and Aggression effectively.

- Advise managers and staff on issues relating to security and the minimisation of violence and aggression towards staff and the protection of the Trust's property and assets.
- Advise managers in carrying out risk assessments relating to violence and aggression issues that are preventative, pro-active and reactive to changing needs of an area.
- Monitor and review any actions for effectiveness and/or success.
- Carry out initial violence and aggression investigations in accordance with guidelines such as but not limited to those published by the Health and Safety Executive and NICE guidance document NG10 Violence and aggression: short term management in mental health, health and community settings.
- Provide support to victims of violence and aggression whilst signposting staff and managers affected by incidents to the Trusts Supporting Staff Involved in an Incident, Complaint or Claim Policy.
- Ensure full co-operation with the Police or other agencies such as the Health & Safety Executive or Care Quality Commission in investigations and subsequent actions i.e. sanctions and redress.
- Analyse the Trust's compliance performance in terms of seeking sanctions and redress related to violence and aggression incidents.
- Analyse the Trust's Incident Reporting system to identify trends and take appropriate action to minimise any reoccurrence.
- Advise and support the Security Management Director as required.
- Present violence and aggression incidents to the Health and Safety Committee in routine reports such as Quarterly Incident Reports.
- Manage the Trust's written warning process in accordance with the Violence and Aggression Warning Marker SOP.

In relation to this policy, the Local Security Management Specialist is responsible for:

- Advising the Trust on the legal requirements on points to prove for offences against the person.
- Providing advice and guidance to the Security Management Director in terms of sanctions and redress against perpetrators.

4.7. Role of Fire & Security Advisor

The Trust Fire & Security Advisors will work together with the Local Security Management Specialist to:

- Support the implementation of this policy.
- Implement measures (relevant to role and job description) as is reasonably practicable concerning the management of fixed building and asset security arrangements, also where actions are required to mitigate identified violence and aggression risks.

4.8. Role of Health and Safety Manager

The role of Health and Safety Manager has been merged with the role of Local Security Management Specialist and as such is a dual / combined role. Health

and Safety responsibilities (in addition to LSMS responsibilities listed under section 4.6) are outlined in the Health and Safety Policy.

4.9. Role of Senior and Line Managers

Senior managers and line managers will:

- Ensure staff work in an environment that is as safe as possible which includes community visits to a patient's home.
- Complete Violence and Aggression risk assessments and reduce the risks identified.
- Ensure support is offered to staff following violent or distressing incidents in accordance with the Supporting Staff Involved in an Incident, Complaint or Claim Policy.
- Ensure that safety measures are reviewed following an incident.
- Ensure staff are appropriately trained in local procedures and incident reporting requirements.
- Ensure all front line staff attend conflict resolution training.
- Ensure all staff attend Customer Care training where appropriate.
- Ensure all staff are risk assessed where appropriate for the requirement and attendance at Dementia, Breakaway and Physical Intervention Training.

4.10. Role of Employees

Employees will:

- Co-operate with the Trust discharging its statutory duty as an employer.
- Take reasonable care of their own health and safety and consider how their actions or omissions may affect their safety and that of others.
- Identify high-risk situations and agree action plans with managers and team leaders.
- Report incidents of violence and aggression (physical and non-physical) in accordance with the Incident Reporting and Management Policy.
- Co-operate with any subsequent investigations following reports of violent and aggressive incidents.
- Undertake training identified as mandatory and relevant to their role.
- Always practice in a professional way in accordance with Trust codes of conduct, job descriptions, policies, guidelines and training received.
- Adhere to professional registrations, codes of conduct, performance and ethics relevant to job role.
- Highlight environmental issues that may increase the risk of violence.
- Be aware of how their own behaviour might be perceived by others.
- Follow Trust Policies, Standard Operating Procedures, Safe Systems of Work and other identified control measures.

Employees are expected to comply with the Violence and Aggression Policy, and a failure to do so could be deemed to be a disciplinary matter.

4.11. Role of Health and Safety Representative

In addition to section 4.10 and role of any employee, Health and Safety Representatives of associations and unions recognised by the Trust will also:

- Work in accordance within the requirements of their union and capacity as a safety representative, complying with professional codes of practice.
- Complete training as is necessary to fulfil their role.
- Attend meetings such as the Health and Safety Committee to represent their membership on matters concerning the management of violence and aggression.

4.12. Role of the Occupational Health Department

There are a number of services that can be provided (or signposted to) by the Occupational Health Department in the event of psychological or physical harm suffered as a result of a violence and aggression incident. These include:

- Psychological support and counselling;
- Referral and assistance regarding accessing Physiotherapy Services;
- Support with Return to Work Programmes; and
- Advice on modifications and reasonable adjustments to the work place or work activities.

Services can be accessed following management or self-referral.

Further information is provided in the Supporting Staff involved in an incident, complaint or claim policy.

4.13. Role of Sodexo

Security officers are employed under contract by the Trusts partnered hotel services provider. Sodexo are responsible for the day to day line management of the security officers who work 24/7 at the NDDH site (one officer per shift). The nominated line manager is the Portering Manager, Sodexo.

The Security contract is monitored by the Deputy Director, Facilities Department in association with the Facilities Governance and Assurance Lead.

Operational support concerning the proactive and reactive management of violence & aggression and theft is undertaken by the Trust Health and Safety Manager and Local Security Management Specialist.

Operational support concerning proactive management of fixed buildings and asset security arrangements is undertaken by the Trust Fire and Security Officer.

5. Violence and Aggression Risk Management

5.1. Risk Management Process

Prevention of violence at work must start with a full assessment of the risks. The risk assessment should be carried out by appropriately trained staff gathering information from a number of sources at both organisational and employee level, help and assistance can be obtained from the Local Security Management Specialist.

The risk assessment process should be:

- For the identification of violence and aggression hazards;
- For evaluating violence and aggression risks;
- To agree action plans; and
- To implement monitor and review measures to reduce risk.

The risk assessor must ensure they have completed a suitable and sufficient risk assessment for all the activities being undertaken and must produce control measures that reduce the risk to the lowest level that is reasonably practicable.

Further information concerning the completion of risk assessments can be found in the Risk Management Policy.

5.2. Risk Assessments for Locations and Terms

Where a risk of violence and aggression has been identified a risk assessment should be undertaken in accordance with the Risk Management Policy for each ward, unit, department or team. The assessment should identify areas where a more detailed risk assessment is required and should include an examination of the physical layout and security measures of the area assessed.

It is recognised that there are some specific circumstances and situations where the risk in the Trust may be higher. These include:

- Where the employee is a lone worker.
- Where staff are dealing with relatives and carers who may be anxious, angry.
- Where patients that have medical conditions that may well give rise to challenging behaviour.
- Where staff are making home visits.
- When patients are being seen alone or with single chaperone.
- When the number and locality of staff that may be able to respond to situation does not provide adequate support.
- Where environmental factors which may give rise to violence and aggressive behaviour such as levels of lighting, noise, distractions, number of people present, location of furniture, clear lines of sight, potential weapons, colour schemes.

5.3. Risk Assessments of Individual Service Users

Individual service users may be subject to a risk assessment for Violence and Aggression. This assessment, where appropriate, will support existing patient care plans for a patient presenting with challenging behaviour.

Therapeutic behaviour management techniques written into a care plan or noted as control measures on a risk assessment to reduce the likelihood of a patient becoming violent and aggressive must be followed.

Information contained within assessments and plans must be shared during handovers with staff commencing shifts or others involved in the patients on-going care.

Where it is identified that an individual service user may present a risk to staff or others, the appropriate health care professional must ensure that:

- A Challenging Behaviour risk assessment (see Appendix B) with relevant action / care plans is completed with support from their respective teams and specialist advisers, where appropriate.
- The assessment and actions are documented in the patient's healthcare record and if appropriate on Trust information systems in accordance with Trust policy.
- All appropriate staff and services are informed of any actions that need to be taken.
- The handover procedures are robust and in accordance with applicable procedures such as (but not limited to) the Patient Safety Briefing and Bedside Handover SOP or Community Nursing Safe Effective Handover Tool.
- Where care is delivered by staff outside of their immediate team, e.g. out of hours weekends, the information is shared in a timely and effective manner.
- A review of the risk assessment and control measures is undertaken if a further incident occurs or at the set review date.

5.4. Markers on Patient Records

Following certain violence and aggression incidents where circumstances warrant placing an alert against a patient's healthcare record, the warning marker will be placed once approved following procedures outlined in the Violence and Aggression Warning Marker Standard Operating Procedure.

5.5. Risk Assessments for Community, Home Visits and Lone Workers

Staff undertaking community and home visits may be particularly vulnerable. Local teams and managers are expected to ensure that systems are in place that meet their staff requirements and comply with Trust policy.

Where the risk of violence to staff is assessed as significant, or liable to arise because of the work activity, and where that risk cannot be avoided e.g. by providing the service in another suitable location such as a Medical Centre, appropriate risk control measures must be taken to reduce the risk of violence & aggression to the absolute minimum so far as reasonably practicable.

The Trust has a Lone Working Policy which details how lone workers can protect themselves to minimise the risk and make their working environment safer. This policy is accessible on the Trust's intranet. Managers who have identified Lone

Workers within their departments / wards must complete a Lone Worker Risk Assessment. This is particularly important for high risk staff undertaking community or home visits.

If the risk is related to an individual service user, the process described in 5.3 must be implemented.

Based upon national guidance, best practice and following an overarching assessment, lone worker safety devices have been identified as an appropriate additional layer of protection to complement existing control measures to manage the risk of violence and aggression in patient homes and other community settings.

Devices have been issued to certain community teams where lone working activities carry risk factors that warrant their use.

Community staff must use lone working safety devices and / or other forms of technology issued to them, subject to risk assessment (e.g. work mobile phones, tablets).

Handovers must be completed in accordance with applicable policies and procedures such as the Community Nursing Safe Effective Handover Tool.

5.6. Risk Assessments for Work Environment and Building Design

The Local Security Management Specialist will work in collaboration with the Trust Fire and Security Advisors and Departmental Managers, as well as design and estate facilities teams, to ensure work environments are as safe and secure as possible to reduce the risk of violence and aggression.

6. Incident Reporting

All incidents of physical and non-physical violence and aggression including unacceptable behaviour should be reported in accordance with the Trust's Incident Reporting and Management Policy. The immediate supervisor and/or line manager must also be informed at the first available opportunity.

7. Security at NDDH

At the NDDH site, under contract, there is one security officer on site 24/7.

If any member of staff at NDDH feels that a situation is such, that it is beyond their control and there is a threat to their own safety or that of others, the Security officer can be summoned immediately in emergency situations via the Switchboard Operator by dialling 2333 requesting security.

Switchboard will make an immediate response concerning Security attending an incident. The operator will also contact the Clinical Site Manager (bleep 500) where the caller requests Site Management support. Clearly state the ward or area requiring assistance and the nature of the incident.

In non-emergency situations, the security officer can be contacted via the Sodexo Helpdesk (ext 5900) or via the Switchboard Operator by dialling 0.

8. Involving the Police

Trust Wide inclusive of all sites and locations occupied or visited by staff where Police assistance is considered necessary in the event of an emergency that cannot be dealt with by Trust and / or contracted staff (e.g. Security Officer), staff must be satisfied that at least one of the following criteria has been met:

- There is an identifiable and immediate risk to life or property
- The adult or child at risk is suffering or are at risk of suffering immediate and significant harm
- It is reasonably believed that a crime has been committed or is about to be committed and / or
- Attendance of a Police Officer is necessary to prevent a breach of the peace.

Where the criteria has been met and in emergency situations: Dial 9 (internal) followed by 999.

In non-emergency situations for example reporting a theft or criminal damage discovered after the event to obtain a crime reference number and to log the incident, the Police can be contacted via 101 or via the Devon & Cornwall Police Online crime reporting form.

Concerning Police involvement regarding any incident of physical or non-physical violence and aggression (e.g. physical assault, hate crime, threats made). Prior to Police involvement and upon investigation with clinical advice and input, it may be established that the assault was not intentional.

Contributory factors to non-intentional assaults or the like include:

- Medical factors; the patient not fully aware of their actions due to illness or treatment;
- Mental ill health or severe learning disability; or
- Adverse reactions to medication administered.

The view of the person assaulted should also be sought in each incident.

The manager allocated to the incident (via DATIX) is responsible for the ensuring an investigation is conducted in a manner proportionate to the incident with advice support and assistance provided where required by specialist advisors such as the Local Security Management Specialist as is necessary.

9. Communication

Where patients are identified as being violent or potentially violent, it will be necessary to share information about such patients in accordance with the employer's duty to protect the health and safety of staff and to protect the staff of other organisations in accordance with Data Protection and Caldicott requirements and the Crime and Disorder Act 1998.

Employees of the Trust must communicate to their colleagues if there is a likelihood of a patient displaying violent or aggressive behaviour. This information must be recorded clearly in the patient care plan and referral documentation.

The sharing of and disclosure of information to other organisations may occur for the purposes of community safety and security provided requirements are satisfied as

outlined in the Violence and Aggression Warning Marker Standard Operating Procedure.

10. Sanctions Management

10.1 Available Sanctions

A wide range of sanctions can be taken for physical and non-physical assaults dependant on the severity of the incident. These measures may include:

- Verbal Warning
- Warning Letter / Acceptable Behavioural Agreement
- Withholding Treatment
- Exclusion from premises
- Secure Controlled Access
- Civil Proceedings and Anti-Social Behavioural Orders
- Criminal Prosecution

Relevant sanctions will be recommended by the Local Security Management Specialist only after discussion with the victim and the relevant clinician. On occasions advice may also be sought from the Trusts Legal Department, patient's consultant, GP, Devon and Cornwall Police or other external stakeholders such as (but not limited to) Devon Partnership Trust or South West Ambulance Service. The Security Management Director will give the final approval for the course of action to be followed.

A staged approach will be generally undertaken. In such cases a verbal warning would precede any 'Written Warning' and this would precede any 'Acceptable Behavioural Agreement', although there is no requirement to escalate the response in any particular order should the situation warrant immediate action.

Depending on the individual's circumstances and seriousness of each case, the options outlined above can be taken in conjunction with one another or in isolation.

Warning letters are issued to patients in accordance with procedures and an approval process outlined in the Violence and Aggression Warning Marker Standard Operating Procedure.

11. Violence and Aggression Implementation Processes

The Trust acknowledges that a measured approach to managing the problem of Violence & Aggression is required and has adopted two processes dependent if the individual circumstances are intentional violence and aggression or due to challenging behaviour where a patient lacks capacity.

11.1 Challenging Behaviour

Where a patient lacks capacity to make decisions around acceptable levels of behaviour because of their clinical condition (in the expert judgement of a relevant clinician), the management of incidents will need to be modified in consultation with the clinician. Staff should refer to the Mental Capacity Act Policy and Deprivation of Liberty Safeguards (DoLS) Policy.

See also Challenging Behaviour Patient Risk Assessment (Appendix B). Completion of the patient specific risk assessment will support the decision making process concerning the implementation of appropriate control measure to mitigate violence and aggression risks.

11.2 Altered Mental State

Where there are no medical factors or capacity issues identified as a contributing factor to the unacceptable behaviour, consideration should be given to any altered mental state of mind that may be caused by the nature of the patient's contact with our services.

Examples could include a patient suffering bereavement, being given a terminal diagnosis, or being a victim of an assault. In such situations actions should be reasonably proportionate to these circumstances.

11.3 Managing Intentional Violence and Aggression

The process for the management of violence and aggression is outlined in flowchart format under Appendix C.

11.4 Stage 1 – Verbal Warning

Delivering a Verbal Warning

Where a patient, relative or visitor is violent or abusive, the member of staff or senior member of staff should explain to the patient what is and is not acceptable behaviour and he/she should outline what the possible consequences of any further repetition of unacceptable behaviour could be. An experienced member of staff (and or security) should always witness this explanation. Identification of any triggers for the behaviour may be useful in future prevention.

The main aim of the Verbal Warning process is twofold:

- To ascertain the reason of the behaviour displayed as a means of preventing further incidents or reducing the risk of them reoccurring; and
- To ensure that the patient, relative or visitor is aware of the consequences of further unacceptable behaviour.
- In the case of a patient, it may be appropriate to issue a Code of Conduct leaflet which contains information useful to prevent further escalation in their behaviour.

The incident and local actions taken must be reported and investigated in accordance with the Trust incident reporting procedures. The fact that a Verbal Warning has been given should be recorded in the patient's notes.

NB: A Verbal Warning should be delivered no more than twice.

Where a verbal Warning would be inappropriate

A Verbal Warning would be inappropriate where it has been ascertained that in the expert judgement of a relevant clinician a patient lacks capacity to make decisions around acceptable levels of behaviour due to the patient's clinical condition. The management of incidents will need to be modified in consultation with the clinician. Staff should refer where appropriate to the Mental Capacity Act Policy and Deprivation of Liberty Safeguards (DoLS) Policy for assessing capacity, best interest decision making and related considerations. Further guidance for challenging behaviour can be found at Appendix D and the Restraint and Restrictive Practice Policy. Stage 2 – Warning Letter and / or Acceptable Behaviour Agreement.

11.5 Stage 2 – Written Warning letter and / or Acceptable Behavioural Agreement

Developing a Warning Letter

Warning letters issued to patients and the placing of markers against patient healthcare records will be undertaken in accordance with the Violence and Aggression Warning Markers Standard Operating Procedure.

The presence of a mental disorder should not preclude appropriate action from being taken, and it is important to note that the incident must still be recorded in accordance with directions.

Developing an Acceptable Behavioural Agreement

A warning letter may contain an Acceptable Behavioural Agreement an option that can be considered for patients, relatives or visitors, to address unacceptable behaviour where verbal warnings or a warning letter have failed, or as an immediate intervention depending on the circumstances. An Acceptable Behavioural Agreement is a written agreement between the parties aimed at addressing and preventing the recurrence of unacceptable behaviour and can be used as an early intervention process to stop unacceptable behaviour from escalating into serious behaviour.

Key stakeholders and relevant personnel, including staff union or professional representatives, should organise and attend a pre-meeting to discuss the conditions that will be set out in the Acceptable Behavioural Agreement letter

Where it is considered safe and appropriate to do so, the perpetrator may be invited to attend a meeting where the agreement is made. It is important that the perpetrator is involved into this process as it may encourage him or her to recognise the impact of their behaviour, take responsibility for his/her actions and improve his/her behaviours. The Trust's Local Security Management Specialist will provide guidance and support to staff to manage this process.

All senior managers responsible for organising the Acceptable Behavioural Agreement meeting should meet prior to the meeting to consider:

- The desired outcome
- Appropriate conditions of the behavioural agreement.

During the meeting the following issues should be covered:

- Reason for establishing the Acceptable Behavioural Agreement.
- Explanation as to why the identified behaviour is unacceptable.
- Clear expectations of what constitutes continued unacceptable behaviour.

- Details of the mechanisms for seeking a review via local complaints procedure (refer to Trust complaints procedure).

Where a patient, relative or visitor fails to attend the meeting without good reason or notification, reasonable attempts must be made to contact them.

When an Acceptable Behavioural Agreement would not be appropriate

The use of an Acceptable Behavioural Agreement would not be appropriate in the following circumstances:

- Where the patient's clinician or the Security Management Director, after having consulted with all relevant staff and obtained clinical advice, has reached the conclusion that the incident was clinically induced, such as a mental disorder, and / or where an Acceptable Behavioural Agreement could adversely affect the patient's well-being or recovery.

- Other than in exceptional circumstances, for anyone under the age of 16 (an Acceptable Behavioural Agreement with the child's parent (s) or guardian (s) may however be appropriate).

Monitoring an Acceptable Behavioural Agreement

Monitoring is essential if the Acceptable Behavioural Agreement is to be effective. Therefore, the roles and responsibilities in respect of monitoring must be clearly outlined so that any further unacceptable behaviour is recorded and appropriate action can be escalated should that become necessary. It is important that the Clinical Manager or the relevant Senior Nurse Manager documents all these for future referencing.

Where a patient, relative or visitor fails to comply with the terms outlined in the Acceptable Behavioural Agreement, consideration should be given to alternative procedural, civil or criminal action and initiating Stage 3 (below).

11.6 Stage 3 – Written Final Warning

A final written explanation of potential exclusion from the premises and the withholding of treatment may be considered if unacceptable behaviour persists or is of a significant serious nature.

This stage will only be implemented following a review of the case by the Local Security Management Specialist who will recommend the action to be taken.

This letter, which can only be sent by the Trust's Security Management Director or Chief Executive, should notify the perpetrator if there is a repetition of his/her unacceptable behaviour, then this warning letter will remain on their personal record for a period of one year from the date this letter has been issued and will be taken into consideration with one or more of the following actions:

- The withdrawal of NHS Care and Treatment, subject to clinical Advice

- Exclusion from premises with conditions / Security Controlled Access

- The matter will be reported to the Police with a view that the Trust will seek a criminal prosecution by the Crown Prosecution

- The Trust will seek legal advice and consider civil proceedings or seeking sanctions such as an Anti-Social Behavioural Injunction (ASBI). Any legal costs incurred will be sought from the perpetrator

The patient's General Practitioner and Consultant should be notified in writing and, where appropriate, the letter served in person by the Local Security Management Specialist or by recorded delivery.

11.7 Stage 4 – Strategy Meeting

In cases where there is failure to comply with stages 1, 2, and 3 and or further incidents of unacceptable behaviour are reported a strategy meeting for all professionals involved in the case will be called by the Local Security Management Specialist to examine all available information and to consider which course of action would be appropriate as set out in the final warning letter.

- The withdrawal of NHS Care and Treatment, subject to clinical Advice
- Exclusion from premises with conditions / Security Controlled Access
- The matter will be reported to the Police with a view that the Trust will seek a criminal prosecution by the Crown Prosecution
- The matter will be reported to the NHS Protect Legal Protection Unit with a view that the Trust will seek criminal or civil proceedings or other appropriate sanctions including the obtaining of an Anti-Social Behavioural Order. Any legal costs incurred will be sought from the perpetrator.

Further guidance and explanations of the courses of action as described above can be obtained by contacting the Local Security Management Specialist.

12. Process 'B' for Managing Challenging Behaviour

Process B should be followed where it has been ascertained that, in the expert judgement of a relevant clinician, a patient lacks capacity to make decisions around acceptable levels of behaviour due to the patient's clinical condition and the management of incidents will need to be modified in consultation with the clinician. A Challenging Behaviour – Patient Risk Assessment must be completed can be found at Appendix B.

Staff should refer where appropriate to the Mental Capacity Act Policy and the Safeguarding Adults Policy. Further guidance for challenging behaviour can be found at Appendix D, the Challenging Behaviour Strategy and the Restraint & Restrictive Policy

The presence of a mental condition should not preclude appropriate action from being taken. It is imperative that clinical opinion in matters relating to service users or patients with mental health problems or learning disabilities. The identified needs of the individual will be balanced against the needs of other patients and the right of all staff to work in a safe and secure environment.

13. Training

13.1 Conflict Resolution Training

The Trust requires that all front line staff (those dealing directly with the public) receive the National Syllabus in Conflict Resolution Training. This training is intended to help prevent situations escalating and to diffuse potentially abusive and violent incidents. This training includes the causes of violence, the recognition of warning signs and de-escalation techniques.

13.2 Higher Risk Groups

Staff in higher risk groups may require a more in-depth level of training in defusing situations where aggression is being displayed or in responding to physical violence. This training may include the following:

- Dementia Training
- Breakaway Training
- Physical Intervention Training

Physical intervention training is applicable to staff in patient facing situations and the training course is still applicable to staff in patient facing situations working at the NDDH site (in addition to the presence of 24/7 security staff).

Training requirements will be determined by risk assessment conducted by the service manager and staff. The Health & Safety Manager and the Local Security Management Specialist will support risk assessment and identification of available training. Workforce Development will be responsible for the provision of training identified following risk assessment.

13.3 Training matrix and booking

Booking for all Violence & Aggression training will be undertaken through Workforce Development via STAR, signed records must be kept of all training undertaken in the Trust. These records will be held centrally and reported Trust wide through ESR records. Individuals are encouraged to keep a copy of this in their portfolio.

14. Monitoring Compliance with and the Effectiveness of the Policy

14.1. Standards/ Key Performance Indicators

The Trust undertakes to evaluate the effectiveness of this policy and the associated guidelines, the key performance indicators comprise:

- Number of incidents being reported
- Number of significant event reports
- Number of serious investigations
- NHS Staff survey results (Violence & Aggression section)
- The uptake of training programmes

- Compliance with Clause 24 of the NHS Standard Provider Contract

14.2. Process for Monitoring Compliance and Effectiveness

Monitoring compliance of this policy against all minimum requirements in Clause 24 of the NHS Standard Provider Contract will be the responsibility of the Local Security Management Specialist. This will be monitored on a continuous basis using the Trust's Incident reporting system managed by Corporate Governance. It will provide baseline information on the number, nature and location of incidents of violence and aggressive behaviour within the Trust.

Regular reports of incidents of violence and aggression will be submitted to the Health and Safety Committee Incidents are routinely presented in the quarterly incident reports.

Where non-compliance is identified, support and advice will be provided to improve practice.

Responsibility

The Local Security Management Specialist will be responsible for monitoring and reporting violence and aggression incidents to the Health & Safety Committee.

15. Equality Impact Assessment

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age			X	
Disability			X	
Gender			X	
Gender Reassignment			X	
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership			X	
Pregnancy			X	
Maternity and Breastfeeding			X	
Race (ethnic origin)			X	
Religion (or belief)			X	
Sexual Orientation			X	

16. References - Legislation

- Health and Safety at work Act 1974
- Management of Health and Safety at Work Regulations 1999
- Criminal Justice and Immigration Act 2008 Part 8 Section 119

- Directions to NHS Bodies on Security Management Measures 2003 (Amendment) Directions 2006
- The Counter Fraud and Security Management Service (Establishment and Constitution) Order 2002 SI 2002/3039
- Section 3 (1) of the Criminal Law Act 1967

References

The Health and Safety Executive (HSE) website provides further information and resources: www.hse.gov.uk.

- 'Risk Assessment for Work Related Violence'. HSE website page.
- 'Work Related Violence'. HSE website page.
- Violence at Work: A Guide for Employers. (2006)
- The NHS Security Management Service (NHS SMS) website provides further information and resources: www.nhsbsa.nhs.uk.
- Concordat between the Health and safety executive & the NHS Counter Fraud & Security Management Service. (2005)
- A Professional Approach to Managing Security in the NHS. (2003)
- Conflict Resolution Training. Implementing the National Syllabus. (2004)
- Non Physical Assault Explanatory Notes. A framework for Reporting and Dealing with Non-physical Assaults against NHS Staff and Professionals. (2004)
- Prevention and Management of Violence Where the Withdrawal of Treatment is not an Option. (2007)
- Tackling Violence against Staff: Explanatory Notes for Reporting Procedures Introduced by Secretary of State Directions, in November 2003 (updated June 2009). (2007)
- NHS Security Management Manual. (2008) (Restricted access to Local Security Management Specialists)
- Not Alone: A Guide for the better protection of lone workers in the NHS. (2009).
- Department of Health. (2010). The NHS Constitution: The NHS belongs to us all. London: Department of Health. Available at: www.dh.gov.uk
- Ipsos MORI. (2010). Violence against frontline NHS staff: Research study conducted for COI on behalf of the NHS Security Management Service. London: Ipsos MORI. Available at: www.nhsbsa.nhs.uk
- NHS Protect: Meeting Needs and Reducing Distress Guidance on the prevention and management of clinically related challenging behaviour in NHS settings 2013.
- Positive and proactive care: reducing the need for restrictive interventions. Guidance for those working in health and social care settings; commissioners of services, executive directors, frontline staff and those who care for and support people. (April 2014) Department of Health.
- NICE Guideline NG10 Violence and Aggression: short-term management in mental health, health and community settings.

17. Associated Documentation

- Challenging Behaviour Strategy
- Deprivation of Liberty Safeguards (DoLS) Policy
- Health and Safety Policy
- Incident Management Policy
- The Use of Ligature Cutters Standard Operating Procedure
- Lone Worker Policy
- Mental Capacity Policy
- North Devon Healthcare NHS Trust Code of Conduct leaflet
- Observation of Patients Policy
- Patient Safety Briefing and bedside Handover SOP
- Police Welfare Checks Standard Operating Procedure
- Restraint and Restrictive Practice Policy
- Risk Management Policy
- Safeguarding Adults Policy
- Safeguarding Children Policy
- Search of Persons & Property Standard Operating Procedure
- Secure Environment Policy
- Violence and Aggression Warning Markers Standard Operating Procedure

Appendix A: Examples of physical and non-physical assault including abusive telephone calls

Examples of physical and non-physical assault

1. **Physical assault;** Examples could include:

   - Intentional physical contact on a person that has resulted in bodily harm and injury such as a bite, scratch, bruise, reddening of the skin etc.
   - An intentional, unlawful threat to cause bodily harm or injury.
   - A circumstance which creates in the other person a well-founded fear of imminent peril or danger.
   - Battery – the wilful or intentional touching of a person against that person's will by another person.
   - Offensive touching.
   - Sexual Assault – sexual contact against a person's consent or will.
   - Unwanted physical contact by another.
   - Spitting

2. **Non-physical assault;** Examples could include:

   - Offensive language, verbal abuse and swearing which prevents staff from doing their job or makes them feel unsafe.
   - Loud and intrusive conversation.
   - Unwanted or abusive remarks.
   - Negative, malicious or stereotyping comments.
   - Invasion of personal space.
   - Brandishing of objects or weapons.
   - Offensive gestures.
   - Threats or risk of serious injury to a member of staff, fellow patients or visitors.
   - Bullying, victimisation or intimidation.
   - Stalking.
   - Alcohol and drug fuelled abuse.
   - Unreasonable behaviour and non-cooperation such as repeated disregard of hospital visiting hours.
   - Any of the above which is linked to destruction of or damage to property.

3. In short, unacceptable / inappropriate behaviour can be defined as any incident where a staff member feels harassed, abused, threatened, bullied (not by a colleague), insulted or assaulted in circumstances relating to their work or whilst they are at work.

   Note: staff-on-staff bullying does not fall under the remit of security management. Any such issues will be managed by Human Resources.

4. Abusive Telephone Calls

If you experience the type of behaviour previously described in the form of a phone call, you should:

- Inform the caller that you do not wish to be spoken to in the manner being used

If the caller persists:

- Reiterate that you do not wish to be spoken to in the manner being used and that you will terminate the call should they persist

If the caller persists:

- Inform the caller that you will not be spoken to in that manner and that you are terminating the call
- Then put the phone down and report the incident to a Senior Manager and via the Trust's Incident Reporting system

Should the caller continue to ring and display this inappropriate behaviour you must refer on to a senior member of staff / line manager with all the relevant details.

If the caller is still persistent and displays this inappropriate behaviour this becomes a point of law under "The Protection from Harassment Act 1997" and must be reported on the Trusts incident reporting system (DATIX) and brought to the attention of the Local Security Management Specialist in the first instance who may then refer the matter to the Police if appropriate.

5. It is important to note that examples of physical and non-physical assault can be either displayed in person or by telephone, letter or e-mail, or any other form of communication such as graffiti on Trust property and buildings.

Appendix B: Challenging Behaviour - Patient Risk Assessment

Northern Devon Healthcare NHS
NHS Trust
Incorporating community services in Exeter, East and Mid Devon

Challenging Behaviour - Patient Risk Assessment

Section A - Patient details:

Patient Name: …… DOB: / / Patient No ……

Address……..

Postcode: ……... Date of Assessment: / / Time: ……

Unit …… Ward/ Dept. ……

Section B – Risk indicators: (answer all statements below)

Is the patient displaying physical signs? **Yes** ☐ **No** ☐
(E.g. tense and agitated, sweating profusely, voice/ pitch change, dilation of pupils, physical signs of aggression etc.)

Is the patient a risk to staff or others? **Yes** ☐ **No** ☐
(E.g. aggression, violence)

Has there been a previous episode of violence/ aggression? **Yes** ☐ **No** ☐
(E.g. patient lashing out, verbal threat etc. this admission or previous admissions)

Is the patient presenting challenging behaviour? **Yes** ☐ **No** ☐
(E.g. inappropriate demands, poor service response etc.).

Is the patient a risk to themselves? **Yes** ☐ **No** ☐
(E.g. suicide, self-harm etc.).

Section C - Initial Management Plan to manage risks identified:

(See Appendix E and / or Restraint & Restrictive Policy for further guidance – Challenging Behaviour)

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Section D - Action Stages Available: (this section must be completed)

1. Is the Initial Management Plan above suitable to manage risks?

   □ Yes, no further action at this stage

   □ No, go to question 2

2. Has the Patient Management Plan been amended and the risk managed?

   □ Yes, detailed below and no further action at this stage

   □ Further action required, go to question 3

3. Has a consultation/ discussion taken place with Team Leader/ Nurse in Charge/ Head of Department and outstanding actions agreed to manage risk?

   □ Yes, detailed below and no further action at this stage

   □ Further action required, go to question 4

4. Team Leader/ Nurse in Charge/ Head of Department must organise a meeting with senior members of staff - Patient Management Team/ Manager on Call/ Medical staff/ Modern Matron/ Senior Nurse/ Local Security Management Specialist

   □ Actions agreed and detailed below

Further Actions taken to manage risk following action stages 2, 3 and/ or 4

Action must include next review time no later than 24 hours

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Section E – Person completing risk assessment:

Completed by: …… Signed: ……

Designation:…… Date……

CHECK LIST

Risk Assessments of Individual Service Users

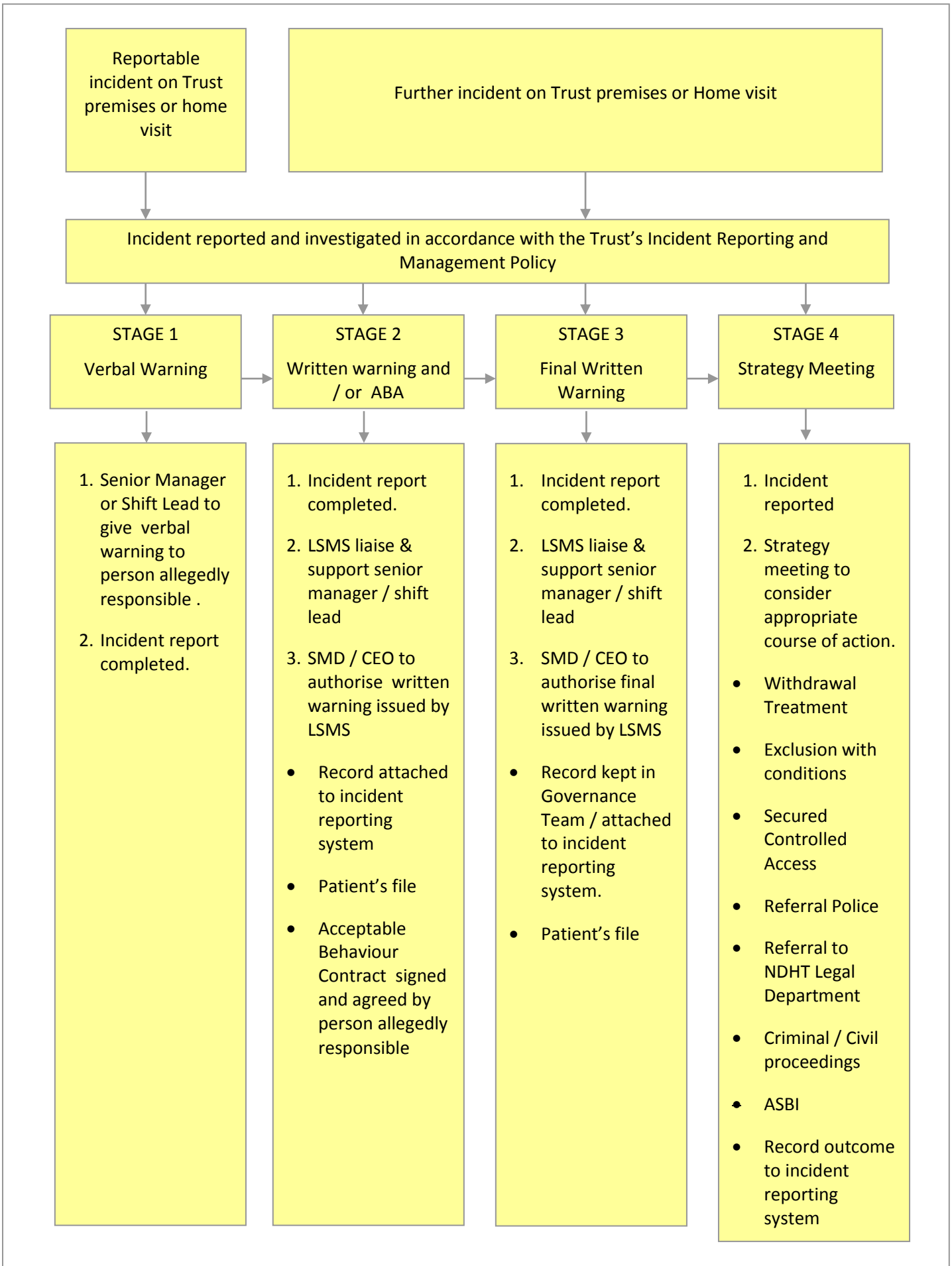
Individual service users may be subject to a risk assessment for Violence and Aggression.

Where it is identified that an individual service user may present a risk to staff or others, the appropriate health care professional must ensure that:

- A Violence and Aggression risk assessment with relevant action plans is completed with support from their respective teams and specialist advisers such as the Local Security Management Specialist, where appropriate.
- The assessment and actions are documented in the patient's healthcare record and if appropriate on Trust information systems in accordance with Trust policy.
- All appropriate staff and services are informed of any actions that need to be taken.
- A process is put in place to ensure that where there are shift changes; information is passed on via the handover process.
- Where care is delivered by staff outside of their immediate team, e.g. out of hours weekends, the information is shared in a timely and effective manner.
- A review of the risk assessment and control measures is undertaken if a further incident occurs or at the set review date.

If this risk assessment was completed following an incident, please ensure the incident is reported on the Trusts incident reporting system (DATIX) in accordance with the Incident Reporting and Management Policy

Appendix C: Managing Violence and Aggression Flowchart



Appendix D: Management of Challenging Behaviour Guidance

(a) Guidance for the Challenging Behaviour

(b) Flow Chart

(c) Intervention Methods

(a) Guidance for the Management of Challenging Behaviour

1. At the outset of aggressive behaviour, identify whether it is unintentional due to patient's condition i.e. look at capacity issues. If this is deemed not to be the case, follow the Trust's Violence & Aggression Policy.

2. If necessary, contact Security / Police for assistance to ensure the safety of staff and other patients. Where appropriate use de-escalation techniques.

3. If this is deemed to be the case, take the following action:

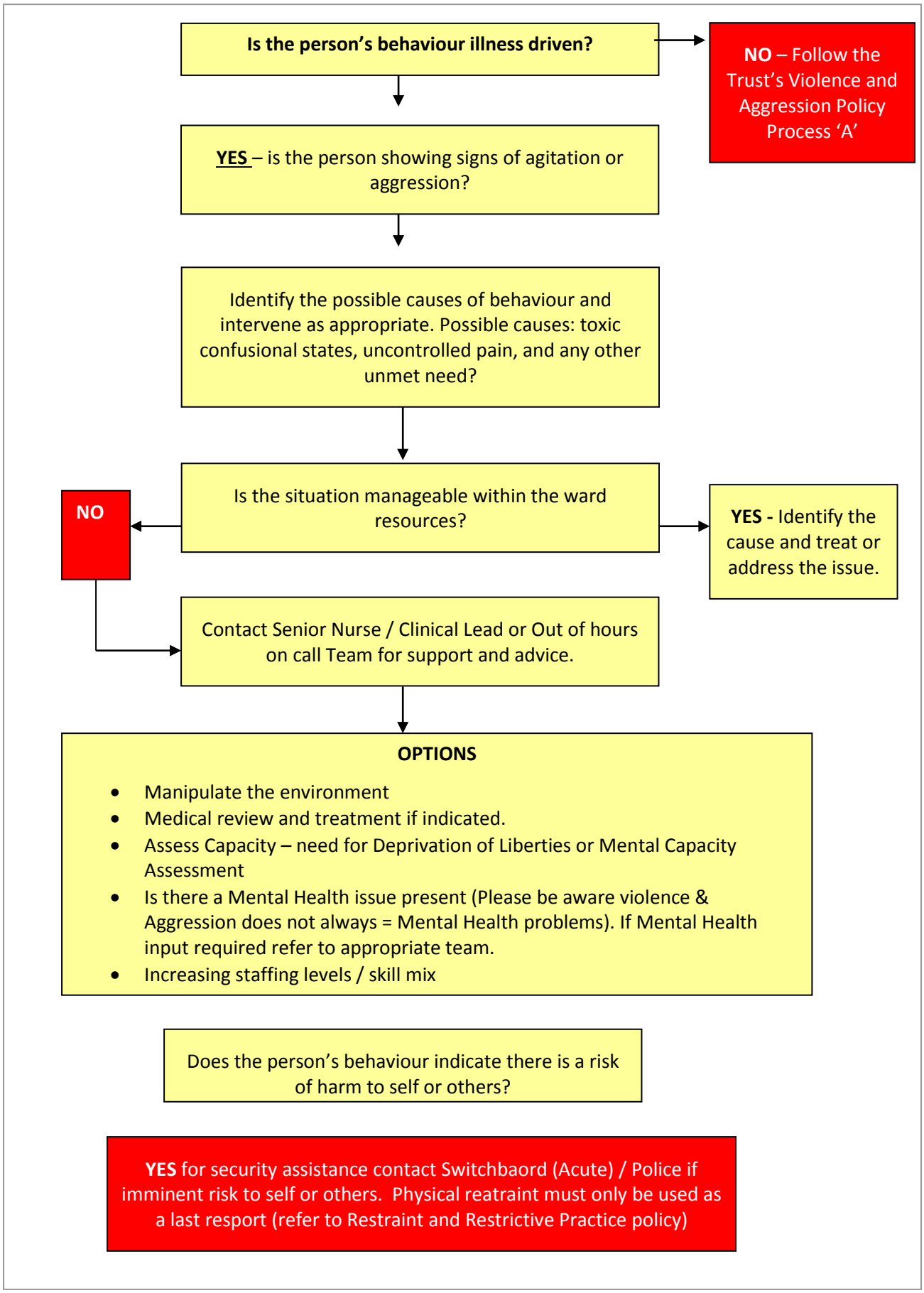
- Identify possible causes of behaviour and intervene as appropriate
- Identify whether the situation is manageable within Ward resources
- If yes, identify cause and treat or address the issue

4. If no, contact the Senior Nurse / Clinical Lead or the Out of Hours on call Team for support and advice. Senior Nurse / Clinical Lead will consider the following:

- Increasing staffing levels / skill mix
- Manipulating the environment
- Medical review and treatment if indicated
- Assess capacity

5. Once the situation is under control, continue with patient's care plan including nursing staff required, investigations and treatment. Identify risk factors that would indicate a relapse. .

(b) Flow Chart - Management of Challenging Behaviour



c) Intervention methods for dealing with agitated or aggressive patients

All interventions should occur simultaneously and promptly

Environmental interventions

- Create a calm environment
- Turn off TV / radio
- Remove other patients to another room or take patient somewhere quieter
- Remove objects that can be used as weapons, e.g. chairs, glass bottles etc.
- Get help from trained staff
- Check whether lighting can be dimmed.

Behavioural interventions

- Talk slowly and softly
- Never turn your back to the patient
- Place yourself between the exit and the patient
- Be aware – eye contact may help establish a rapport, or may seem threatening
- Innocuous questions about sleeping and eating may prove a useful distraction
- Convey a genuine sense of concern
- Allow patient to verbalise feelings, but cut short if anger is escalating
- Restraint by trained staff may be necessary with removal to a safer secluded area.

Medical interventions

- Consider another cause of the agitation, e.g. alcohol withdrawal, delirium
- Consider issues relating to the patient's capacity
- Review medication as appropriate