Hertfordshire Partnership University NHS Foundation Trust

HPFT

Violence & Aggression

Including Mental Health Units Use of Force Act 2018

The following policy offer guidance to HPFT Staff about:

- Responsibilities
- Managing both verbal and physical aggression / violence.
- Post incident support for staff and service users.
- Documentation
- Training

Policy

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Executive Lead	Executive Director Quality and Safety
Lead Author	Head of Safety
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Target Audience	All HPFT Staff who come into contact with service user, relatives, carers and members of the public.

Document on a Page			
Title of document	Violence & Aggression Policy Including Mental Health Units Use of Force Act 2018		
Document Type	Policy		
Ratifying Committee	Health Safety & Security Committee		
Version	**Issue Date**	**Review Date**	**Lead Author**
8	20th June 2022	20th June 2025	John Fanning, Head of Safety
Staff need to know about this policy because (complete in 50 words)	Violence and Aggression towards health care staff is a major concern for health care providers, Nurses are the second highest occupational group to experience violence at work after police. This policy provides guidance, procedure, and best practice in relation to the prevention of violence and aggression and Use of Force.		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	• The use of force must always be used proportionately, in accordance with the law, and only ever as a last resort. • All uses of force must be rights-respecting, lawful and compliant with the Human Rights Act 1998. • Patients and, where appropriate, their families and carers are provided with information about the use of force, and their rights in relation to any use of force that may be used by staff in a mental health unit.		
Summary of significant changes from previous version are:	This policy has been amended to include the requirements of the Use of Force Act 2018		

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PART 1 – Preliminary Issues:

1. INTRODUCTION

Introduction & Need for Policy

Hertfordshire Partnership University NHS Foundation Trust (HPFT) is committed to providing safe and positive care and ensuring the wellbeing of all its patients, service users, carers and staff. We will ensure our care is the least restrictive, the most positive and takes account of human rights, choice and engagement, and collaboration. We aspire to utilise the least restrictive approach and where we do use restrictive practice, ensure they are safe and positive, are done in collaboration with service users and their families/carers and are supported by best practice, a clinical model and sit within the framework of trauma informed care and human rights

Violence and aggression refer to a range of behaviours or actions that can result in physical / psychological harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained, or the intention is clear.

The policy concerns the following:

- Antisocial, offensive or disruptive behaviour
- Verbal abuse including racial abuse, threatening behaviour, harassment
- Physical violence/assault and psychological harm.
- Damage to personal or Trust property

The Mental Health Units Use of Force Act (2018) states that:

"Every individual has the right to be treated with dignity and in a caring therapeutic environment which is free from abuse. The use of force (which refers to physical, mechanical or chemical restraint, or the isolation of a patient) can sometimes be necessary to secure the safety of patients and staff. The use of force always comes with risk and can be a traumatic and upsetting experience for patients when they are at their most vulnerable and in need of safe and compassionate care. The use of force can also be upsetting for those who witness it, such as other patients or visitors"
(Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England and police forces in England and Wales)

The Trust (HPFT) is at the forefront of providing integrated health and social care and provides services for people with mental health problems and learning disabilities. This policy therefore reflects the Trusts 'Making Our Services Safer Together' (MOSStogether) strategy.

The MOSStogether Strategy supports the aims of the Quality Strategy to deliver Great Care and achieve Great Outcomes together, using the least restrictive practices. The objectives, focusing on the safety domain are:

- Delivering safe care in top quality environments, with regards to the seclusion and restrictive practice
- Fostering a learning and just culture
- Fostering a culture of safety.

This policy does not cover aggression or violence between employees, which is covered within the Trust 'Harassment and Bullying Policy and Procedure'.

The policy fully supports the recommendations of NICE, Violence and aggression: short-term management in mental health, health and community settings (2015), Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings (2016), Positive and Proactive Care: reducing the need for restrictive interventions (2014), Violence prevention and reduction standard (2020), Restraint Reduction Network (RRN) Training Standards (2019) Mental Health Units Use of Force Act (2018) and Covid-19 Guidance (2020).

Further information is available on the HPFT intranet site 'Making Our Service Safer Together' Strategy.

All Trust policies referred to in this policy are available on the HPFT intranet site.

2. Legislation

Mental Health Act 1983 (2007) / Mental Capacity Act 2005 (Codes of Practice)

Within both Codes of Practices there is clear guidance concerning the use of restrictive interventions. This policy considers both 'Codes'. Please refer to the most current 'Code of Practices' for further advice.

Legal Framework / Human Rights Act (1998)
A Human rights-based approach to the use of force
The use of force must be lawful and compliant with the articles of the European Convention on Human Rights as incorporated into domestic law via the Human Rights Act 1998. The Trust will ensure that it has an established mechanism that enables patients to report any potential breaches of human rights. "Human rights are the fundamental freedoms and protections which everyone is entitled to. They cannot be taken away – but some rights can be restricted in specific circumstances for a legitimate reason, as long as that restriction is proportionate". The Articles of the Human Rights Act 1998 which are pertinent to the use of restraint in mental health settings are:

- **Article 2: Right to Life.**

This obliges the Trust to protect anyone under its care from risk to that person's life, whether self-inflicted or by another, whether by act or omission. Article 2 imposes a procedural obligation on the Trust to conduct an investigation in circumstances including: where the person has attempted suicide while so detained and has sustained serious injury (or potentially serious injury); where the Trust owed a duty to take reasonable steps to protect the person's life because the person was under the Trusts control or care and the Trust knew (or ought to have known) there was a real and immediate risk to the person's life. This can also include voluntary patients.

- **Article 3: Prohibition of torture, inhuman or degrading treatment.**

No restrictive intervention should be used unless it is absolutely necessary to do so in all the circumstances of the case. Action that is not proportionate or necessary may well breach a patient's rights under article 3. 'Inhuman or degrading treatment' does not have to be deliberate and can be unintentional. To avoid this all the individual circumstances of the service users case should be factored into any application of force.

• **Article 8: Respect for private and family life.**
Restrictive intervention may breach a patient's article 8 rights if it has a sufficiently adverse effect on the patient's private life, including their moral and physical integrity.

• **Article 14: protects from discrimination**.
In addition to what is set out above as in the Mental Health Units (Use of Force Act (2018) statutory guidance:

• **Article 5** Restrictions that alone, or in combination, deprive a patient of their liberty without lawful authority will breach article 5 of the ECHR (the right to liberty). HPFT and its staff are legally obliged to respect patient's rights and take reasonable steps to protect those rights. There are legal frameworks including those under the Mental Health Act 1983 and the Mental Capacity Act 2005 that are designed to ensure that any use of force is applied only after a proper process has been followed. Such legal frameworks require any force used to be necessary and proportionate, and the least restrictive option.

Being Trauma Informed
Trauma, personal and/or caused by the system, whether historical or current is a real issue for us to tackle as part of improving safe and positive care and reducing restrictive practices. We will work to deliver care that is trauma aware and sensitive to the impact of actual, potential, and vicarious trauma on the lives of everyone who encounters services, including those who work within it. We will work to ensure that our processes and pathways do not re-enact people's experiences of trauma, but promote safety and recovery. We will build and maintain cultures and atmospheres where both services users and staff feel supported, validated, and included
This policy hence provides information on potential causes, and guidance to all Trust staff on how to prevent risks to themselves, service users and the general public, and where necessary for the planning and implementation of high-quality and robust management of violence and aggression within the Trust.

Staff need to be aware of the legal and ethical issues which are pertinent in the management of aggression and violence. The Relating to People training courses (Respect Training) consider both non-physical techniques and physical techniques to manage an aggressive episode and, whether staff are working alone or as part of a team.

The physical management of aggression and violence may result in a restriction of the liberty (e.g. in relation to physical interventions) and autonomy of the person and may be unlawful. Criminal charges such as false imprisonment and assault & battery may arise from the unlawful use of restrictive physical interventions (RPI's). The management of aggression and violence must therefore always be justified in law.

Use of restrictive interventions must be undertaken in a manner that complies with the Human Rights Act 1998 and the relevant rights in the European Convention on Human Rights.

Unless a service user is detained under the Mental Health Act 1983 or subject to a deprivation of liberty authorisation or order under the Mental Capacity Act 2005, health and social care provider organisations must ensure that the use of restrictive interventions does not impose restrictions that amount to a deprivation of liberty.

Where an informal service user has been subject to a restrictive intervention including a physical intervention (restraint) the Multi-disciplinary Team must review whether the

service user should be detained under the Mental Health Act 1983 or subject to a deprivation of liberty authorisation.

For further information see the DOLS policy and MHA Legislation. https://hertfordshirenhs.interactgo.com/Interact/Pages/Section/Default.aspx?Section=3159
Additional clinical guidance can found in Appendix A.

Lawful Defence and Reasonable Force

To enable the application of force and/or the restriction of liberty of a person to be recognised as legitimate there are two criteria which must be satisfied:

- A legitimate reason to use force or restrict liberty must exist
- The force and / or restriction used must be Justifiable, Appropriate, Reasonable and Proportionate.

Reasonable Force

Definition: *"The force used should be no more than was necessary to accomplish the object for which it is allowed (so that retaliation, revenge and punishment are not permitted). Secondly, the reaction must be in proportion to the harm which is threatened in both degree and duration"* (Dimond B., Legal Aspects of Nursing 2011)

The action will be judged with consideration to the facts as the individual perceived them to be at the time, even if he or she later realises it was wrong or unreasonable i.e. If you have an honestly held belief that you or another are in imminent danger, then you may use such force that is **necessary** to avert that danger.

Mental Health Units Use of Force Act (2018)

The Mental Health Units (Use of Force) Act 2018 came into force in England on 31st March 2022. Please see https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018 for full details.

The act defines the different types of force as:

- physical restraint: the use of physical contact that is intended to prevent, restrict or subdue movement of any part of the patient's body. This would include holding a patient to give them a depot injection
- mechanical restraint: the use of a device that is intended to prevent, restrict or subdue movement of any part of the patient's body, and is for the primary purpose of behavioural control
- chemical restraint: the use of medication that is intended to prevent, restrict or subdue movement of any part of the patient's body. This includes the use of rapid tranquillisation (see National Institute for Health and Care Excellence (NICE) guideline [NG10] Violence and aggression: short-term management in mental health, health and community settings)

The act acknowledges that there are circumstances where it may be difficult to avoid the use of force to ensure the safe care and treatment of the patient, and the safety of other patients and staff. For example a need to restrain a patient who is resisting or refusing help with personal care and support. Even within these situations, it is still essential that the relevant legal principles are applied and that the use of force is proportionate.

Other Legitimate Defences

Exercise of statutory powers and duties. These mainly come from the authority to use force under the Mental Health Act (1983).

Self Defence. The law imposes duty on a potential victim to retreat and escape and it is only when there is no opportunity to disengage that self-defence is likely to be considered legitimate.

To Prevent a Breach of the Peace. This is defined as a situation where *"harm is done or likely to be done to a person or in his presence, to his property: or harm is feared through an affray, riot, assault or other disturbance"*.

To Prevent a Crime. Section 3 of the Criminal Law Act 1967 states that *"A person may use such force as is reasonable in the circumstances in the prevention of a crime or in effecting or assisting in the lawful arrest of offenders or of persons unlawfully at large"*

Further advice on the Legal Framework is available within 'Appendix One' of the Memorandum of Understanding, College of Policing: The Police Use of Restraint in Mental Health & Learning Disability Settings. http://www.college.police.uk/What-we-do/Support/uniformed-policing-faculty/Documents/ERG_Final_Copy.pdf

3. SUMMARY

The Trust views violence and aggression against their staff, service users, visitors or property as unacceptable. The Trust recognises and accepts its responsibility for the prevention and management of non-physical and physical assaults in accordance with relevant legislation both within its inpatient and community services. The Trust will make every effort to provide a safe therapeutic environment.

The Trust will so far as is reasonably practicable, ensure that staff have the following:

- A safe system of work
- A safe working environment
- Adequate training, supervision and instruction
- Information relevant to the employee's safety at work
- The provision of support for service users, staff and others who have been exposed to traumatic events.

4. OBJECTIVES

The objective of the Policy is to:

- Provide guidance on how situations can be dealt with in a way that minimises the risk to users of the service.
- Ensure practice complies with the Mental Health Units (Use of Force) Act 2018
- Promote safety of staff, Service user and all those who come into contact with HPFT services and staff.
- Identify best practice
- Set the standards across the Trust
- Ensure safeguards in place to manage episodes of violence and aggression
- Reduce the use of restrictive practices within the Trust
- Safe use of restrictive practices and force as a last resort

5. Scope

The scope of this document concerns all Staff, Service Users, Carers, visitors and member of the public who come into contact with HPFT services.

6. Definitions & Terms Used

Violence and aggression refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

For the purpose of clarity, the Trust uses the following definitions:

'***Physical assault***' is defined by the Department of Health as:

> ***"The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort."***

'***Non-physical assault***' is defined by the Department of Health as:

> ***"The use of inappropriate words or behaviour causing distress/or constituting harassment."***[1]

<u>Unacceptable behaviour</u>

Unacceptable behaviour is not defined but some examples are given below:

- Offensive or abusive language, verbal abuse and swearing which targets / marginalises people
- Loud and intrusive conversation
- Unwanted or abusive remarks
- Negative, malicious or stereotypical comments
- Invasion of personal space
- Brandishing of objects or weapons
- Physical assault
- Near misses i.e. unsuccessful physical assaults
- Threats or risk of serious injury to a member of staff, fellow service users or visitors
- Abusive telephone calls, emails and letters
- Bullying, victimisation or intimidation
- Stalking
- Alcohol or drug fuelled abuse
- Unreasonable behaviour and non-cooperation such as repeated disregard for NHS policy ie.
    - Smoking on premises, or
    - Any of the above which is linked to destruction of or damage to property

[1] Non-Physical Assault Explanatory Notes, A framework for reporting and dealing with non-physical assaults against NHS staff and professionals, NHS Security Management Service 2004

NB – It is important to remember that such behaviour can be either in person, by telephone, letter or e-mail or other form of communication such as graffiti on NHS property.

Terms used in this policy

Advance decision A written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future.

Advance statement A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.

Advocate A person who represents someone's interests independently of any organisation, and helps them to get the care and support they need.

Breakaway techniques A set of physical skills to help separate or break away from an aggressor in a safe manner.

Carer A person who provides unpaid support to a partner, family member, friend or neighbour who is ill, struggling or disabled.

Children People aged 12 years or under.

De-escalation The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression.

HPFT Refers to the Trust, Hertfordshire Partnership Foundation University NHS Trust.

Incident An event or circumstance which could have resulted, or did result in, unnecessary damage, loss or harm to a service user, member of staff, visitor or member of the public under the care of the Trust or on Trust premises. For the purposes of violence and aggression incidents this is any event that involves the use of a restrictive intervention – physical interventions, rapid tranquillisation or seclusion (but not observation) – to manage violence or aggression.

Mechanical restraint A method of physical intervention involving the use of authorised equipment, for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part(s) of the body of the service user.

Mental Health Unit is described as a health service hospital or independent hospital in England (or part thereof) that provides treatment to in-patients for a mental disorder. The types of in-patient service which would be considered within the definition of a mental health unit (this is not an exhaustive list) include:

- Acute mental health wards for adults of working age and psychiatric intensive care units
- Long-stay or rehabilitation mental health wards for working age adults
- Forensic inpatient or secure wards (low/medium and high)
- Child and adolescent mental health wards
- Wards for older people with mental health problems

- Wards for people with a learning disability or autism
- Acute hospital wards where patients are “detained under the Mental Health Act 1983 for assessment and treatment of their mental disorder”

MHA Refers to **‘**Mental Health Act’

Mosstogether Strategy The Trust’s approach to ensuring the least restrictive practices are used, setting out how service users will feel safe across our services, and as a partner in their own care and treatment, enabling a positive experience. It also aims to support in the reduction of violence and aggression to both staff and services users, across all of our services.

Observation A minimally restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with a service user to ensure the service user's safety and the safety of others. There are different levels of observation, as defined in Positive engagement An intervention that aims to empower service users to actively participate in their care. Rather than 'having things done to' them, service users negotiate the level of engagement that will be most therapeutic.

Physical Interventions A skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user.

PMAV Refers to the ‘Prevention and Management of Aggression and Violence’

PRN. (Pro Re Nata) When needed. In this guideline, p.r.n. refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression; it does not refer to p.r.n. medication used on its own for rapid tranquillisation during an episode of violence of aggression

Rapid tranquillisation Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

RPI Refers to ‘Restrictive Physical Intervention’.

Restrictive interventions Interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, physical interventions, mechanical restraint and rapid tranquillisation.

Seclusion Defined in accordance with the Mental Health Act 1983 Code of Practice: 'the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others'.

Violence and aggression A range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

Young people People aged between 13 and 17 years.

7. Duties and Responsibilities

All staff have a responsibility to prevent non-physical and physical assaults, however, some professional groups and managers have specific responsibilities which are detailed within Section 8 to 40. Monitoring of incidents of non-physical and physical assaults is essential for safety of everyone. Staff have a responsibility to ensure accurate and timely reporting of incidents.

Duties within the Organisation

It is the responsibility of the organisation's operational management to ensure policy distribution, implementation and compliance throughout the organisation.

Lead Directors

The Chief Executive is ultimately responsible for ensuring that the Trust meets its responsibilities with regard to the delivery of services.

Responsible Person As directed by the Mental Health Units (Use of Force) Act 2018 HPFT must appoint a '**responsible person'** whose role it is to ensure that the organisation complies with the requirements of the Act. The role of the responsible person is nominated as the Executive Director of Quality & Safety

• HPFT should ensure that whoever is appointed has the relevant skills and experience to undertake the responsibility of this role and should publish the name of the **responsible person.**

HPFT should ensure the **responsible person** has the support of all senior management in performing their role and has the necessary resources available to them.

• The **responsible person** should attend appropriate training in the use of force to ensure they understand the strategies and techniques their staff are being trained in.

• It is important they are guided by the impact of trauma on their patients and the potentially re-traumatising impact of the use of force.

• Within HPFT the **responsible person** is appointed in relation to all the mental health units across the trust. This is to ensure a consistency of approach to the use of force across the organisation.

• The **responsible person** may delegate some of their functions under the Mental Health Units (Use of Force) Act 2018 to other suitably qualified members of staff within HPFT, however they retain overall accountability for any delegated duties being carried out.

Key Groups with a Policy Role

The Professional leads: Prevention and Management of Aggression and Violence have the following responsibilities; development and review of the policy, Mental Health Minimum Data Sets, MOSS data sets, Flash Report, Specialised Services Quality Dashboards, Training and clinical support.

Staff Groups or Committees

Restrictive Practice Committee, Safety Committee, Health, Safety & Security Committee, Strategic Business Units (SBU) Patient Safety Meetings monitor Restrictive Practice Data and set individual SBU reduction targets.

Trust Policy Co-ordinator

The Trust Policy Co-ordinator has the following responsibilities:
Responsibility for distribution and implementation of procedural documents.

Part 2 – What needs to be done and who by

8. Environmental and Clinical Risk Assessments

Measures to reduce violence and aggression need to be based on comprehensive risk assessment and management. The 'Clinical Risk Assessment and Management for Individual Service Users' policy should be read in conjunction with this policy. Any risks and management strategies must be clearly highlighted within the service user's electronic patient records.

Members of staff have a duty of care to themselves and to others with whom they come into contact in the course of their work as laid down in the Health and Safety at Work Act 1974 and any subsequent amendment or legislation.

As a protective measure it is essential that working environments and practices need to be thoroughly assessed and where there are identified risks such as Violence and Aggression, e.g. Lone Working practices etc. these need to be highlighted and a reduction strategy should be developed to minimise / mitigate the risk.

All managers are therefore responsible for undertaking an Environmental Risk Assessment of their working environment on at least yearly basis, or more frequently when there have been significant changes to practices or service delivery. (See Appendix B)

Clinical risk assessments must be completed in line with the current 'Clinical Risk Assessment and Management for Individual Service Users' policy and where there has been identified an ongoing risk of potential violence and aggression from a service user then an individualised support plan must be developed to minimise the risk, this should also be highlighted on the Patient ALERT system within the Electronic Patient Records (PARIS).

Evidence supports that previous trauma has an impact on service user's presentation and the use of reactive interventions can lead to this re-traumatisation. As part of a proactive approach to reducing restrictive interventions it is important that assessment at the point of admission considers these.

9. Advance Statements and Decisions

Advance statements and decisions might have an important role in management and prevention of aggression and violence. (NICE 2015)

Staff should check the service user's electronic patient records for Advance Statement and Decision within the care documents section on admission and incorporate these wishes within the care plan.

Advance statement and decision should only be overridden in exceptional circumstances such as emergency procedures etc. and further guidance / advice should be sought the mental health legislation department.

If a service user has not made any advance decisions or statements about the use of restrictive interventions, encourage them to do so as soon as possible (for example, as part of the community support plan or during admission).

Ensure that carers are involved in decision-making whenever practicable if the service user agrees. Carers should be involved in decision-making for all service users who lack mental capacity in accordance with the Mental Capacity Act 2005.

Advocacy needs to be considered where a service user does not have a informal advocate such as a family / friend support network.

10. Managing Unacceptable Behaviour

The aim must be to minimise the risk of harm of all involve

All Unacceptable Behaviour by service users, visitors, relatives or carers must be reported in line with the Trust's Learning from Adverse Events policy and where appropriate to the police.

Action should be taken using the skills of de-escalation as appropriate to the situation. It is therefore essential that **all** staff have received appropriate training as discussed in Section 40-41. *(For further guidance on de-escalation please see Appendix C)*.

All behaviour has a function (sensory, pain, seeking care/attention, wanting something tangible, escaping/avoiding an event/place/person). It is important the functions of the behaviour are considered and responded to in a timely manner.

HPFT does not tolerate abusive language towards its staff members. These discussions may need to occur following de-escalation as this may heighten the situation if broached at the time.

A range of measures can be taken by the Trust (depending on the severity of the situation) to assist in the management of unacceptable behaviour by seeking to reduce the risks:

- Clinical risk assessment and review of service provision.
- Subsequent Action (Appendix D)
- Informal / formal notification letters (Appendix E&F)
- Withdrawing Treatment (See 'Treatment withdrawal' below)

11. Treatment Withdrawal

The Trust will support clinical teams and staff in consideration of the withdrawal of treatment where there is evidence of violence and abuse from service users. The withholding of NHS treatment will always be a last resort but it is an option available to managers and staff working in the NHS.

Clinical teams and staff will be supported in their consideration of the need to withdraw treatment from service users where there has been an appropriate risk assessment undertaken. The team must ensure a comprehensive risk assessment has been completed for each individual service user. The reasons why the withdrawal of treatment is considered the best option should also be documented.

The Trust's Risk Manager, Lead Nurses and other professional leads must be involved in these considerations so that the appropriate legal guidance and duty of care

considerations are incorporated. This will also ensure that the Trust is supporting teams in this difficult area.

Teams need to consider alternative options about treatment delivery which must include different provider organisations.

NB: Treatment cannot be withheld from a service user as a result of the behaviour of a person accompanying or visiting the service user.

12. Action In Community Settings

For further guidance please refer to 'Lone Working Policy':
https://hertfordshirenhs.interactgo.com/Interact/Pages/Section/Default.aspx?Section=3159

As a quick guide; Staff working in the community may be particularly vulnerable, especially as lone workers. The Trust's Lone Working Policy should be followed together with any procedures local to the team.

If safe to do so, the member of staff should talk to the individual and answer any reasonable queries they may have, showing due regard to confidentiality.

If the disruptive / aggressive behaviour persists then the worker must leave, if in the service user's own home, or ask the individual to leave if in another venue. It may be necessary to request assistance from the police (refer to section 36). Staff are to report the incident under the Trust's 'learning from Adverse Events' policy.

Concerns about the service user's welfare and the inability of the member of staff to deliver the service should be immediately discussed with the line manager and action agreed depending on a risk assessment of the situation.

The service users clinical risk assessments should be immediately updated and reflect current risk in line with the 'Environmental and Clinical Risk Assessments' section above.

13. Responding To Verbal Abuse From Telephone Callers

During a call, if a caller is abusive, racist, sexist or demeaning, the Trust does not expect the member of staff to continue that call.

The caller should be notified that if the abuse continues the call will not continue. If the abuse continues, the caller should be told that the call is now being terminated. The nature of the call should be recorded and the matter discussed with the line manager or deputy for further action depending on the Trust involvement with the caller, mitigating circumstances and the level of risk. All actions must be fully documented as set out within this policy.

Further action should be considered as set out in Appendix E.

For calls being received via the BT network, the BT Nuisance Call Advisers may be able to provide support in cases where it can be proved that repeated calls have been made where the sole intent was to be abusive. (This includes silent callers.) They will not become involved if the person has lost control when contacting the Trust for legitimate reasons.

14. Information for patients about their rights in relation to the use of force

The Mental Health Units (Use of Force) Act 2018 places a requirement on Trusts to publish information about their rights in relation to the use of force. Written information for service users is attached in Appendix J and an easy-read version in Appendix K. Staff must record in the Electronic Patient Record (Paris) that they have shared information on the use of force with service users by ticking the appropriate box in the care plan document.

15. Responding to Physical Aggression (Attempted / Actual)

Wherever possible staff should attempt verbal and non-verbal de-escalation techniques and start negotiations with the individual. *(For further guidance on de-escalation please see Appendix D)*.

The use of physical interventions in the management of any situation should be undertaken as a last resort.

Incidents that occur very suddenly and without time to de-escalate or summon help may require immediate physical interventions. The use of such intervention is acceptable in law providing the amount of force is necessary and proportionate that is sufficient to stop the attacker and/or stop injury to yourself or others.

The Trust believes that disengagement from violent or potentially violent situation is preferable but also recognises that at times safety of self or others would supersede that.

Where it is necessary to undertake a physical interventions the aim of such techniques is not used to punish, inflict pain, suffering or humiliation, or establish dominance.

Ensure that the techniques and methods used to restrict a service user:

- are proportionate to the risk and potential seriousness of harm
- are the least restrictive option to meet the need
- are used for no longer than necessary
- take account of the service user's preferences, if known and it is possible to do so
- take account of the service user's physical health, degree of frailty and developmental age.

It is expected that staff undertaking physical interventions have been trained by attending an appropriate course as provided by the Trust. It is essential that if any physical intervention using more than one member of staff is required to stabilise the situation, that one member of staff should manage the incident in line with the training given.

Robust leadership skills are an essential quality during any intervention and are key in ensuring the safety of all involved, therefore the team responding need to identify an appropriate leader using principles of human factors which states the importance of the conductor role as taught.

Where staff have not been trained in the use of physical intervention, they should not attempt to use them unless in extreme circumstances and where they, or another person are in immediate danger.

Use of Force Act 2018 states

• people must not be deliberately restrained in a way that impacts on their airway, breathing or circulation.

The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen.

• there must be no planned or intentional restraint of a person in a prone or face down position on any surface, not just the floor.

• if exceptionally a person is restrained unintentionally in a prone or face down position, staff should either release their holds or reposition into a safer alternative as soon as possible.

• staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purpose of an immediate rescue in a life-threatening situation

NICE guideline [NG10] Violence and aggression advises

• Do not routinely use manual restraint for more than 10 minutes.

• Consider rapid tranquillisation or seclusion as alternative to prolonged restraint (longer than 10 mins)

HPFT utilises RESPECT techniques in regard to managing violence and aggression, RESPECT incorporates manual restraint techniques that fully comply with NICE and RRN STANDARDS in respect to managing violence and aggression.

When staff are aware they may become involved in the use of physical interventions where practicable they should remove any items which may cause injury to themselves or others such as badges, pens, watches etc. When a decision has been made for staff to use the techniques staff must follow the following principals, based on the Trust's training model:

- One member of staff will take a leading role (Conductor) and will direct the action of the team and ensuring that reasons for the decision being made are documented after the intervention.
- Staff will work together as a team.
- Only recognised physical interventions approved by the Trust should be used including holding only long bones e.g. forearms, upper arms and legs.
- The lead staff member will give an ongoing explanation of staff actions to the service user.
- The lead staff member will be responsible for ensuring the monitoring of the physical and psychological needs of the service user, monitoring base line physical observations throughout the procedure.
- The lead staff member will explain the actions required from the person and allow sufficient time for these to be understood and carried out.
- Other staff will remain on hand in case extra assistance is required (Preferably out of sight of the service user).
- At least one member of staff will be allocated to remain with other service users, if other service users are present within the unit / department.

The Trust recognises that the above may present as a challenge to clinicians in the initial stages of stabilising a situation however once it is under control the process must be followed.

a) Physical Observations During Physical Interventions (vital signs)

The lead staff member (Conductor) should continue to speak to the service user throughout the intervention. This should occur even if there is no verbal response.

The lead member of staff must ensure staff monitor vital signs, Breathing, Pulse, Oxygen Saturation levels (where possible).

All staff should monitor the service user throughout observing for signs of distress e.g. difficulty in breathing, cyanosed hands and feet, fits/seizures, vomiting and choking if any signs of distress are noted then this is reported to the lead member of staff (Conductor) and the person should be immediately released and appropriate interventions, medical or nursing, must be employed.

Continue to monitor the service user's physical and psychological health for as long as clinically necessary after using physical interventions as per 'Supportive Observation and Physical Health' policies.

Please see the following link for information regarding the Patient Safety Alert (2015): 'The importance of vital signs during and after restrictive interventions/manual Restraint' https://www.england.nhs.uk/wp-content/uploads/2015/12/psa-vital-signs-restrictive-interventions-031115.pdf

b) Prolonged Physical Intervention In excess of 10 minutes (Supine position – Service User Lying on Their Back)

Where a Supine Restrictive Physical Intervention has been used in excess for 10 minutes then medical assistance must be sought through either the Responsible Clinician or On-Call rota for further advice.

Consider rapid tranquillisation or seclusion as alternatives to prolonged use of physical interventions (longer than 10 minutes).

The Ward/On-Call Manager should:

- be informed of any service user who has been subjected to any form of physical interventions that lasts for more than 10 minutes for advice;
- see the service user as soon as possible;
- visit and talk to the service user about the incident and ascertain if he or she has any concerns or complaints and if so assist in putting them forward.

The ward/on-call manager may delegate this task to a member of staff who has a good relationship with the service user.

The Practice Development & Patient Safety Team can be contacted for advice when available.

c) Prone Physical Interventions

The Trust no-longer provides training in the use of prone techniques however recognises that at time service users can end up in a prone position for a number of reasons outside of staff control, where this occurs it is essential that the service user are repositioned into a supine position as soon as practicable.

All prone restrictive physical interventions require a 72 hour fact finding investigation to be undertaken as described in the Trusts Learning from Adverse Events policy and shared with PDPS Team.

d*) Releasing from a Physical Intervention*

Releasing a person from a physical intervention should take place at the earliest opportunity and staff should be guided by the lead person identified as above. The principles of 'Gradient Support' should be adopted by staff as per training. The service user should be informed of what is happening and why it is happening and what the expectations are from them when they are released. Staff should obtain agreement on immediate future actions, from the service user prior to release.

Types Of Restraint utilised within the Trust (Respect Techniques):
All of the techniques taught within the Respect training programme have been biomechanically assessed to ensure when used they are safe, do not cause pain to the person they are being used on and approach situations utilising the least restrictive option first. Please see Appendix N for full list of techniques taught.

16. Negligible use of force

The duty to record the use of force does not apply if the use of force is negligible. This does not mean that it is irrelevant to the person's care and treatment but describes those situations where there is a light and gentle proportionate pressure. This may apply when providing personal care and giving reassurance. Such support must be recorded in the careplan.
The careplan must record :

- why negligible use of force is necessary and what other less restrictive options could be considered
- a clear operational description of what the negligible use of force is
- how frequently and in what circumstances it would be used
- what the outcome of the activity might be if negligible force isn't carried out
- if the patient has consented to negligible use of force
- how much discomfort it may cause the patient
- any special considerations for the patient
- the review period of the careplan, including involvement of the person, family, carers and advocate as appropriate.

Where there is any doubt about use of force, staff must record this as an incident as Use of Force. Where a patient resists any negligible use of force which results in the staff member increasing the support or changing into a trained RESPECT hold this must be recorded as physical restraint.

17. Weapons

Offensive weapons are defined in the Prevention of Crime Act 1953: 'Offensive weapon' means any article made or adapted for use for causing injury to the person, or intended by the person having it with him for such use by him or by some other person.

As the weapon's use is dependent on the intention of the person carrying it, such matters will be for the police, the prosecuting authorities and the courts to decide on and it is anticipated that most cases will be clear-cut – for example, is there a good reason for going to hospital with a broken table leg or iron bar?

Where staff are threatened with a weapon attempts should not be made to physically disarm the individual. Ask the service user to put the weapon down but on no account ask for the weapon to be handed to yourself.

Those present should attempt to keep the situation contained and call the police for assistance. They must also maximise withdrawal of others and themselves from the situation where possible.

For guidance on when to call for police assistance please refer to Appendix B

18. Practice Issues and Potential Use of Physical Interventions

Physical Interventions can be used in order to undertake different forms of treatment (e.g. Self-Harm, Personal Care, Vaccines, Medication, Medical investigations, etc.), where there is legal authority[2] to treat the individual without consent. It should not be used unless there is such legal authority.

Authority maybe gained through the use of such legislation as:

- Mental Health Act (1983),
- Mental Capacity Act (2005)
- Court of Protection

Further advice can be sought from the MH Legislation Dept. / PDPS team.

19. Pregnant Services User

For further guidance please refer to the Trust's 'Management and Care of Pregnant Service Users' Policy.

20. People With Intellectual Disability And Mental Health / Behavioural Problems: Guidance On Covid-19 For In-Patient Psychiatric Settings

There are approximately 1.2 million people with an intellectual disability (ID) in the UK. They have comorbid mental health problems at a rate of about 40%, which is substantially higher than the general population.

[2] Legal Authority refers to either consent as in the case of a person with capacity or that they are detained Mental Health Act (1983). Those who lack capacity and are not detained MHA would require the decision of a MDT, may be an IMCA involved and possibly Court of Protection involvement depending on the gravity of the decision

This vulnerability becomes more pronounced in the wake of the COVID-19 pandemic. The risk to this group can be conceptualised as

- Physical health: Increased risk of mortality and morbidity due to COVID-19
- Mental health: Increased risk of worsening mental health symptoms and behaviour that challenges or increased risk of mental illness relapses and behaviour that challenges. Some of this behaviour may lead to diagnostic overshadowing- ie, it may mask serious underlying physical conditions.

For latest guidance please refer to the HIVE.

21. Taking Blood Without Consent

The taking of blood under the Mental Health Act is authorised as an "ancillary treatment" for treatment with medications such as clozapine and lithium and can be enforced for detained service users who do not consent to blood testing.

The degree of resistance and its origins (e.g. religious objections) to the blood sampling should be taken into consideration where this approach is been considered.

Any other blood testing without consent should only occur after consideration of the criteria that need to be met for physical interventions to legally occur under the Mental Capacity Act:

- The person lacks capacity and it will be in the person's best interests *and;*
- It is reasonable to believe that it is necessary to restrain the person to prevent harm to them *and:*
- Any physical intervention is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm

Further advice can be sought from the MH Legislation Dept. / PDPS team.

22. Recorded Guidelines When Cohorting Service Users on Inpatient Wards

Psychiatric inpatients are particularly vulnerable to the transmission and effects of COVID-19. As such, healthcare providers should implement measures to prevent its spread within mental health units, including adequate testing, cohorting, and in some cases, the isolation of service users, this may in turn lead to anxiety / frustration amongst individuals culminating in aggressive outbursts.

For further guidance on how to implement Cohorting please refer to current guidelines on the Hive.

23. Medication

Any medication administered to prevent aggressive/violent behaviour should be administered in accordance with the Trust Medication policy and procedures, and subject to local team decision making in relation to MDT risk assessment and identified need. In some cases it may be necessary and appropriate to administer rapid tranquillisation. Guidance on rapid tranquillisation is given in the HPFT Management of Acute Behavioural Disturbance Policy.

Where Intramuscular Medication is used as part of a management approach this must be indicated within the Datix incident report form (secondary management section).

24. Seclusion / Longer Term Segregation

Seclusion / LTS must be undertaken in accordance with the Trust's 'Seclusion' Policy.

25. Searching Service Users And Their Property

The undertaking of necessary and lawful searches of both service users and visitors can make an important contribution to the effective management of disturbed/violent behaviour in psychiatric in-patient settings. Unlawful, insensitive and unnecessary searches can also exacerbate disturbed/violent behaviour. Searches should be undertaken in accordance with the HPFT Policy for "Searching Service Users and their Property."

26. Supportive Observations

Observations of service users must be based on comprehensive risk assessments and need.

For further advice please refer to the Trust's 'Safe and Supportive Observations' Policy.

27. Deprivation Of Daytime Clothing / Aids Necessary For Daily Living

Service users should never be deprived of appropriate daytime clothing during the day, with the intention of restricting their freedom of movement, neither should they be deprived of other aids necessary for their day living.

28. Safety Pods™

As part of a multifaceted approach to preventing and managing aggression within the Trust using the least restrictive approach, Safety Pods have been introduced. Currently the only Safety Pod which has been authorised for use is the Ultra-Shield Pod and leg cushion (For further advice / guidance please contact the PD&PS Team).

Training has been developed / incorporated into the Respect Training modules to meet the specific needs of introducing the Pods into clinical practice and staff must be trained in their use prior to using them.

Where the safety pod is used as part of a restrictive practice this is to be indicated within the Datix as highlighted; Use of Safety Pod – Supine, or Use of Safety Pod – Seated.

The use of safety Pods maybe incorporated in the service user's person centred care management approach.

As part of the weekly environmental checks the Pods need to be checked for signs of wear/tear, ripping, or deflation and should be reported/replaced or refilled by UK Safety Pods (UK) only.

29. Mechanical Restraint

Mechanical restraints (Handcuffs / Splints) are not a first-line response or standard means of managing disturbed / violent behaviour in acute mental health / learning disability care settings. In the event that they are used, it must be a justifiable, reasonable and proportionate response to the risk posed by the service user, and only after a multidisciplinary review has taken place. Legal, independent expert clinical advice should be sought and documented.

Use mechanical restraint only as a last resort and for the purpose of:

- managing extreme violence directed at other people or
- limiting self-injurious behaviour of extremely high frequency or intensity.

Health and social care provider organisations should ensure that mechanical restraint in adults is used only in high-secure settings (except when transferring service users between medium and high-secure settings and its use is reported to the trust board.

Consider mechanical restraint, such as handcuffs, when transferring service users who are at high risk of violence and aggression between medium and high-secure settings. In this context, restraint should be clearly planned as part of overall risk management.

30. Infection Prevention Control and Personal Protection Equipment

Staff must follow the current Infection Prevention Control and Personal Protection Equipment guidelines (N.B. Please see Covid-19 section on HIVE for specific issues).

31. Resuscitation Equipment / Staff Training

Where physical interventions or restrictive practices maybe used emergency equipment must be available as per Trust's 'Resuscitation' Policy.

All registered nursing staff must be 'Intermediate Life Support' trained and all other staff should be 'Basic Life support' trained.

32. Post Incident Clinical Review

A post incident review should always take place by the multi-disciplinary team following a violence & aggression incident. This should include the following:

- Review of Triggers and Pre-disposing factors.
- Review of Risk assessment.
- Review of care plan which should include involving the service user in taking are much responsibility as they can.
- Integrating the service user back into the environment.
- Development of a Positive Behavioural Support plan.
- MDT review of service user's legal status.

A review should also take place if the service user is moved to a more secure setting, medicines are changed or the service user is discharged or legally charged.

33. Support For Service User

Service user's experiences of staff dealing with aggression and violence can have a traumatic effect on their wellbeing and future recovery, therefore following an incident; the service user must be offered post incident support, to allow re-integration to normal unit activities.

Staff should plan the process of re-integration **with** the service user into the unit carefully, taking into account the individual needs and risks posed, so previous and current experiences of such events are considered to facilitate a value based approach to post incident support. Where a service user does not have the capacity to engage in this process, staff are to ensure they are aware of the recovery phase of the PBS Plan/ Care Plan and use these strategies.

This process should allow for opportunities to revisit any identified concerns or issues, so the level of support is continuous and relates to on-going care and presenting needs. The steps would include:

- All incidents are reviewed to offer immediate support so as to understand the impact of events and where possible proactive support is developed. This should be developed through on-going assessment, joint support plans, considering the impact of previous experience.

- Where practical to do so, support plans or the development of support plans are jointly reviewed to reflect presenting needs, this may include:

    - **FACTS:** Consider the facts and how they were seen by all parties: does the service user understand why restrictive practices were used and is there an opportunity to give context, emerging thoughts and feelings relating the such events

    - **FEELINGS:** How does the service user feel now, after the event?

        - Does the service user feel that restrictive practices were necessary / proportionate?

        - what is the outcome and plan to manage / resolve and support?: It is important to document actions, immediate plans and how differences / ongoing protection may be reconciled

    - **FUTURE:** How can we minimise the need for any further episodes of restrictive practices in the future?

        - Proactive: One to one review and basic support
        - Review support plans
        - Facilitate additional support based on need – this must include the view of the service user:

- Relatives carers / spiritual care
- External advisers / review if considered appropriate
- Literature & relevant information

- Offer agreed follow-up and review, so events are not stand alone, but a review and joint plan of continuous needs

Ensure that all details of post incident support process are fully recorded in the care record as part of the daily running record. This should include what or how on-going support / follow-up will look like. The Care Plan / Well Being Plan / PBS Plan should be updated to reflect this.

Following the use of restrictive practices it is essential that the nursing staff re-establish the therapeutic relationship with the service user.

34. Staff Post- Incident Support

For further guidance please see 'Guidelines for the Provision of Staff Welfare and Support following a Distressing or Critical Incident' Policy on the Trusts intranet: https://hertfordshirenhs.interactgo.com/Interact/Pages/Section/Default.aspx?Section=3159

Post-incident support is seen as a matter of good management practice, to limit wherever possible the effects of exposure to distressing workplace events. Responding appropriately to the needs of a member of staff who has been through a distressing experience is important and by using recognised methods the Trust will aim to make sure that everyone who has been involved in an incident can feel supported and be given an opportunity to talk about and work through their experience. Initially this support should be offered through the clinical management structure.

Where staff require further support staff or managers should review the Health & Wellbeing Section of the intranet: https://hertfordshirenhs.interactgo.com/Interact/Pages/Section/Default.aspx?Section=3295

or contact the:

Employee Assistance Programme

24/7 access to emotional, financial, legal and relationship support and advice

Tel: 0800 111 6387

Web: www.my-eap.com Username: HERTSNHSWELL

35. Damage To Personal Property

The Trust will consider reasonable claims for compensation in respect of damage caused to personal property as a direct result of a violent incident involving the employee who is owner of the property provided that the employee has taken all reasonable precautions to avoid the damage.

All claims should be made to the line manager (and police if appropriate) as soon as is reasonably possible after the incident and the appropriate documentation completed in line with standing financial instructions.

The Trust 'Standing Financial Instructions', gives details of ex-gratia payments to service users and staff for loss or damage caused by service users.

36. Assistance From Non-Clinical Staff

Assistance from non-clinical staff such as security guards (who are adequately trained) should be sought as early as possible before a potentially aggressive / violent situation can escalate.

The person in charge of the area must liaise with any helpers who arrive and be clear about what help is required from them.

37. Police Assistance

The events occurring will indicate at what point police assistance is required.

Where practicable, and where there is no clear emergency, it will be good practice to discuss any decision to call the police with the ward/unit manager or on call manager before doing so.

It may be appropriate to take account of any past police intervention with the service user before making a decision to call the police.

For guidance on when to call for police assistance please refer to Appendix B

Contacting Police:
In an emergency situation – telephone 999 or Local emergency number
(Use only for emergencies, for example when a disturbance is taking place in a ward etc.)

Remember:
999 calls receive a graded response to the call based on the information provided and the nature of the emergency. A 999 call will not automatically receive an enhanced response; it is therefore necessary to clearly deliver the urgency of the request and ensure accurate information is relayed to the operator to aid a prompt response:

- State – name and job title.
- State – exact location, hospital, ward/department, postcode
- State clearly the nature of the emergency e.g. violence, level of threat, weapons etc.
- Confirm the telephone number

The Trust will support staff in contacting the police for help in any situation in order to manage incidents.

Police will provide a graded response, When the police are involved the following details are required for the report:

- The attending Police officer's name and number
- The station they came from and telephone number
- What action the police are taking
- Crime reference number

Further advice is available within the Memorandum of Understanding, College of Policing: The Police Use of Restraint in Mental Health & Learning Disability Settings. http://www.college.police.uk/What-we-do/Support/uniformed-policing-faculty/Documents/ERG_Final_Copy.pdf

In some circumstances, the police may be called to manage patient behaviour within a health or care setting. In these cases, mental health professionals continue to be responsible for the health and safety of the person. Health staff should be alert to the risk of any respiratory or cardiac distress and continue to monitor the patient's physical and psychological wellbeing.

The Mental Health Units (Use of Force Act) 2018 states that whenever the police are called to assist mental health unit staff they are required to wear and operate a body camera at all times when reasonably practicable. If the police officer has a body camera they must wear and keep it operating (recording) at all times. However, there may be special circumstances that justify not wearing or operating a camera, it is for the police officer(s) to determine in line with current College of Policing guidance on the use of body cameras whether special circumstances apply.

38. CS, PAVA[3] spray and TASER guns

CS, PAVA[1] spray and TASER guns have been used very occasionally in mental health settings by the police. The police will only use PAVA or TASAR as a last resort and only when they have tried all other methods of control or in really serious cases e.g. extreme violence. If PAVA is used there is an information sheet that officers can give to the person sprayed and to the owner of the property where PAVA is used.

39. Electronic Patient Records (EPR)

All incidents must be recorded with the services users' EPR daily entries section and this should form the basis for review of the risk assessment and wellbeing Plan /Care Plan / Positive Behaviour Support Plan.

Where the incident is assessed such that this is a continued risk then staff must also update the EPR 'Alert System' thus highlighting the risk to others.

A DATIX must be completed as per Section 39.

[3] 2-chlorobenzylidene malononitrile (CS) and pelargonic acid vanillylamide (PAVA)

40. Incident Reporting (Datix) and Incident Review

Incident reporting

All incidents of violence and aggression involving service users, staff, contractors or visitors must be recorded on Datix, the Trust's electronic incident reporting system, **within 24 hours** of the incident occurring. In community services this should include instances where a service user is arrested or charged in connection to an assault of a third party. **This should include physical, verbal or mental abuse of staff or service users.**

Incident review

For near miss, no harm and low harm violence and aggression incidents at a minimum each incident should be reviewed by the relevant team manager to ensure all relevant details have been added, actions taken post incident, and areas of reflection are recorded prior to amending the status of the incident to 'completed'. There is a mandatory field on Datix for managers to complete where details of any investigation completed should be recorded. Where facts are not clear or there is felt to be a potential for learning the team manager should ensure that a 3 day report is completed. 3 day reports completed should always be added to the Datix record.

In April 2018 the Trust implemented a Moderate Harm Panel which meets weekly to review incidents reported on Datix reported as moderate harm and above which would include incidents of violence and aggression. Decisions are made on those that meet the threshold for reporting as a serious incident in keeping with the NHS Serious Incident Framework. Outcomes are added to the Datix record and any learning disseminated. There is an expectation that 3 day reports will be completed for incidents of moderate harm and above to establish facts, identify notable practice and any areas of reflection. On an exception basis the Panel may decide they have sufficient information and a 3 day report won't be needed.

If a violence and aggression incident is reported as a serious incident an investigator will be allocated by the SBU Management Team who is independent of the team where the incident occurred to undertake the investigation and complete a report.

As part of local governance processes teams should have in place a process for regular review of their violence and aggression data to enable monitoring of trends and themes and to identify where further actions may be needed.

Consideration should always be given by the team whether a violence and aggression incident against a person or Trust property is assessed as being a crime; this should then be reported to the Police. Details of the Police Unique Reference Number (URN) should be requested and recorded in the incident form. Statements will be requested and taken by the Police in processing of a crime and staff should be supported by their managers to ensure this happens.

Service users who are assaulted have the right to make a complaint to the Police. Staff should support service users in this process. The manager of the area should be informed if Police are contacted.

The Trust has a joint working protocol in place with the Police. Advice can be sought from the Trust's Health, Safety and Security Lead.

Please refer to the Safeguarding Adults Policy where there is a safeguarding issue identified.

Please refer to Incidents & Serious Incidents Requiring Investigation Policy

Following an incident of violence or aggression clinical notes on the Trust's electronic patient record systems and any additional supporting documentation such as observation record sheets must be completed as soon as possible after the event in line with Trust policies and procedures. This should include taking witness accounts or staff statements as soon as possible after the incident.

Where a service user has exhibited or has a history of violence and aggression then this should be highlighted using the PARIS ALERT NOTE to ensure other staff working with the service user are made aware of potential risk.

Staff should ensure that they know their legal rights and should be advised to seek advice from their Union or staff organisation when required. Staff side to be consulted on terms of reference relating to the investigation of violence and aggression towards staff.

The findings of the investigation will be shared with the staff member and with the relevant Team Manager for the purposes of learning. Key points of learning to be presented at the Safety Committee.

For further guidance on incident reviewing process see Appendix Q.

41. Complaints

Service users must be aware how to make a complaint. Any complaints must be investigated following the Trust Complaints Procedure.

Staff may wish to consult their own professional association or Trade Union for advice.

42. Training

The Trust provides such training as is necessary to ensure, as far as is reasonably practicable, the Health & Safety at Work of its employees. A range of training opportunities is available to allow staff to gain and enhance their skills.

All staff whose need is determined by the Environmental Risk Assessment above must receive ongoing mandatory training as set out in the Training Needs Analysis, per 'Relating to People' programme.

The manager/supervisor must identify which training module from the Relating to People (R2P) training their staff are required to attend following a risk assessment and the mandatory training guidance agreed within their SBU.

If staff believe they require more training than indicated as required by their line manager, they should discuss this in more detail within supervision.

In addition to the manager providing the risk assessment for staff, help and guidance can be obtained from the Practice Development & Patient Safety Team. Further details of training are given in Appendices M and N.

The Mandatory Training planner can be found on the Hive or through the local training managers of services outside of Hertfordshire.

Where staff who have attended the relevant training and have been 'referred' or 'failed' to achieve the required learning objectives then the line manager must complete an occupational risk assessment and liaise with human resources regarding the appropriateness of continuing to work within the area.

All staff are responsible for maintaining their required level of training identified within the training matrix for their need including refresher training.

Where staff fail to attend the identified training / achieve the required course learning objectives / maintain refresher training as required then this should form part of the individual's personal development plan and where necessary further advice should be sought from Human Resources.

All bank staff should have received the relevant Trust training for the area they are required to work in as discussed above before being employed in those areas. Where this is not the case then the bureau / agency should manage the situation as above.

The Agency who provides staff to work within HPFT are required to provide the necessary PMAV training as highlighted above before their staff can work within the Trust.

The Trust will monitor the competency of Agency staff and make recommendations as necessary.

43. Training Matrix:

Course	For	Renewal Period		Delivery Mode
Module 3b (RESPECT Training ©)	Medical Staff. Community Nurses. Pharmacists. Social Workers. Allied Health Professionals (Non-Inpatient). Psychological Therapies.	Once followed: Annual Refresher	Taught course – 1 day. Taught course - ½ day.	For taught courses, contact the Learning & Development Team. You can check for future dates within Discovery, and request a specific date
Module 4 (RESPECT Training ©)	In-patient Registered & Non-Registered Nurses. In-patient OT's.	Once followed: Annual Refresher	Taught course – 4 days	As Above

	(For staff not listed in Module 5)		Taught Course – 1 day.	
Module 5 (RESPECT Training ©)	PICU, MSU Services, LSU Services, Assessment & Treatment Services, Acute services.	Yearly	Taught course – 2 days	As above
Combined Module 4/5 Course.	PICU, MSU Services, LSU Services, Assessment & Treatment Services, Acute services.	Once followed: Module 5 Annual Refresher	Taught course – 2 days	As above

44. Process for monitoring compliance with this document

- Practice Development and Patient Safety Team are responsible for the extrapolation / dissemination of restrictive practice data to Strategic Business Units on a monthly basis. This data then forms the quarterly Integrated Safety Report.

- Strategic Business Unit Patient Safety Groups to monitor trends and targets concerning restrictive practices and feedback through the Safety Committee Group on a monthly basis.

- The Restrictive Practice Group monitors trends and action plans regarding SBU Data and reports their finding to the Safety Committee.

- Practice Development and Patient Safety Team produces Quarterly Safety and Annual Safety Reports.

- The data is presented to the Quality Risk Management Committee, the Integrated Governance Committee and Trust Board.

- Practice Development and Patient Safety Team produce the Data for the MHMDS monthly, SSQD quarterly and CQC data as required.

Key process for which compliance or effectiveness is being monitored	Monitoring method (i.e. audit, report, on-going committee review, survey etc.)	Job title and department of person responsible for leading the monitoring	Frequency of the monitoring activity	Monitoring Committee responsible for receiving the monitoring report/audit results etc.	Committee responsible for ensuring that action plans are completed

Restrictive Practice Data	Extrapolation of data from Datix, producing the Mental Health Minimum Data Sets and Making Our Service Safer Report.	Senior Professional Lead: PMAV Team Practice Development Patient Safety Team	Monthly	Mental Health Minimum Data Sets – External / Internal. MOSS DATA – Ex Dir., Medical Directors, HON's, PG Leads,	Safety Committee, Health Safety and Security Committee, SBU: Patient Safety Groups.
Training Data	Report of training compliances	Learning and Development Team	Monthly	Learning and Development Team	Safety Committee, Health Safety and Security Committee, Restrictive Practice Committee, SBU: Patient Safety Groups.

Part 3 – Document Control & Standards Information

43. Version Control

Version	Date	Author	Status	Comment
V3	November 2005	Senior Professional Lead: Prevention Management of Aggression & Violence	Superseded	Archived
V4	19.8.08	Senior Professional Lead: Prevention Management of Aggression & Violence	Superseded	Archived
V5	April 2012	Senior Professional Lead: Prevention Management of Aggression & Violence	Superseded	Archived
V6	6th October 2017	Senior Professional Lead: Prevention Management of Aggression & Violence	Superseded	Archived
V6.1	7th October 2019	Senior Professional Lead: Prevention	Superseded	Section 33, 34 & 35 combined and updated.

		Management of Aggression & Violence		
V6.2	September 2020	Senior Professional Lead: Prevention Management of Aggression & Violence	Superseded	Archived
V7	12th May 2021	Senior Professional Lead: Prevention Management of Aggression & Violence	Superseded	Full Review
V8	20th June 2022	Head of Safety	Current	Full Review

44. Embedding a culture of equality and respect

The Trust promotes fairness and respect in relation to the treatment, care and support of service users, carers and staff. The Trust is committed to minimising the use of force through the promotion of positive cultures, relationships and approaches that understand the trauma history and triggers of individuals, and that will prevent escalation and any need to use force.

Respect means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity. The Trust need to ensure services are culturally appropriate, and respectful and responsive to the cultural differences, beliefs and practices of the patient population being served. This should include understanding of cultural identity and heritage, and the discrimination faced by many people from Black and minority ethnic backgrounds, in particular by black men. The use of force can have serious and sometimes fatal consequences, as was the case of Olaseni (Seni) Lewis, a young black man who lost his life following the disproportionate and inappropriate use of force in a mental health unit. This prompted the introduction of the Mental Health Units Use of Force Act 2018 also known as Seni's law.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

As part of the process described in section 32-33. 'Post Incident Review' and 'Support For Service User' the following should be considered;

Evaluate, together with the service user, whether adjustments to services are needed to ensure that their rights and those of their carers (including rights related to protected characteristics as defined by the Equality Act 2010) are respected, and make any adjustments that are needed.

Adjustments might include providing a particular type of support, modifying the way services are delivered or the approach to interaction with the service user, or making changes to facilities.

Any changes must be recorded within the service user's care plan.

Service user, carer and/or staff access needs (including disability)	This policy offers a framework where service user can be supported in the least restrictive manner ensuring the safety of staff, services user and others within HPFT services.
Involvement	The policy aims to provide a process by which service users are cared for in the least restrictive manner taking into account their advance statements and decisions.
Relationships & Sexual Orientation	The policy should be applied taking into account family, partners and carers who are providing support to the person receiving the service. For all relationship presentations the same rules should apply.
Culture & Ethnicity	It is recognised that some service users from ethnic minority backgrounds may require further support for example interpreting services.
Spirituality	This policy should not specifically impact on this area however it must be read in conjunction with existing practices.
Age	This policy impacts on all age groups and as such should be read in conjunction with existing practices and reasonable adjustments should be made where appropriate.
Gender & Gender Reassignment	It is recognised that this policy may impact on this area and where there is conflict staff should make reasonable adjustments to meet the individual's needs.
Advancing equality of opportunity	The purpose of this policy is to ensure service user needs are met with the least restrictive manner.

45. Relevant Standards

- NICE, NG10, Violence and aggression: short-term management in mental health, health and community settings (2015)
- NHS Litigation Authority (2014)
- Standards for Better Health
- Violence Prevention and Reduction Standards (2020)

46. Associated Documents

This Policy should be used in conjunction with the following HPFT policies all of which can be accessed via the staff intranet:

- Harassment at Work
- Advance Directives
- Learning from Adverse Events Reporting, Managing and Investigating
- Records Management and Management of Care Records
- Searching Service Users and their Property
- Complaints
- Working out of hours, travelling and long workers
- Medicines Policy
- Guidelines for the Care and Management of Pregnant Service Users
- Single Equalities Scheme
- Acute Behaviour Disturbance (Rapid Tranquillisation) Policy
- Sharps And Inoculation Injuries
- Health & Safety Policy
- Seclusion & Longer Term Segregation
- Guidelines for the Provision of Staff Welfare and Support following a Distressing or Critical Incident

47. Supporting References

The following references and guidance are applicable to this policy:

- NICE NG10. Violence and aggression: short-term management in mental health, health and community settings (2015)
- Positive and Proactive Care: reducing the need for restrictive interventions (2014)
- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges
- Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings (2016)
- Restraint Reduction Network Training Standards (2019)
- Code of Practice for Trainers in the Use of Physical Interventions. BILD publications.
- Conflict Resolution Training, NHS Security Management Services 2004
- NHS Security Management Service Framework for reporting and dealing with non-physical assaults 2004 (available from www.cfsms.nhs.uk)
- Department of Health (2000). Zero Tolerance Pack. Department of Health. Leeds.
- Department of Health and Department for Education and Skills (2002). Guidance for Restrictive Physical Interventions. Department of Health Publications. London.
- The NIMHE "Mental Health Policy Implementation Guide, Positive Practice Standards
- National Institute for Clinical Excellence (2005), Clinical Guidelines 25, The Short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.,
- United Kingdom Central Council (2002). The Recognition, Prevention and Therapeutic Management of Violence. UKCC Publications. London.
- Department of Health (1999) Health Service Circular 1999/226 Campaign to stop violence against staff working in the NHS: Zero tolerance zone. HMSO: London
- Department of Health (2005) Delivering Race Equality in Mental Health Care and the Government's response to the Independent Inquiry into the death of David Bennett
- Department of Health (2001) Health Service Circular 2001/18 Withholding Treatment from Violent and Abusive Patients in NHS Trusts
- National Patient Safety Agency (2004) Understanding the patient safety issues for people with learning disabilities.

- Secretary of State Directions on work to tackle violence against staff and professionals who work in or provide services to the NHS. Department of Health, Counter Fraud and Security Management, November 2003 http://www.nhsbsa.nhs.uk/security
- Prevention of Crime Act, 1953. UK Gov.
- Violence prevention and reduction standard (2020)
- Covid-19 Guidance (2020).
- Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England, and police forces in England and Wales

48. Consultation

The following People and Groups were consulted:

Job Title of person consulted
Practice Development & Patient Safety Lead
Inclusion & Engagement Team Manager
Head of Safer Care and Standards
Datix Lead
Directorate Manager (Mental Health Legislation)
MHA Operational Manager
Deputy Director Quality and Safety
Heads of Nursing
Medical Leads
Restrictive Practice Committee
Policy Development Group including service user representation.
Experts by Experience

Additional clinical guidance

Showing respect for diversity generally includes the following:

• creating and sustaining inclusive environments where every patient feels valued, listened to and supported.

• recruiting and supporting diverse staff groups which reflect the local community.

• positively challenging practices and behaviour which have the potential to cause patients or staff to feel degraded and/or excluded.

• an outline of the law covering all the protected characteristics under the Equality Act 2010; this should recognise the distinct experience of abuse, discrimination and inequality experienced by groups with different protected characteristics.

• how to demonstrate respect for individual beliefs, values, cultures and lifestyles and appreciating the differences.

Avoiding unlawful discrimination, harassment and victimisation includes the following:

As with 'Showing respect for diversity generally' an outline of the law covering all the protected characteristics under the Equality Act 2010; this should recognise the distinct experience of discrimination, harassment and victimisation experienced by groups with different protected characteristics. This should cover in particular:

• direct discrimination (for example on the basis of disability, race, age, or sex).

• indirect discrimination.

• reasonable adjustments, and how they are relevant to use of force (for example environmental changes).

• The Public Sector Equality Duty

• how use of force monitoring and data can identify themes and issues which affects those involved (patients, staff and managers) and in turn, how this should be acted upon.

• the important role of independent advocates in helping patients to challenge the inappropriate use of force

The use of techniques for avoiding or reducing the use of force includes the following:

• understanding the challenges and constraints experienced living in mental health units (for example the impact of living under blanket restrictions, sensory issues, missing family and friends, being away from familiar surroundings, or feeling unsafe)

• recognising the high levels of trauma amongst patients in mental health units, particularly among women and girls, people with autism or a learning disability, and people from black and ethnic and minority backgrounds

• creating positive physical environments

• person-centred care, including preventative approaches such as Safewards and where applicable Positive Behaviour Support

• conflict avoidance and resolution (within inter-personal relationships and groups)

• staff clinical supervision, reflective practice, and development and mentoring

• understanding of the difference between coercion or threatening to use force and de-escalation so that staff understand that trying to gain compliance through coercion or threats is not ethical or in line with the least restrictive approach (see the section on training to understand the effect of a threat to use force and coercion)

The risks associated with the use of force includes the following:

• preparing care plans which identify individual risks associated with the use of force, and how these risks are minimised (including by not using force)

• physical, psychological and emotional effects on those subject to the use of force

• physical, psychological and emotional effects of witnessing the use of force

• physical, psychological and emotional effects on staff applying the use of force

• the risk of deaths and serious injuries caused by, or connected to, the use of force

• medical emergency procedures – to include vital signs monitoring and response, and raising the alarm if concerned about a patient's health

• roles and responsibilities during an incident – in the exceptional event of the police being called to assist staff in the management of a patient, it is important that everyone is aware of the role of the police and the healthcare staff in managing the incident properly and safely, and the procedures to be followed

The impact of trauma (whether historic or otherwise) on a patient's mental and physical health includes the following:

• the impact of sexual, physical and emotional abuse on survivors' experience of the use of force

• coping with loss, fear and anxiety

• strategies for building self-esteem and regaining a sense of control

• modelling non-violent, healthy relationships

• understand the meaning of 'trauma' and how it can impact on people's experience of use of force

• how the use of force can trigger a trauma memory

• understanding that the use of force can be traumatic for patients experiencing it and the staff applying it

• considering how the sex of the person applying the use of force could trigger trauma memories for certain patients, particularly women and girls who are disproportionately likely to have experienced violence and abuse from male perpetrators

• recognition of potential symptoms of trauma and how behavioural symptoms can be linked to trauma

• an understanding of trauma through a developmental perspective that applies to all ages not just children

The impact of any use of force on a patient's mental and physical health includes the following:

• the impact of use of force in further traumatising or re-traumatising patients whose mental ill health may already have been exacerbated by forms of trauma

• ensuring use of force is never applied as a punishment or as a means of causing pain, suffering or humiliation

• the impact of the sex of the person applying the use of force to the patient and the sex of the patient subject to the use of force

• the impact of the use of force in relation to the age of the patient

• the impact of the use of force in relation to the person's health condition or impairment

The impact of any use of force on a patient's development includes the following:

• risk of unmet or misunderstood needs being conceived as wilful, challenging behaviour (leading to coercive and punishment-based interventions)

• preventing institutionalisation and preparing patients for family life and relationships within the community

How to ensure the safety of patients and the public includes the following:

• the process by which patients and their families or carers are informed of the approaches and techniques which may be used

• the process by which patients and their families or carers are involved in agreeing their own care plan and arrangements to take active steps to prevent and pre-empt distress and conflict arising

• the impact of the use of force on staff's mental and physical health whether this is caused by a patient's physical aggression or by observing the use of force and how this is mitigated within the organisation

• the role of observers in any use of force incidents

• the role of independent advocates in assisting patients and their families or carers in agreeing plans and raising concerns about the use of force

• Duty of Candour in regulation 20 of the 2014 Regulations in respect of the use of force

The principal legal or ethical issues associated with the use of force includes the following principles (from Positive and Safe Care 2014):

• the use of force must never be used to punish or be for the sole intention of inflicting pain, suffering or humiliation

• there must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken

• the nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm

• any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need

• any restriction must be imposed for no longer than absolutely necessary

• what is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent

• use of force must only ever be used as a last resort

• the involvement of people who use services, carers and independent advocates is essential when reviewing plans for the use of force

• understanding of human rights and discrimination legislation and how this interacts with other mental health, and health and social care legislation

• the (very limited) circumstances in which the use of force is appropriate and what are the reasons for its use or not; The legal framework for use of force but, in particular circumstances justifying the use of force *Mental Capacity Act 2005*

• the rights of service users and staff to be in a safe environment

Trauma informed care and practice

Trauma, both personal or caused by the system, whether historical or current is an area of care and practice for us to address as part of improving safe and positive care and reducing restrictive practices. We will strive to be increasingly trauma aware and sensitive to the impact of actual, potential, and vicarious trauma on the lives of everyone who encounters services, including those who work within it. This will involve the integration of trauma informed care into all of our training and specific training in teams to support this.

Therapeutic environments and activity and dedicated space for calming, soothing and de-escalation

A therapeutic environment provides the best opportunity for recovery and wellbeing. Meaningful Activity is essential to this, and a key component in reducing restrictive practice, a purposeful admission, enhancing health and wellbeing and making the stay of service users more positive.

Activity, and the way it is delivered provides, (amongst other things):

• A meaningful conduit for therapeutic engagement and developing therapeutic relationships

• Can be used to cope with symptoms and the challenges that living on an inpatient ward can bring

• Promotes maintenance and development of individuals skills, roles and routines. The ward is a place where people can discover or rediscover skills and values that can be taken forward into the community

• Offer people an opportunity to take an active role in promoting their own recovery and mental wellbeing

• Can alleviate boredom and supports the model of recovery and wellbeing

A programme of activities will be available throughout the day and week and be a key component of the service users care and treatment: It will be seen as routine and as essential as medication.

Activity will be embedded in the ward culture, owned by all and be routinely and consistently offered as part of the therapeutic model of care.

To support this there needs to be

• Identified spaces and rooms both on and off the ward (in and outdoors) that 1:1 and group activities can take place

• A range of resources and equipment: leisure, creative, educational etc.

Staff knowledge, skills and training

Staff education and training are essential to promoting and supporting calm, safe and respectful environments where the use of force is kept to a minimum. It is essential that staff are properly trained to provide safe, trauma informed, person centred care, where people are treated with dignity and respect and their views and feelings are understood and their specific needs are met. Training provided will support an overall human right-based approach, which is focussed on the minimisation of the use of force and ensures any use of force is rights respecting. Training will focus on creating a positive environment for care which pre-empts, takes active steps to avoid, or de-escalate distress and conflict. Staff will be skilled and knowledgeable to know when they can and should use appropriate and proportional force, as well as be able to recognise what is inappropriate or excessive use force. Training will be co-designed and delivered with those with live experience. The training is certified with NAVIGO as part of the Restraint Reduction Network and is also supported by the Safewards implementation programme.

Collaboration and care planning

Service users and their families/carers (where relevant) will be involved in the planning, development and delivery of care and treatment. This will show respect for service users past and present wishes and feelings. Response to distress will be included, as part of knowing the person, and will form part of the care plan. Crisis response plans and Positive Behaviour support plans will also be part of this.

Where force has been used or is predicted to need to be used, the care plan will set out ways of supporting future prevention as well as post situation follow up and care.

Safewards

The clinical model of safe wards is to be embedded across all inpatient services as a way of improving safety and harmony between staff and services users by working together on

the interventions, which support the reduction of flashpoints and conflict and support the non-use of force**.** The Safewards Model depicts six domains of originating factors: the staff team, the physical environment, outside hospital, the patient community, patient characteristics and the regulatory framework. These domains give risk to flashpoints, which have the capacity to trigger conflict and/or containment. Staff interventions can modify these processes by reducing the conflict-originating factors, preventing flashpoints from arising, cutting the link between flashpoint and conflict, choosing not to use containment, and ensuring that containment use does not lead to further conflict. The trust is adopting the implementation of the interventions from Safewards in a structured, supported way. The interventions are included within the Respect training and are as follows:

- Clear Mutual Expectations
- Soft Words
- Talk Down
- Positive Words
- Bad News Mitigation
- Know Each Other
- Mutual Help Meeting

Examples Requiring a Police Response

An immediate risk to life and limb

A patient has returned from authorised s17 leave and is in possession of a large knife. If the patient produces this weapon and threatens harm to staff an immediate police response will be necessary. If that patient left the weapon unattended in their room and staff can safely take possession of it, immediate police attendance would not be proportionate.

Immediate risk of serious harm

A patient is exhibiting disturbed behaviour on a ward after returning from leave believed to be under the influence of drugs. Nursing staff have attempted to seclude the patient for their own and others' safety following one nurse being punched causing grievous injury which requires assessment in an Emergency Department. Nurses are now asking for police support to complete the seclusion because of the further risk of serious harm to staff. A police response would be appropriate.

Serious damage to property

A patient in an inpatient unit has caused damage to ward infrastructure including a kitchen area where they have broken chairs, tables, windows and appliances, the floor is covered in debris and the patient continues to cause damage and throw the debris around the room. A police response would be appropriate.

Offensive weapons

A patient has told staff upon return from leave that they have a knife on them for their own protection because they believe that nursing staff will harm them by giving them more drugs. It is known the patient has a history of possessing offensive weapons or sharply pointed implements. A police response would be appropriate.

Hostages

A patient has closed the door to their own room whilst a nurse is inside and is shouting, threatening to harm the nurse if anyone enters the room. The patient is asking to be allowed out of the unit as a condition of releasing the nurse and state they will harm them unless this is agreed to. There is no indication one way or the other as to whether the patient has a weapon and the noise from within the room suggests that furniture has been piled against the door to block entry. A police response would be appropriate.

College of Policing: Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings (2015)

HPFT ENVIRONMENTAL RISK ASSESSMENT

Hertfordshire Partnership NHS Foundation Trust			VIOLENCE & AGGRESSION Assessor Signed By Manager……Date of Risk Assessment							
What are the Hazards?	**Who might be harmed and how?**	**What are you already doing?**	**Consequence** 1-Insignificant 2-Minor 3-Moderate 4-Major 5-Catastrophic	**Likelihood** 1-Rare 2-Unlikely 3-Possible 4-Likely 5-Almost certain	**Risk Grading** SxL = Risk Grading	**What further action is necessary?**	**Action by whom**	**Action by when**	**Done**	**Review**
Lone working Aggression in confined spaces Unintentional physical assault Aggression due to mental instability while carrying out personal care Escorting unpredictable service users Verbal abuse from service users	Staff Staff Staff Staff Staff Staff	Carry out clinical risk assessment Constant observation Carry out dynamic clinical risk assessment Training on dealing with complaints professionally				Provide information to include emergencies. Multi discipline discussion on how hazards & risks can be eliminated or reduced. Remove from situation. Ensure escape route to safety. Constant clinical assessment by staff in a dynamic manner to assess threat level Clinical risk assessment observation. Cover arms to prevent scratches etc. Carry out constant dynamic clinical risk assessment Assign a mentor if required				

DE-ESCALATION OF POTENTIAL NON-PHYSICAL AND PHYSICAL ASSAULTS

A service user's anger needs to be treated with an appropriate, measured and reasonable response.

Staff should accept that in a crisis situation they are responsible for avoiding provocation. It is not realistic to expect the person exhibiting disturbed/violent behaviour to simply calm down.

Staff should learn to recognise what generally and specifically upsets and calms people. This will involve listening to individual service user's and carer's reports of what upsets the service user, and this should be reflected in the service user's care plan.

Staff should be aware of, and learn to monitor and control, their own verbal and non-verbal behaviour, such as body posture and eye contact etc.

Where possible and appropriate, service users should be encouraged to recognise their own trigger factors, early warning signs of disturbed/violent behaviour, and other vulnerabilities. This information should be included in care plans and a copy given to the service user. Service users should also be encouraged to discuss and negotiate their wishes should they become agitated

Where de-escalation techniques fail to sufficiently calm a situation or service user, staff should remember that verbal de-escalation is an ongoing element of the management of an escalating individual. Verbal de-escalation is supported but not replaced by appropriate physical intervention.

De-escalation is always the preferred intervention when confronted with violence. This should only be superseded when delaying the use of other interventions which result in physical harm. In order to de-escalate a violent or potentially violent situation, staff should always act in a calm and confident manner. Open body posture, non-personalised approach and the display of active listening skills can reduce a violent response. It is essential for staff to be able to demonstrate confidence in the de-escalation techniques. The following guidance should be followed.

Verbal Skills: Staff should attempt to convey that their situation is understood by helping the person to talk about whatever it is that is troubling them by firstly adopting an unhurried approach and;

- Use the person's preferred name
- Focus on the emotional content, use a soft tone of voice if possible
- Only use facts, don't make promises that can't be kept
- Ask the person to put down (not hand over) any weapons
- Help the person address the reasons for the outburst step by step
- Offer alternative solutions to the problem
- Avoid making the person lose face
- Build on the service user's strengths helping them take control of their actions
- Remind the person throughout the conversation of your name
- Do not rush your response or the individual.

Non-verbal Skills: The following skills can be used in conjunction with the verbal skills above;

- Avoid confrontation in front of other people where possible
- Avoid/reduce 'audiences'
- Be aware of opportunities in the environment for exit (own and other person's)
- Be aware of opportunities in the environment for the use of weapons
- Avoid sudden movements
- Avoid sustained eye contact and standing directly in front of the person
- Avoid cornering the person
- Show warmth and continued calmness
- Create space by moving furniture or stepping back
- Use an open posture

If appropriate, sit near or next to the person e.g. using arms of chair to lower height, do not tower over the person

Physical intervention should be avoided if possible, but may be necessary if it seems that someone will otherwise be hurt.

De-escalation techniques: One staff member should assume the lead of a potentially disturbed/violent situation.

The staff member who has taken the lead should:

- consider which de-escalation techniques are appropriate for the situation
- manage others in the environment, for example removing other service users from the area, enlisting the help of colleagues and creating space
- explain to the service user 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.

The staff member who has taken lead should ask for facts about the problem and encourage reasoning. This 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 service user'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 service user concerns.

The staff member who has taken the lead should ensure that their own non-verbal communication is non-threatening and not provocative. This will involve:

- paying attention to non-verbal cues, such as eye contact and allowing greater body space than normal
- adopting a non-threatening but safe posture

- appearing calm, self-controlled and confident without being dismissive or over-bearing.

Where there are potential weapons the disturbed/violent person should be relocated to a safer environment where at all possible.

Where weapons are involved a staff member should ask for the weapon to be placed in a neutral location rather than handed over.

Staff should consider asking the service user 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 practiced, the seclusion room should not routinely be used for this purpose.

SUBSEQUENT ACTION
- SPECIFIC REMEDIES REGARDING NON-PHYSICAL ASSAULT

Before undertaking the following process consideration should be given regarding the specific communication needs of the individual. Staff should be aware of the individual needs such as communication, capacity to understand and where necessary reasonable adjustments must be made. Staff may want to engage with Advocacy, Speech and Language Therapist, MENCAP guidance etc. before engaging with the individual.

a) Informal Action
Initially, incidents should be managed informally unless the incident is of a serious nature warranting moving straight to formal action e.g. an actual or anticipated physical assault on a member of staff.

In the case of non-physical assault the seriousness of the incident needs to be considered. Verbal abuse could be dealt with through a warning letter, but where verbal abuse involves threats the police should be involved.

Hate crime e.g. that motivated by racism, religion or belief, homophobia or a person's disability can be discussed with a local Hate Crime office who are specially trained police officers.

The harassment of individual members of staff should be dealt with using the Harassment at Work policy and procedure.

The line manager should write to the visitor, relative or carer informing them that their behaviour is unacceptable and reinforce the Trust Policy. The letter should be written in language which meets the individual's communication requirements. If required, the Trust document "Guide to Translating Service User Written Information provides details of organisations for the translation of letters, if required.

Attempts should be made in the letter to clarify the situation. It may be that the actions were a result of fear and assurances can be obtained that there will not be a reoccurrence. In this case, no further action may be required.

In many cases, the harasser may stop without the need for any further action.

If the harassment persists after an informal approach, which has included the line manager's intervention and a written advice about their behaviour, or the behaviour has been recorded as too serious for an informal approach, then a formal approach should be considered.

b). Formal action
If all reasonable steps have been taken informally, and have not been successful, formal action should be taken.

There should be a meeting of the staff team, senior managers, health and safety and security advisors and, where appropriate clinicians involved in a service user's care, to decide what action to take. The meeting should consider the seriousness of the incidents. The meeting also needs to be mindful of any support needs of the harasser, e.g. they may be receiving a service from another section of the partnership Trust.

Clear evidence of unacceptable behaviour is required and there must be evidence that all reasonable action has been taken before using the formal route. Legal advice may be required which should be accessed through the Trust Risk Management Department.

Details of possible action are set out below:

Formal Letter A senior line manager to write a formal letter to the visitor, relative or carer informing them that their behaviour is unacceptable and any further incidents will not be tolerated. This letter should make clear the consequences of continuing their unacceptable behaviour. Advice should be sought from the Trust Risk Manager on the wording of the letter which should meet the individual's communication needs. The Trust document "Guide to Translating Service User Written Information" provides details of organisations for the translation of letters.

Acknowledgement of Responsibilities Agreement (ARA) This is a written agreement between parties aimed at addressing and preventing the recurrence of unacceptable behaviour. The sample letters are given in Appendices E-G **These letters are for guidance and should be adapted for the communication needs of the individual involved.**

Generally (ARAs) should be used with caution when concerning service users as incidents are responded to within the care plan. (Refer to Section 28 'Treatment Withdrawal'.)

Sample letters for dealing with violence and aggression towards staff in community hubs are given in Appendices H-I. **These letters are for guidance and should be adapted for the communication needs of the individual involved.**

Exclusion from Trust Premises If a decision is reached that the person is not permitted to visit the area for either a specified period or indefinitely or be excluded from direct involvement with health/social care staff.

If the person is the parent or guardian of a child receiving treatment, service managers need to ensure as far as possible that the child's care is not compromised.

Any decision to ban an individual from visiting the Trust must be documented on an incident form, with a copy of the letter sent to the individual attached. The sample letters can be adapted for this purpose.

Legal Process If the police have not already been informed, a decision will need to be reached as to whether or not to inform the police and arrangements made to support the process should criminal charges be brought. The advice of the Local Security Management Services Manager and the Risk Management Department should be sought who will liaise with the Security Management Services Legal Protection Unit regarding consideration of further action.

For clarification of legal proceedings refer to the Local Security Management Manager or the Trust Risk Management Department

0All concerned must be kept informed and support must be offered by the manager to members of staff or the key worker if a service user is involved. The Risk Management

department will also support the individual if a court appearance is necessary.

Where the matter has been reported to the police and the police have decided not to pursue the matter, the Trust should consider whether to initiate private prosecution and/or civil proceedings. The SMS Legal Protection Unit works with health bodies and provides advice on cost-effective methods of pursuing a wide range of sanctions against offenders.

Acts of damage to Trust property must be reported to the police and documented on an incident form.

Staff who are injured as a result of a violent or aggressive incident can make a claim to the Criminal Injuries Compensation Agency and will be supported by the Trust in this action. For further details refer to the CICA website: www.cica.gov.uk

Glossary of Terms:

Advance decision A written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future.
Advance statement A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.
Advocate A person who represents someone's interests independently of any organisation and helps them to get the care and support they need.
Physical Interventions A skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user.
Self-harm Deliberate harm to oneself as a way of dealing with very difficult feelings, painful memories or overwhelming situations and experiences.
Violence and aggression A range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained, or the intention is clear.

Acknowledgement of Responsibilities Agreement (ARA)

ARAs are an option that can be considered for relatives or visitors, to address unacceptable behaviour where verbal warnings have failed or as an immediate intervention depending on the circumstances. ARA is a written agreement between 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 more serous behaviour.

Generally (ARAs) should be used with caution when concerning service users as incidents are responded to within the care plan. (Refer to Section 28 ‘Treatment Withdrawal’.)

NB: ARAs should be used with caution where a perpetrator may not be responsible for their actions. If the relative or visitor is also a service user any action should take place in conjunction with clinical option.

Other than in exceptional circumstances, for anyone under the age of 16 (an ARA with the child's parents(s) or guardian(s) may however be appropriate).

All key stakeholders and relevant personnel, including staff union or professional representatives, should organise and attend a pre-meeting to discuss conditions.

Where it is considered **safe** to do so, the perpetrator should then be invited to attend a meeting where the agreement is made. Appropriate persons should attend, but careful consideration should be given to the number of staff attending as the situation could be perceived as intimidating and threatening to the perpetrator if too many are present. Involving the perpetrator in the process is important as it may encourage them to recognise the impact of their behaviour take responsibility for their actions and improve their behaviour.

The agreement itself should specify a list of acts or behaviours which an individual has been involved in with a view to get agreement and cooperation from them not to continue their behaviour.

ARAs should last at least for a period of six months, however, any reasonable period can be specified depending on the nature of the behaviour addressed, with a balance of both general and specific recommendations. The terms of the ARA should be outlined formally in a written document for the perpetrator a copy of which they should be asked to sign.

The terms of the agreement must be written in a manner which can be easily understood by the individual concerned. If they sign, and the unacceptable behaviour ceases, it may be appropriate to acknowledge this in a letter to the perpetrator.

The meeting should be planned and organised appropriately in order to avoid intimidation. Cultural and ethnic sensitivities should be borne in mind in order to ensure that all possible aggravating factors are excluded at the outset. ARAs are in no way linked to criminal proceedings and care must be taken to ensure the meeting is not misinterpreted as such.

If the person has not yet reached the age of 16 is interviewed they must be a accompanied by their parent, guardian or appropriate adult to whom all correspondence must be issued.

Appropriate senior personnel representing the health body should ahead of any ARA meeting consider:

- the desired outcome: and
- appropriate conditions of behavioural agreement

During the meeting the following issues should be covered:

- reason for agreement
- explanation as to why the identified behaviour is unacceptable
- clear explanation that such behaviour must stop
- consequences of continued unacceptable behaviour: and
- details of the mechanism for seeking a review e.g. via local complaints procedure.

If the relative or visitor fails to attend the meeting without good reason or notification, reasonable attempts to contact them should be made.

A template which can be adapted to suit local needs is given in Appendix G.

Roles and responsibilities in respect of monitoring must be clearly outlined so that any further unacceptable behaviour is recorded and appropriate further action can be taken should that become necessary.

Where a relative or visitor fails to comply with the tem outlined in the ARA, consider should be given to alternative action.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Address
Tel:
Fax:
Email:
www.hpft.nhs.uk

Address of recipient

Insert Date

Dear

Acknowledgement of Responsibilities Agreement between <insert name of relative, visitor or member of the public> and < insert name of health body or location>

It is alleged that on the <insert date> you <insert name> used/threatened unlawful violence/acted in an anti-social manner to a member of NHS staff/whilst on NHS premises (delete as applicable).
Behaviour such as this is unacceptable and will not be tolerated. This Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse. This was made clear to you at the meeting you attended on <insert location and date> to acknowledge responsibility for your actions and agree a way forward.
I would urge you to consider your behaviour when attending the < insert name of trust/ location> in the future and comply with the following conditions as discussed at out meeting:
<list of conditions>

If you fail to act in accordance with these conditions and continue to demonstrate what we consider to be unacceptable behaviour, I will have no choice but to take one of the following actions: *(*to be adjusted as appropriate):

- The matter will be reported to the police with a view to this health body supporting a criminal prosecution by the Crown Prosecution Service.

- The matter will be reported to the NHS Security Management Service Legal Protection Unit with a view to this health body supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from yourself.

- Consideration will be given to obtaining a civil injunction in the appropriate terms. Any legal costs incurred will be sought from yourself.

A copy of this letter is attached. Please sign the second copy and return to me to indicate that you have read and understood the above warning and agree to abide by the conditions listed accordingly.

If you do not reply within fourteen days I shall assume tacit agreement.

Sincerely,

Signed by senior staff member
Date
I, <insert name> accept the conditions listed above and agree to abide by them accordingly.
Signed

Date

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Address
Tel
Email
www.hpft.nhs.uk
Insert Date

Address of recipient

Dear

Acknowledgement of Responsibilities Agreement between <insert name of patient, visitor or member of the public> and < insert name of health body or location>

I am writing to you concerning an incident that occurred on <insert date> at <insert name of health body or location>.
It is alleged that you <insert name> used/threatened unlawful violence/acted in an anti-social manner to a member of NHS staff/whilst on NHS premises (delete as applicable).

Behaviour such as this is unacceptable and will not be tolerated. This Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse. This was made clear to you in my previous correspondence of <insert date> to you. We have attempted to contact you <insert details> to invite you to a meeting to discuss the matter and agree an acceptable conduct when attending these premises. However, we have not had a response from you.

I would urge you to consider your behaviour when attending the <location> in the future and comply with the following conditions
<list of conditions>

If you fail to act in accordance with these conditions and continue to demonstrate unacceptable behaviour, I will have no choice but to take the following action: *(*to be adjusted as appropriate):

- The matter will be reported to the police with a view to this health body supporting a criminal prosecution by the Crown Prosecution Service

- The matter will be reported to the NHS Security Management Service Legal Protection Unit with a view to this health body supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from yourself.

- Consideration will be given to obtaining a civil injunction in the appropriate terms. Any legal costs incurred will be sought from yourself.

I enclose two copies of this letter for your attention, I would be grateful if you could sign one copy, acknowledging your agreement with these conditions and return it to me in the envelope provided. In the event that I receive no reply within the next fourteen days, it shall be presumed that you agree with the conditions contained herein.

I hope that you should find these conditions acceptable. However, if you do not agree with the details contained in this letter about your alleged behaviour or feel that this action is

unwarranted, please contact in writing < insert details of local complaints procedure> who will review the decision in light of your account of the incident(s).

Yours sincerely,

Signed by senior staff member.

I, <insert name> accept the conditions listed and agree to abide by them accordingly.

Signed

Dated

Final Written Warning

Hertfordshire Partnership University NHS Foundation Trust

Address
Tel
Email
www.hpft.nhs.uk
Insert Date

Address of recipient

Dear

FINAL WARNING

I am writing to you concerning an incident that occurred on <insert date> at <insert name of health body or location
>.
It is alleged that you <insert name> used/threatened unlawful violence/acted in an anti-social manner to a member of NHS staff/whilst on NHS premises (delete as applicable).
Behaviour such as this is unacceptable and will not be tolerated. This trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse. This has been made clear to you in <insert details of previous correspondence/ meetings>.

If there is a repetition of your unacceptable behaviour, one or more of the following actions will be considered:
(to be adjusted as appropriate)

- The matter will be reported to the police with a view to this health body supporting a criminal prosecution by the Crown Prosecution Service.

- The matter will be reported to the NHS Security Management Service Legal Protection Unit with a view to this health body supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from yourself.

- Consideration will be given to obtaining a civil injunction in the appropriate terms. Any legal costs incurred will be sought from yourself.

If you consider that your alleged behaviour has been misrepresented or that this action is unwarranted, please contact in writing < insert details of local complaints procedure> who will review this decision in the light of your account of the incident(s).
Yours sincerely,
Signed by senior staff member
Date

V&A Example letter 1 (informal):

Hertfordshire Partnership University NHS Foundation Trust

Address
Tel:
Fax:
Email:
www.hpft.nhs.uk

Insert Date

Address of recipient

Dear

Private and Confidential

Dear *XXXXX*
I am writing to you concerning *brief sentence regarding incident / issue on (DATE) at (PLACE)*

Staff reported that *[summary of incident & impact on those involved].*

'Empathy paragraph' – *wording to recognise any issues we are aware of causing concern to the service user/ carer .*

We do not tolerate abusive and threatening behaviour to our staff. Our staff members are dedicated to supporting our service users and they should be able to do this without being subjected to threats and abusive behaviour.

'Outcome' paragraph *if relevant – XXXX eg I understand that you have since spoken to XXX Team Leader, and have expressed remorse for your actions which we thank you for.*

I would urge you to ensure that you behave respectfully to all NHS staff in the future. If there were further similar incidences we would need to consider what further action we might need to take.

Should you have any questions about this letter please do not hesitate to contact me regarding this on *manager's contact details*

Yours sincerely

Senior Manager *(Service manager / Service Line Lead)*

V&A Example letter 2 (formal):

Hertfordshire Partnership University NHS Foundation Trust

Address
Tel:
Fax:
Email:
www.hpft.nhs.uk

Insert Date

Address of recipient

Dear

Private and Confidential

Dear [XXXX]

I am writing to you concerning (*brief sentence regarding incident / issue on (DATE) at (PLACE)*

The incident which has been reported in statements given by the staff involved as follows [*Give a brief account of the incident. It must include the nature and severity of the incident and outline the actions taken at the time e.g. that they were given a formal verbal warning or sent a copy of respect letter no 1.*

Due to the nature of the incident (*detail actions now taken e.g this has now been reported to the Police and statements from staff have been shared with the Police/other action taken).*

We do not take these decisions lightly but the safety and security of our staff, service users and visitors is of primary concern to the Trust Board. We cannot and will not tolerate behaviour that jeopardises this. We also reserve the right to pursue prosecution for any offence. This could result in you no longer being permitted to access Trust premises and or receive treatment for a period of time

If you have any questions regarding this matter please do not hesitate to contact me on (*provide contact details*) or alternatively you can contact our Patient Advice & Liaison service (PALS) on **01707 253916**

Yours sincerely
Service Manager/ Service Line Lead

The use of force and restrictive practice within HPFT
An information leaflet for people who use our services, their families and carers

The Use of Force Act

The Mental Health Units (Use of Force) Act became law in November 2018. The aim of the Act and the statutory guidance is to clearly set out the measures that are needed to both prevent the inappropriate use of force and ensure accountability and transparency about the use of force in mental health units.

Every person has the right to be treated with dignity and in a caring therapeutic environment which is free from abuse. The use of force can sometimes be necessary however to ensure the safety of people who use our services and staff. We call this restrictive practice.

What is restrictive practice?

Restrictive practices are things that limit the rights of a person, like being able to move around freely. Sometimes we need to use restrictive practice to keep the people who use our services safe. This may be when a person is hurting themselves or another person or when they become angry and damage the environment.

As a Trust, we recognise that the use of force always comes with risk and can be a traumatic and upsetting experience for people who use our services when they are at their most vulnerable and in need of safe and compassionate care. The use of restrictive practice can also be upsetting for those who witness it, such as other patients or visitors.

What are the types of restrictive practices?

Chemical restraint - This is when a person is given medication to support them in stopping a certain behaviour by calming them down. The medication is not being given to treat a medical condition but is an intentional way to aid calming and manage behaviour. The medication might be administered via a tablet or injection.

Physical restraint – This is when another person physically holds a person so they cannot move.

Seclusion – This is when a person is placed in a locked room that they cannot leave until they are acting safely.

Longer Term Segregation – This is when a person is separated from other service users or staff for a longer period of time to keep them and others safe. This might be because a person finds it difficult to cope with other people being around them or they are in danger of hurting others.

Environmental restraint – This is when environmental safeguards are in place to stop a person moving freely from one area to another or to stop them from doing something. There may be locked gates, fences and doors on the unit to keep people safe. A person may only be able to go through these with staff or with the agreement of the care team.

Our view on the use of force and restrictive practice

The law says that restrictive practices can only be used if there is a risk to safety right at that time and that it must be used in the least restrictive way.

Within our services, the use of force is only ever used proportionately and as a last resort. It is never used to cause pain, suffering, humiliation or as a punishment.

It is expected that staff undertaking physical interventions have been trained by attending an appropriate course as provided by the Trust. During physical interventions staff are trained to ensure that the techniques and methods used to restrict a person:

- are proportionate to the risk and potential seriousness of harm
- are the least restrictive option to meet the need
- are used for no longer than necessary
- take account of the person's preferences, if known and it is possible to do so
- take account of the service user's physical health, degree of frailty and developmental age.

The use of force may occur through escorts and seated holds and supine restraint. The use of prone restraint is not permitted within the Trust. Safety pods and leg cushions are also used for seated and supine restraint as the evidence suggests that these offer greater therapeutic support.

What steps do we take to try to avoid the use of force and restrictive intervention?

MOSStogether is the Trust's Strategy for reducing Restrictive Practices within our services and provides a framework for staff and the people who use our services to work together to help people feel safe and have a positive experience.

MOSStogether sets out a number of strategies which we use to reduce the need for restrictions. These include developing Positive Behaviour Support Plans for people who use our services. A Positive Behavioural Support Plan helps us to understand a person's behaviour better and identifies the approaches that help a person to stay calm.

The MOSStogether strategy also includes the use of the Safewards methodologies. Further information about Safewards can be found here: https://www.safewards.net/.

Some examples of our use of Safewards strategies include staff working with people who use our services to agree mutual expectations. These are agreed actions we expect from each other, for example, listening to and respecting each other.
We also try to work together with service users in a polite and respectful way using soft words, listening, asking and suggesting, explaining, encouraging, and providing positive feedback.

We also recognise the importance of getting to know each other, especially a person's interests and activities, likes and dislikes and favourite things. Staff will also offer reassurance if a person is feeling anxious to support in helping them to feel safe.

How can you become involved in care planning around the use of force and restrictive intervention?

Staff will seek a person's views on the use of restrictive interventions, as well as talking to their families and carers (If agreed by the person). An advanced decision or statement can also be made which sets out a person's wishes in relation to how restrictive intervention should occur if they become unsafe. We will always endeavour to follow someone's wishes, but if there is clear and immediate danger, this may not always be possible. Staff are also responsible for ensuring that carers are involved in decision-making whenever practicable if the service user agrees.

What happens after an incident which involves the use of restrictive practice?
Following any incident involving the use of a restrictive practice, staff will always attempt to talk to the person about what happened and discuss how to prevent future occurrences and any concerns that the person may have.

With the permission of the person, we will also let their family or carer know about any untoward incident that has necessitated the use of force. This is likely to occur during MDT and CPA meetings at which families, carers and advocates are invited to attend.

What information do we record and report on the use of force?
Staff record all incidents of restrictive practices on the electronic patient record system and within the Trust's incident reporting system. Anonymised data is also sent outside of HPFT to the CQC and NHS Digital as part of the external monitoring process of our services.

How do we review our practices and what action do we take if an inappropriate use of force is identified?
All incidents of restrictive practice are reviewed locally. Details of incidents are also sent to senior members of HPFT via the Trust's incident reporting system. Restrictive practice is reviewed monthly and discussed at a Trustwide restrictive practice meeting. Where there is a potential inappropriate use of restrictive practice this is reported to the Trust safeguarding team as well as local safeguarding teams for review and where necessary independently investigated. An internal investigation may also take place if concerns are identified.

What are your legal rights?
All restrictive practices affect a person's human rights. We recognise that the physical management of aggression and violence may result in a restriction of a person's liberty and autonomy and therefore management of aggression and violence and self-harm must therefore always be justified in law. Use of restrictive interventions must be undertaken in a manner that complies with the Human Rights Act 1998 and the relevant rights in the European Convention on Human Rights.

The rights of people who use our services are protected by the Mental Health Act 1983, deprivation of liberty authorisations, the Mental Capacity Act 2005, and the Equality Act 2010 (including the duty to make reasonable adjustments). The use of restrictive interventions must therefore not impose restrictions that amount to a deprivation of liberty unless there is a legitimate reason and that its use is justifiable, appropriate, reasonable and proportionate.

Contact details for advocacy
People who use our services have a legal right to independent advocacy and the Trust will fully support a person in their decision to request an independent advocate. Within Hertfordshire and Norfolk, advocacy is provided by POhWER: https://www.pohwer.net/ and within Essex, it is provided by Re-think: https://www.rethink.org/

All staff are able to support service users in requesting advocacy services.

How can you complain about the use of force?
If a person feels that their care has been unsatisfactory then we encourage them to talk to their Named Nurse, Team Leader or Modern Matron. A person can also make a formal complaint if they wish to or contact the HPFT Patient Advice Liaison Services (PALS) via hpft.pals@nhs.net or by phone on 01707 253916. Further information about making a formal complaint can be found here: https://www.hpft.nhs.uk/contact-us/compliments-and-complaints/

An advocate can also provide support and pursue a complaint on a person's behalf.

Where can you find further information?

You can find further information about the use of force and restrictive practice in the Trust's Violence and Aggression including Use of Force policy. You can request access to this policy via a Freedom of Information request. As a minimum the policy is reviewed every three years. Our Violence and Aggression policy and MOSStogether Strategy has been developed in accordance with legal and national frameworks and best practice guidelines and included the involvement of relevant groups including Experts by Experience.

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Use of Force Act

EasyRead Version

as one

easy read

Our Values
Welcoming Kind Positive Respectful Professional

What is the Use of Force Act?

The Government has written guidance to help people understand the law about using force in mental health units.

This is called the **Use of Force Act**.

Using force means to stop somebody from causing damage, hurting themselves or hurting others.

We sometimes call this **Restrictive Practice.**

A **mental health unit** is where people stay to have treatment for their mental health condition.

Everyone has the right to be treated well and to be safe from harm in mental health units.

Sometimes force is needed to stop people from hurting themselves or other people.

Sometimes force is used when it is not needed. This is abuse.

The Use of Force Act aims to:

- Prevent situations where force may need to be used.

- Reduce the use of force in mental health units.

- Make sure force is only used when everything else has been tried.

- Stop people being treated unfairly because of who they are, their background or beliefs.

- Make sure that everyone knows when force has been used.

- Make sure everyone understands why force has been used.

What is Restrictive Practice?

Restrictive practices are things that limit the rights of a person, like being able to move around freely.

Sometimes we need to use restrictive practice to keep you or other people safe.

Restrictive practice is used to stop a person from doing **behaviours of concern.**

A **behaviour of concern** might be a behaviour like:

- when you hurt yourself or hurt another person.

- when you are angry and break things.

- When you run away from people who help you.

What are the types of Restrictive Practice?

Chemical Restraint

This means giving you medication to keep you calm.

This is different to your regular medication.

Physical Restraint

This means someone holding a part of your body to stop you from moving it.

It might also mean holding you to stop you from moving.

It is not the same as holding hands to cross the road.

Seclusion

This means keeping you on your own, away from other patients.

Longer Term Segregation

This means keeping you on your own, away from other patients for a long time.

Environmental Restraint

This is when actions or systems stop you being able to move in your space freely or stops you from being able to join in an activity.

There may be locked gates, fences and doors on the unit to keep you and others safe.

You may be able to go through these with a member of a staff.

What can we do to reduce using force?

The **MOSS Together Strategy** shows how staff and patients can work together to use the least restrictive practices possible.

MOSS stands for Making Our Services Safer

If you receive the right support and feel safe, staff should not need to use restrictive practices.

To help make sure that you receive the right support we will work with you to write a **Positive Behavioural Support Plan**.

A Positive Behaviour Support Plan helps us to understand your behaviour.

It explains how you behave when:

- you are in pain

- you are upset

- you are angry

It also describes what makes you angry or upset, for example when people do not understand your needs.

Understanding your behaviour makes it easier for us to help you stay calm and feel safe.

We can also teach you new ways to stay calm.

Mutual Expectations

We will also work with you to agree Mutual Expectations.

This means that you will agree with staff how you will behave towards each other.

We will listen to and respect each other.

We will be polite to each other and use **soft words**.

Soft words mean being kind and understanding. We should treat everyone the way we want people to treat us.

How we will help you

At **handover meetings** we will talk about positive things that have happened.

A **handover meeting** is when staff share the things that have happened during their shift with staff on the next shift.

We will talk to you to get to know all about you.

We will talk to you about what you like to do and the things you like and dislike.

We will support you if receive bad news and become angry or upset.

We will hold Mutual Help Meetings that all patients and staff can attend.

At these meetings we will:

- say thank you to each other

- share news

- share ideas

- ask for things

We will help you to use calm down methods if you become angry or upset, for example:

- talking to staff

- listening to music

- sensory toys

- stress and massage balls

- going for a walk

- playing games

When you feel anxious we will support you to help you feel safe.

When you go home from the unit you can leave a message for new patients.

You can tell them things you liked and what helped you during your stay.

We will train our staff in using restrictive practice.

We will also train our staff in how to reduce the use of restrictive practice.

We will talk to you about how you want us to help you when you get angry or upset.

We will then write a care plan with you.

We will follow this care plan unless it is unsafe to do so.

For example, if following the care plan might put you or someone else in danger.

If we have to use restrictive practice with you, we will always talk to you about it afterwards to make sure that you are OK.

We will ask you what we could do differently next time.

We will ask if you want us to tell your family about what happened.

We must write down each time we use restrictive practice.

We review every time we use restrictive practice to make sure that it was only used because there was a risk to safety.

We also check to make sure that we used the least restrictive practice for the least amount of time possible.

We will investigate if:

- we think too much force was used,

or

- if you were injured by the force used.

Your Rights

The Human Rights Act says that we all have the right to do the things we want unless there is a risk to us or to others.

You have the right to an **advocate.**

An advocate is someone who helps you to say what you want. Or they can speak for you.

We will help you to talk to an **advocate** if you want one.

There are posters in all units with the contact details of advocacy services.

If you have a complaint

If you have a problem with the care you receive you should talk to a member of staff in the unit.

If you do not want to talk to someone in your unit, you can talk to the Patient Advice and Liaison Service (PALS).

Telephone: 01707 253916

They will listen to you and help you sort things out.

You can also write to the Complaints department.

You can get a form in your unit. Fill this in and post it. You do not need a stamp.

Further Information

If you want to find out more you can ask to see our Violence and Aggression Policy and our MOSS Together Strategy.

You can ask your advocate to show you these.

We wrote our Violence and Aggression Policy and our MOSS Together Strategy using best practice guidance from the government

Experts by Experience have also reviewed these documents.

An **Expert by Experience** is a patient who has used our services in the past.

made with photosymbols®

Approved By
Making Services Better

Produced by
Inclusive Communication Essex

Relating to People Program Module Synopsis

The Relating to People Programme was established in 1997 to meet growing concerns about verbal and physical aggression faced by NHS staff. The programme is based on core objectives as defined within the RESPECT philosophy. The modules include techniques for recognising areas of conflict and strategies for management of aggression including communication models, de-escalation, disengagement and the use of non-aversive physical interventions.

Respect Training meets the Restraint Reduction Network Training Standards (2019) and as such has been accredited to British Institute Learning Disabilities: Accredited Certified Training organisations.
https://bildact.org.uk/certified-organisations/

Some modules of the programme have been revised recently to make more effective use of resources but they still maintain the high standards of the originals and meet all the training needs of their participants.

RESPECT® Modules

Module 3b – 1 day
This module is for staff in clinical settings who are lone workers or work with one other person e.g. community nurses, pharmacists etc. This module includes RESPECT Physical Intervention techniques for prevention, de-escalation and disengagement plus the legal framework. Participants must have attended Module 3a first but this does not necessarily have to be the day before.

Module 3b Refresher – Half Day
This is a yearly update for those who have attended Module 3b.

Module 4 RESPECT-4 days
This module is for staff who work in higher risk areas e.g. in-patient units where disentanglement is not always sufficient and where active intervention may be required. It provides a holistic approach to management of aggression including recognition of, understanding causes, environmental factors, communication models, de-escalation, disengagement techniques and non-aversive physical intervention. In addition, participants will look at the issues around rapid tranquillisation in line with national and trust policies and procedures.

Module 4 RESPECT Refresher- 1day
This mandatory annual update allows staff time to use reflective practice to enhance their techniques and explore any new guidance. Time will be given to staff to practice the physical intervention techniques as taught in Module 4.

Module 5 RESPECT-1 days
Module 5 training is for staff working in particularly challenging environments and owing to the acuity of service users, there may be an increased use of restrictive practices (for example our Medium and our Low Secure Services and also our Psychiatric Intensive Care Unit (PICU). This is in addition to having attended and received module 4 training. During the module 5 training, participants will be given the opportunity to look at the issues around seclusion in line with national and Trust policies and procedures.

RESPECT TECHNIQUES TAUGHT WITHIN THE TRUST

- Break Away techniques are taught within the Respect training programmes with each of the techniques having been biomechanically tested for impact on both assailant and victim.
- Touch Support (from this point all the below are restraint techniques).
- One person escort
- Two person alternative escort
- Two person traditional escort
- Approach from in front
- Approach from the rear
- Introduction to the use of the safety pod and the key differences for a supine restraint.
- Support to the floor or to the safety pod
- T-Position
- Supine Position
- Upper leg management
- Lower leg management
- The use of the safety pod cushion for leg management on the safety pod.
- Changeovers are taught for T-Position, Supine and upper leg management.
- Process to administer RT during supine restraint.
- Seclusion exit:
    - from ground restraint.
    - from the safety pod.
- Prone to Supine
- Sitting someone up from supine
- Standing someone up from seated on the floor.
- Seated Holds generally take place on chairs, beds or the safety pods.
- Seated Holds – The only technique taught is for seated holds is the Two person traditional escort. This is due to the risk of hypoxia in employing the 2 person alternative escort.
- Seated Holds – Leg Management and the use of the safety pod cushion especially within trauma informed care.
- The role of the conductor in the management of an incident, which includes the technical communication skills required.
- The arm stabilisation, and transitioning process working as a 3 person team during the management of an incident.
- Head management (if the service user begins to strike the back of their head on the floor when in the supine position).
- Spitting during a supine restraint.
- Rotation of a service user who has placed themselves in prone.
- Important to recognise any signs of physical health deterioration during restraint. The staff are taught to observe using the BBANC assessment tool (body alignment, breathing, ability to move, noise and circulation).
- Simulation exercises to complete during training.

NHS
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We are here to help you

So we say no to:

- Physical abuse of our staff
- Racial abuse of our staff
- Verbal abuse of our staff

Our values are to be kind and to be respectful.

We should treat each other as we would want to be treated.

as one

Our values
Welcoming Kind Positive Respectful Professional

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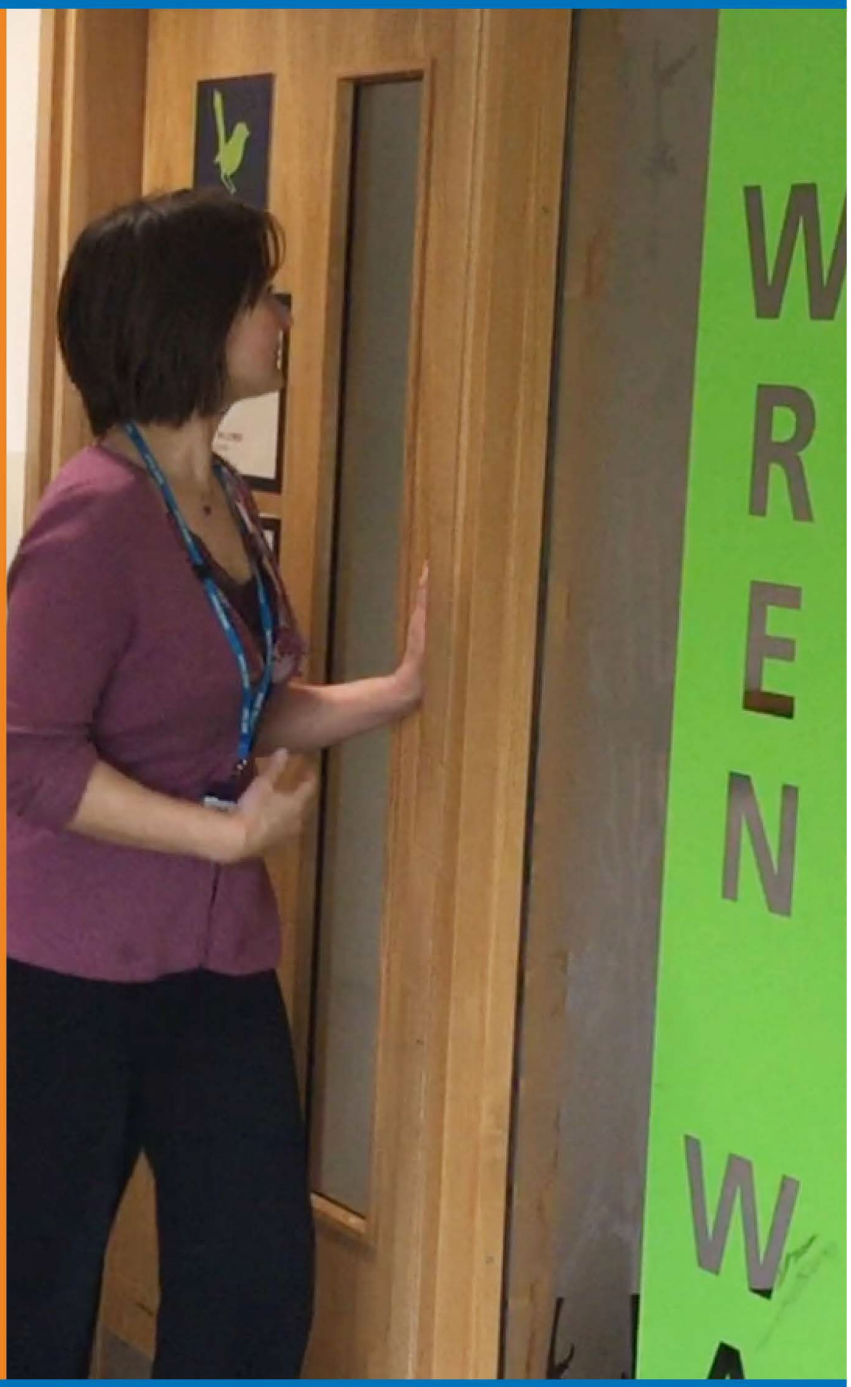

as one

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as one

Our values
Welcoming Kind Positive Respectful Professional

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

We are here to help you

So we say no to:

- Physical abuse of our staff
- Racial abuse of our staff
- Verbal abuse of our staff

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RECOVERY PRINCIPLES WHICH UNDERPIN ALL FORMS OF CARE PROVIDED WITHIN THE TRUST

Principles of Recovery Oriented Practice, which underpin all our services are:

1. **Individual uniqueness and user centrality to service provision:** *in practice:*

- recognises that recovery is a personal journey and unique for each individual.
- understands that Recovery is not necessarily about cure. Recovery outcomes are personal and unique for each person and go beyond an exclusive health focus to include an additional emphasis on social outcomes and quality of life.
- places individuals at the centre of the care they receive. Through a person centred and needs led approach, individual recovery outcomes are achieved.

2. **Real Choices:** *in practice:*

- supports people to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored.
- supports people to build on their strengths and to take as much responsibility for their lives as they can at any given time.
- is proactive in supporting people to take positive risks and to make the most of new opportunities whilst balancing responsibilities for duty of care.

3. **Attitudes and Rights:** *in practice:*

- involves listening to, learning from and acting upon the communications from individual service users, their relatives and others about what is important to each person.
- promotes and protects people's legal and citizenship rights
- supports people to maintain and develop meaningful social, community, recreational, occupational and vocational activities.

4. **Dignity and Respect:** *in practice:*

- consists of being courteous, respectful and honest in our interactions.
- involves sensitivity and respect for each individuals values and culture.
- challenges discrimination and stigma wherever it exists both within our own services and the broader community.

5. **Respectful Partnerships**: *in practice:*

- acknowledges each person is an expert on their own life and that recovery involves working in respectful partnership with individuals, their relatives and carers to provide support in a way that makes sense to them.
- acknowledges the importance of the sharing appropriate information and the need to communicate clearly and to enable effective engagement with services.
- involves working in hopeful, positive and optimistic ways with people who use our services, their families and carers, and the communities within which they live, to support them to realise their own hopes, goals and aspirations.

To be a leading provider, we must offer high quality care with excellent treatment outcomes, within a safe environment which meets the needs of service users.

Our vision is underpinned by eight goals which inform our entire strategy.

- To deliver high quality integrated health and social care services in accordance with recovery principles
- To be the provider of choice for service users, carers, the community and commissioners
- To work in partnership with the community to promote the wellbeing of others, whilst making a positive contribution to the environment
- To be the employer of choice where staff are highly valued, well supported and rewarded
- To create a dynamic and flexible working environment where staff are motivated and committed to providing high quality care
- To embed a learning culture where staff develop their full potential and deliver excellent care
- To ensure a sustainable future through income growth and efficient use of resources
- To be an innovative and learning organisation that embraces new and modern approaches to health and social care

Governance and Assurance Process VA

All incidents are reported through Datix

At a minimum each incident should be reviewed by the relevant team

Escalation: Increased levels of severity will trigger a range of possible options:

- **3 – day investigation depending on local investigation / review process agreed**
- **Moderate Harm Panel**
- **Serious Incident – with designated investigator**

Monthly Review of escalated incidents:

- **Review of Datix V&A incidents resulting in harm –PDPS Team**
- **Review of V&A themes discussed at Moderate Harm Panel**
- **Review of outcomes of V&A Serious Incidents**
- **Review of RIDDOR's relating to V&A**

Quarterly:

- **Analysis in the Integrated Safety Report**
- **Analysis in the quarterly Health Safety & Safety reports**
- **Analysis will include review of:**
  - **Themes and trends**
  - **Compliance with policy – assurance and governance process**
  - **Sharing of learning from V&A incidents**
  - **Review of process for post incident support**
  - **Closing the loop i.e. response to learning**

Annual:

- **As above for the report cycle (annual)**

Hertfordshire Partnership NHS
University NHS Foundation Trust

Immediate Support, for those involved in or witnessing violence and aggression

IMMEDIATE SUPPORT

- Do not leave an effected person without immediate support following an incident.
- Be sensitive and consider the needs of different people and how they react to incidents - some may want to be away from the area in a safe place.
- Provide prompt medical care if required, sign post to GP, A&E and ensure that there is support for the individual e.g. are they safe to drive, support at home?

POLICE

- If appropriate, notify the police as soon as possible and ensure support is in place for the person harmed throughout the process
- Co-operate with interviews, give as much description as possible

ON-GOING SUPPORT

- Identify a person to talk with, a colleague or manager
- Utilise the ongoing support networks: Huddles, SWARM, and SCHWARTZ ROUNDS
- Contact Employee Assistance Programme - Confidential Support 24 Hours a day, 365 days a year Tel:0800 882 4102
- Encourage on-going links with known support mechanisms known and preferred by you!

Our Values

we are...	you feel...
Welcoming	Valued as an individual
Kind	Cared for
Positive	Supported and included
Respectful	Listened to and heard
Professional	Safe and confident

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