Leicestershire Partnership NHS Trust

Violence Prevention and Reduction Policy

This Policy describes all Trust processes for the prevention and management of violence and aggression.

Key Words:	Aggression, Management, Incident Review, Debrief, Restrictive Practices, Body Worn Camera	
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Type of Policy	Clinical	Non Clinical √

Contents

1.0 Quick Look Summary

Pertinent easy read points

This policy provides a framework for the management of violence and aggression directed at staff and service users. It provides detailed guidance on:

- Trusts approach and arrangements for violence prevention and reduction across our services.
- The roles and responsibilities of all staff in the management of violence and aggression.
- The role of Trust committees and sub-groups in ensuring that there are adequate arrangements in place to monitor the implementation and effectiveness of controls required to reduce the risk of violence and aggression to staff.
- The requirements for the training of staff to ensure that they are adequately prepared to deal with the risk associated with violence and aggression in their workplace.
- Procedures to be followed by staff to ensure that all incidents of violence and aggression are reported and dealt with appropriately.

Leicestershire Partnership NHS Trust is committed to the health, safety and wellbeing of all employees and those who access its services.

It should be recognised that the majority of service users and patients are not violent and should not be perceived as such. The causes of violence and aggression within our healthcare settings are often complex and can be attributed to many factors. However, it is recognised that there may be instances when staff and service users may be faced with potentially violent or aggressive incidents.

The Trust has a responsibility to support all members of staff who act reasonably, legally and within due professional standards when dealing with violence and aggression.

1.1 Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
V1	February 2012	Harmonised policy
V2	August 2012	Updated to meet HSE requirements
V3	March 2015	Period for review has been extended until March 2016 due to the requirement for inclusion of positive and proactive works streams & police liaison guidance.
V4	March 2016	Review to include the staff alarm process
V5	November 2018	Review to include changes post NHS Protect, updates to the Protection from Harassment Act 1997 relating to offence of stalking, abuse involving social media and other minor changes
V6	August 2019	New SOP for incident response Appendix A (9). New alarm documentation. Minor amendments
V6.1	October 2019	Reference to Trusts Prevention and Management of Violence and Aggression removed
V6.2	January 2020	Amendments to 5.8 (accountability) and 6 (RRN). Updated Appendix A. Other minor amendments
V7	March 2021	Policy renamed Policy re-write following extensive review of organisational and management arrangements
V7.1	November 2022	Inclusion of reference to Restrictive Practices Policy & Group with Post Incident Reviews/Debrief section added Training changed to Safety Intervention (previously MAPA) Use of Body Worn Cameras (BWC) added
V7.2	June 2023	Reviewed in line with monitoring requirement section 21 of policy; Audit of Policy by the SMA annually No changes other than policies section updated
V7.3	December 2025	Inclusion of Zero Tolerance at Section 17 Job titles reviewed and updated

1.2 Key individuals involved in developing and consulting on the document

Name	Designation
Accountable Director	Jean Knight
Author(s)	Andy Lee
Implementation Lead	Andy Lee
Core policy reviewer group	
Wider consultation	
LPT Health and Safety Committee	Approving Committee
Least Restrictive Practice Group	All members
Patient Safety Improvement Group	All members
Directorate Health, Safety and Security Action Groups	All members

1.3 Governance

Level 2 or 3 approving delivery group	Level 1 Committee to ratify policy
Health and Safety Committee	Quality and Safety Committee

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity.

1.5 Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010.

This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix N) of this policy

1.6 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

- Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.
- Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for

1.7 Definitions

Violence at Work	The Health and Safety Executive (HSE) defines violence at work as "any incident in which an employee is abused, threatened or assaulted in circumstances relating to their work." This covers the serious or persistent use of verbal abuse – which the HSE says can add to stress or anxiety, thereby damaging an employee's health. It also covers staff who are assaulted or abused outside their place of work – for example, while going home, while working in the community or while travelling if the incident relates to their work.
Physical Assault	The definition of physical assault used in the 2003 directions to the NHS from the secretary of state for Health was *"the intentional application of force against the person of another without lawful justification, resulting in physical injury or personal discomfort."*
Non-Physical Assault	The NHS definition of non-physical assault is 'the use of inappropriate words or behaviour causing distress and / or constituting harassment.'
Disturbed/violent behaviour	A range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence is physically or verbally expressed, physical harm is sustained, or the intention is clear.
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
Harassment	Harassment is not specifically defined in section 7(2) of the Protection from Harassment Act 1997 (PHA). It can include repeated attempts to impose unwanted communications and contact upon a victim in a manner that could be expected to cause distress or fear in any reasonable person (CPS Legal Guidance – May 2018).

Restrictive Interventions	"Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and end or reduce significantly the danger to the person or others; and contain or limit the person's freedom for no longer than is necessary" (Positive and Proactive Care: reducing the need for restrictive interventions (Department of Health – April 2014))
Restrictive Practices	Restrictive practices refer to physical, mechanical and chemical restraint, seclusion and long-term segregation. (Positive and Proactive Care: reducing the need for restrictive interventions (Department of Health – April 2014))
Post Incident Debrief	Any incidents that involve restrictive interventions should have a post incident debrief to find out if the staff or patients involved received any physical or psychological harm. The patient who was involved in the incident should be given the opportunity when they have recovered their composure to discuss the incident with a member of staff.
Plan, Do, Check, Act (PDCA)	PDCA is an iterative four-step management method used to validate, control and achieve continuous improvement of processes.

2 Strategy

The Trust is committed to take a risk-based approach to support staff working in a safe and secure environment, safely against abuse and violence.

3 Introduction

There is a foreseeable risk of violence and aggression within NHS settings. These risks are present in all healthcare environments but within Learning Disabilities and Mental Health Services, this risk may be increased, due to the nature of patient's health issues.

LPT owes a general duty of care to protect its staff from threats and violence at work. The following specific health and safety legislation extends to violence at work:

- Health and Safety at Work Act 1974 (HASAWA);
- Management of Health and Safety at Work Regulations 1999;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013(RIDDOR);
- Safety Representatives and Safety Committees Regulations 1977
- Health and Safety (Consultation with Employees) Regulations 1996.
- Health and Social Care Act 2008
- Violence Prevention and Reduction Standards 2021

The Health & Safety Executive undertake annual inspections across all health sectors, please refer to the operational guidance for more detail.

4 Associated Policies & Procedures

This policy has many associations with other trust policies and procedures and should not be read in isolation. All staff should be aware of related policies and procedures listed in Section 22.

5 Aim

The aim of the policy document is to provide a framework (using Plan, Do, Check, Act approach) to develop procedures and mechanisms in order to:

- To support our staff to discharge their responsibilities as required under relevant H&S legislation.
- To protect service users, staff, and visitors within the Trust from incidents of violence and aggression and to prevent, minimise and reduce the risk of such incidents occurring.
- To ensure that the Trust has in place adequate arrangements to monitor the implementation and effectiveness of controls required to reduce and prevent the risk of violence and aggression to staff.
- Identify causes and assess the likelihood of violence and aggression and identify response measures relative to the risk.
- Ensure that suitable and sufficient support is provided for service users and staff who are exposed to incidents of violence and aggression.
- To demonstrate compliance against the Violence Prevention and Reduction Standards.

6 Organisational Responsibilities

6.1 Chief Executive

The Chief Executive is accountable for all health and safety matters including the prevention and management of violence and aggression. Operational responsibility is delegated to the Executive Director with responsibility for Health, Safety and Security for and Directors who must ensure that appropriate policies, procedures and controls are put in place to manage the risks and effects of violence and aggression.

The Chief Executive will ensure that on a risk prioritised basis, financial resources are made available to support this policy.

The Chief Executive will ensure that the Violence and Aggression Standards are reviewed bi-annually and that a Strategic Violence Group meets a minimum of bi-annually to undertake this and an assessment of violence across the Trust.

6.2 Directors

Directors are to ensure that all areas within their responsibility make appropriate arrangements for the effective planning, organising, controlling, monitoring and reviewing of control measures to manage and prevent violence and aggression put in place operationally within the Directorates/Services.

Directors are to ensure that all operational risks relating to violence and aggression are identified and written risk assessments are completed to address these risks.

Directors must ensure that all matters relating to violence and aggression are formally recorded on appropriate reporting systems e.g. eIRF, SystmOne. That all mitigation and assurances for the management and reduction of violence and aggression within their remit is reported through the governance framework.

The Executive Director of Nursing/AHP's and Quality will offer support and advice to each staff member sustaining moderate harm or following an incident being reported to the HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) through incidents of violence and aggression.

6.3 Deputy Director of Safety and EPRR

The Head of Trust Health and Safety Compliance reports to the Director with who has responsibility for Health, Safety and Security for the organisation and operational management of health, safety and security for the Trust and matters relating to the prevention and reduction of violence.

6.4 Safety and EPRR Team

The Health and Safety Compliance Team will liaise with the relevant external stakeholders as part of their arrangements for collaboration and coordination of health and safety requirements as set out under the Management of Health and Safety at Work Regulations 1999. The Health and Safety Compliance Team will communicate and consult with external stakeholders regarding sharing of information, incidents and lessons learnt.

6.5 Security Management Advisor

Security Management Advisor (SMA) reports to the Head of Trust Health and Safety Compliance for ensuring that the Trust complies with statutory and contractual requirements in relation to violence and aggression. These requirements include:

- Develop and implement organisation policies and procedures to support staff when they encounter violent and aggressive behaviour in the work environment.
- CQC Outcomes.
- Health and Safety at Work Act etc. 1974

The SMA is to work across the organisation to promote:

- Violence prevention and reduction.
- All incidents of violence and aggression are reported in accordance with the Incident Reporting Policy.
- All work areas have a current, comprehensive, and accurate risk assessment covering all risks of violence and aggression for that area.
- Detailed and specific risk assessment are completed for individual service users within their care plan.
- Preliminary investigations are conducted into all incidents of violence and aggression and advice is given to management on follow-up action.
- Where a formal complaint has not been made to the police in relation to a staff/patient incident the issue of suitability for prosecution has been considered, actively encouraging the reporting of such incidents.

- Serious staff assaults are fully investigated, and a report submitted.
- Investigations conducted by the police are monitored and the Head of Health and Safety Compliance is briefed on progress.
- Detailed feedback is given to appropriate line managers and staff on the progress of investigations and lessons learned.
- Writes to all staff involved in a physical assault to offer support and advice.

The SMA attends the Least Restrictive Practice Group in accordance with the terms of reference. Work in this area will include:

- The review and monitoring of all violence and aggression incidents in order to identify trends, control measures and develop risk reduction strategies.
- Work with Learning & Development (L&D) to identify appropriate training to help staff deal effectively with violence and aggression.
- To seek assurance from L&D and Service leads that staff have received appropriate Conflict Resolution and Safety Intervention (previously MAPA) training to ensure that all areas have adequate coverage in line with national expectations.

6.6 Least Restrictive Practice Lead

- Review all incident reports related to restraint or restrictive practices to ensure that these are completed accurately.
- Highlight incidents that have seclusion, prone or prolonged restraint to Ward Sisters/Charge Nurses for further analysis.
- Provide an overview and learning for all incidents involving restraint.
- Support teams with individual plans to reduce the need for restrictive practices.
- Support teams to implement proactive strategies to reduce the need for restrictive practices.
- Escalation to Executive Lead any of areas of concern/areas of good practice related to restrictive practice.

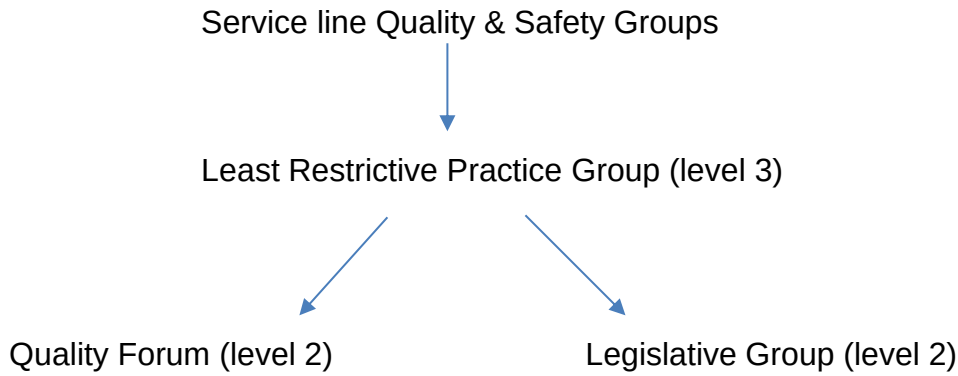
6.7 Health and Safety Committee

The Health and Safety Committee is the overarching Committee for the management and prevention of violence and aggression towards staff within the Trust. The Committee will monitor staff incidents and the arrangements to prevent and reduce the risk of violence and aggression to staff. It will:

- Receive quarterly reports from the SMA.
- Agree policies and best practice guidance in relation to violence and aggression within the Trust.
- Receive support to prevention of violence and aggression within the Trust e.g. Strategic Workforce Group, Learning and Organisational Development Group.

6.8 The Least Restrictive Practice Group

The Least Restrictive Practice Group has level 3 governance responsibility:



and provides a forum for representatives of all LPT services, the SMA and other relevant staff to participate in the review of incidents and participation in the formulation of policies and procedures relating to violence and aggression.

Violence and aggression incidents to service users and staff will be monitored by the Least Restrictive Practice Group in order to:

- Identify trigger factors / trends which may precipitate acts of violence and aggression.
- Establish potential trends between restraining / holding techniques and injuries to service users / staff.
- Ensure that processes take place within a culture of learning lessons.

All staff incidents will also be reported quarterly to the Health and Safety Committee.

6.9 Managers

Line Managers of staff have a duty to prevent and reduce violence and aggress for their staff and patients and will:

- Where a risk assessment identifies the requirement for personal alarms to be used as a control measure for violence and aggression, the line manager will:
- Provide the staff member with appropriate responding alarm/device.
- Make staff member aware of their responsibility of the equipment, the testing of the alarm and he completion of relevant auditable documentation. Audit of completion documentation guidance can be found in Appendix A.
- Monitor process to assess violence prevention and performance.
- Review audits of assurance processes for violence prevention and reduction.
- Monitor corrective and preventative actions.
- Ensure that violence and aggression risk assessments incorporate environmental considerations. Assistance from the SMA and Health and Safety Compliance Team should be sought where necessary. See Appendix B for guidance.
- Ensure that all incidents of violence and aggression relating to their staff are reported in accordance with the Incident Reporting Policy and RIDDOR Guidance.

- Relevant risk assessments are reviewed as soon as is practicable following incidents to ensure control measures are suitable and sufficient to their line management and to staff.
- Communicate all risk issues to ensure that all staff are informed of the significant findings of the violence and aggression risk assessment.
- Enable their staff to understand and share in the process of risk identification and its prevention/reduction.
- Ensure that detailed feedback is given to staff on the progress of investigations and lessons learned. This should include changes made to the physical and control environment.
- Ensure that all members of staff in their area have received training that is appropriate and current to the risks present in their area. All training delivered within the Trust will be part of an endorsed model of training relevant for the service area.
- Ensure that equipment, materials and protective equipment are available for use and fit for purpose e.g. alarms.
- Ensure all staff should have a local de-briefing after an incident and the opportunity of being referred to Occupational Health, if deemed appropriate.
- Support will be provided in line with Trust guidance following any incident of violence and aggression.
- Service users and staff must have access to the Trust complaints / grievance procedure.
- Ensure that appropriate support and advice is given to staff or patient in relation to staff guidance.

For all serious incidents a post-incident review should take place as soon after the incident as possible but in any event within 72 hours of the incident. This review must be led by the senior manager responsible for the ward or department concerned. The following groups should be considered:

- All staff involved in the incident(s).
- Service users involved in the incident(s).
- Carers and family where appropriate.
- Other service users who witnessed the incident.
- Visitors who witnessed the incident.

6.10 Staff

Members of staff are responsible for:

- making themselves aware, by consulting with line managers and colleagues, of all risks relating to violence and aggression for the area in which they work. This will include reading and familiarising themselves with current risk assessments.
- Where staff have been provided with safety equipment as part of a risk assessment e.g. personal alarm/device they must:
    a) Report any safety hazard or defect with equipment you identify to your line manager.
    b) Use the equipment and safety devices supplied properly, in accordance with any guidance, information and instructions received e.g. testing and recording

- Staff must report all incidents of violence and aggression in accordance with the Trust's Incident Reporting Policy. Incident reports must be completed at the earliest opportunity.
- Staff must ensure they are up to date with the training required for their role and are familiar with and use the agreed methods for the prevention and management of violence and aggression, including de-escalation and restraint for the circumstances presented and attend the training identified for their role.
- Where members of staff have not been trained, they should bring this to the attention of their line manager. Untrained personnel should not undertake techniques that they have not been trained to use.
- When confronted by an individual armed with a weapon, the safety of staff and service users in the immediate vicinity is paramount. Staff must only work within their limitations and not place themselves or others at risk by attempting to disarm the assailant. This does not mean that members of staff should not act in self-defence, but they will be expected to justify any force used and that force must be reasonable in the circumstances.

7 Training

Where it has been identified on a risk assessment that alarms are required to be used as a control measure for violence and aggression, local induction, and instruction of how to use must be given and documented as part of the orientation process.

The training requirements for staff members for the prevention and management of violence and aggression are based on violence and aggression risk assessments and an up-to-date training record database is maintained by the Trust Learning and Development Team.

A training needs analysis has been carried out informed by the risk assessment based on role and level of risk. Services and the Learning and Development Team will review the training needs analysis based on legislation, role, and responsibilities.

Services and the Learning and Development Team will review training to prevent and manage violence and aggression in accordance with the risk profile.

8 Guidelines for the Allocation, Monitoring and Responding to Personal Safety Alarms

In all areas that have fixed staff/patient alarm systems an agreed procedure needs to be in place for the allocation, monitoring and responding to any alarm activation **(See Appendix A)**. This will cover In-patient, out-patient and Community Team bases. This is to help areas reduce the number of lost devices and help to ensure that there are sufficient alarms available for staff working in the areas covered with alarm systems. These guidelines have been developed along with the services and with consultation with the staff working in the areas covered.

These guidelines will need to be made specific for each area and have been developed to allow this. This should allow for areas that have current good practice in place to include these in their local procedures. Each area will need to ensure these guidelines are followed and inform all staff of any new requirements.

As there are a number of different alarm systems used in the Trust the potential cost for the replacement of alarms ranges from £75 to £130. Any charging of staff for lost, damaged or non-return of alarms will only be after all those involved have been informed and all circumstances have been reviewed. Only after this if the Manager and HR agrees that this is necessary or appropriate the person is charged.

At no time should an alarm be refused to someone working in the area due to previous loss, damage, or non-return**.**

9 Environmental Considerations within the Violence and Aggression Risk Assessment

9.1 It is recognised that the environment is a major factor in the causation of violence and aggression. NICE NG10 (2015).

All areas must include an assessment of their environment within their violence and aggression risk assessment and a guidance framework is provided to enable a systematic approach in Appendix B. For support and advice contact the Trust SMA, Health and Safety Compliance Team or the LPT Learning and Development Team.

9.2 Use of Technology e.g. CCTV/Proscreen

CCTV Strategy and programme of work on a rolling programme is being implemented within the Trust to support the reduction and prevention of violence and aggression through enhanced technology.

9.3 All new builds and refurbishments will take into consideration the prevention of violence and aggression through design. Project management teams will refer to the secure by design guidance and consult Specialist Advisors prior to and during the design and construction process.

10 Clinical Risk Assessment

All patients receiving care from LPT Staff should be assessed for violence and aggression as part of their initial clinical risk assessment.

Each service user in Community Inpatient, Mental Health or Learning Disability and peripatetic services must have been screened using the LPT Care Programme Approach (CPA) (see Care Programme Approach Policy and Procedure) process on admission and any risks identified. Control measures put in place are to be communicated to appropriate staff and reviewed as part of the service user's on-going care.

The assessment will involve a structured and sensitive interview with the service user and/or carers to ascertain service users own views and any trigger factors, early warning signs of disturbed or violent behaviour and any factors that prevent or help in reducing aggression for that individual.

This process will identify appropriate care planning that includes specific interventions and may lead to establishing advance care directives.

Staff should be aware of the following factors that may provoke disturbed/violent behaviour: abuse, attitudinal, situational, organisational, and environmental issues.

This should be supported by a plan for the recognition, prevention and therapeutic management of violence and subject to regular review. The plan must be accessible for persons whom may come in contact with the service user.

The use of research based risk assessments is encouraged. This will be decided at a local level and agreed with the relevant line managers.

Where a violent or aggressive risk has been identified through clinical risk assessment, this will be shared with all relevant services working within the environment/service e.g. Housekeepers, external stakeholders, Facilities Providers.

11 Use of de-escalation techniques

The primary focus when dealing with aggressive behaviour should be that of recognition, prevention and de-escalation in a culture that seeks to minimise the risk of its occurrence through effective systems of organisational, environmental, and clinical risk assessment and management.

This approach should also promote the least restrictive intervention, therapeutic engagement, collaboration with service users and the use of advanced directives. Services and staff should encourage mutual respect and recognise the need for privacy and dignity.

The use of de-escalation should involve:

- Updating of personalised care plans to include preferred effective de-escalation methods for individual patients.
- Giving clear, brief, assertive instructions negotiate options and avoid threats.
- Moving towards a ‘safer place’, i.e. avoid either party being trapped in a corner.
- Encourage reasoning by the use of open questions and enquire about the reason for the aggression.
- Questions about the ‘facts’ rather than the feelings can assist in de-escalating (e.g. what has caused you to feel angry?)
- Offering to address any issue that is appropriate to do so (e.g., if they are angry because they are thirsty offer a drink).
- Showing concern through non-verbal and verbal responses.
- (Active listening) Listening carefully and show empathy, acknowledge any grievances, concerns, or frustrations.
- Not patronising their concerns.

Full training is provided on the mandatory Conflict Resolution Training (CRT) and where appropriate Safety Intervention (previously MAPA).

12 The Use of Physical Interventions – Restraint Reduction Standards

12.1 Physical interventions should be viewed as a final option in a hierarchy of therapeutic interventions. The Trust advocates the use of emergency responses. This includes specialised skills that are designed to minimise the risk of injury to an individual or others through the use of restrictive holds and blocks or disengagement techniques. The Trust will monitor the use of any restrictive intervention and promotes the use of the least restrictive intervention.

12.2 Searching of Inpatients and their Property.

Where it is considered that patients may be in possession of contraband or other items which may be used to cause harm to staff, patients, or others then they should be searched in accordance with the Trust's Searching of Inpatients and their Property Policy. Members of staff should be aware that the decision to search may provoke violence and aggression so strict compliance with the Searching of Inpatients and their Property Policy is necessary.

13 Use of Body Worn Cameras (BWC)

The primary purpose of the use and activation of Body Worn Cameras (BWC) within Leicester Partnership Trust (LPT) is to improve the safety of patients and staff.

Evidence indicates that the use of video recording devices may reduce the incidence of aggression and violence whilst also providing greater transparency and enabling increased scrutiny for any subsequent actions taken in response to such occurrences.

Following a successful trial of the devices on four Mental Health acute wards in 2022, equipment was purchased by the Trust to enable a longer-term evidence-based assessment of the technology. This comprises of 24 cameras deployed over 4 wards (6 cameras per ward), along with the supporting hardware and software to manage their usage. An interim Standard Operating Procedure and Data Privacy Agreement are in place. These will be reviewed and formalised at the conclusion of the extended assessment period.

14 Police Involvement

The SMA will develop relationships with local police in order to ensure effective partnership working.

Where staff members are subjected to violence, aggression, and abuse at work they have a right to report this to the police and to have an expectation that the police will investigate the matter and the Trust will support that police investigation.

In any situation where violence and aggression is beyond the control of staff in NHS premises or where a community worker is subjected to violence and aggression outside of NHS premises it should be reported to the police using (9)999 without delay. In instances where members of staff are able to control violence and aggression in NHS premises or where community staff are able to resolve or escape from violent situations a formal complaint can be made to the police using (9)101.

The police control room staff will prioritise 999 police responses based upon the following:

- Danger to life
- Use, or immediate threat of use, of violence
- A crime in progress
- A serious injury to a person
- An offender has just been disturbed at the scene
- A need for immediate police attendance such as when a crime is about to be committed.

The Police Narcotics Dog, deterrent, drugs associated with reduction and prevention of violence and aggression.

Except in emergency situations, members of staff should discuss reporting incidents to the police with the senior nurse or line manager. Advice can be provided by the SMA and any police officer dedicated to LPT (currently at the Bradgate Unit).

The Police may in the event of an incident use incapacitating agents. See Appendix C in reference to the care of people following exposer to incapacitate sprays and Tasers.

15 Reporting and Recording

It is vital that all patient incidents of violence and aggression, verbal or physical, are reported either as part of the on-going assessment and care of an individual service user or in order to focus attention and resources on the management of potentially dangerous occurrences.

Staff must report all violent incidents and fears of potential violence to their line manager or person with responsibility for the area.

It is vital to forewarn colleagues using patient markers on Systm1 of any apparent risk at the earliest opportunity i.e. the beginning of the shift during handover or at any time during the shift. These must also be documented in the patient care plans.

In identifying the type of words and conduct/behaviour that cause harassment, alarm or distress staff should use their judgement and sense of proportion, but never accept violence or abuse as “part of the job.

All Incidents that involve violent behaviour must be reported using the Trust electronic incident reporting system. These include incidents involving or resulting in:

- The use of restrictive physical interventions,
- Rapid tranquilisation
- Seclusion
- Any other incidents described in the incident policy.

All incidents must be recorded in accordance with the Trust and professional record keeping policies.

Victims of violence and aggression have a right to request a formal investigation by the police in addition to any action taken by the Trust. The victim has the right to expect the Trust to support any police investigation and provide such evidence as is necessary to pursue enquiries.

Support and involvement from Clinical Trainers and the Local Security Management Specialist will be provided for incidents involving injury or of particularly high risk.

Those involved may also seek additional support from such organisations as the Employee Assistance Programme (AMICA) or Victims Support.

16 Post Incident Reviews/Debrief

Following an incident where restraint, rapid tranquillisation or seclusion is used, the staff should meet quickly after the incident to ensure there are no injuries and to discuss what happened during the incident, as the incident coordinator, may not have been at the incident from the outset and each person's role in the incident. This should allow for incident reports to be completed accurately.

It is important to discuss the trigger factors and what could be done to prevent this type of incident in the future. It is important to ask staff how they feel and whether they need any further support. It is recognised that staff that are involved in incidents that result in the use of restrictive practices may feel the impact emotionally and require support following the incident. However, it is the staff's responsibility to ensure that they let somebody know if they require further support after the debrief.

Directly after the incident, staff should try to rebuild therapeutic relationships with the patient where appropriate. Staff should discuss whether they want support or some time alone. Some patients may require support with ongoing distraction to manage feelings.

Other people who witnessed an incident where restrictive practices may have been used, should also be offered support, as it is recognised that there are physical, psychological and emotional effects of witnessing the use of force. There will also be information available to patients and visitors on the use of force in our services.

The patient who was involved in the incident should be given the opportunity when they have recovered their composure to discuss the incident with a member of staff. They should be reviewed for any injuries and given the opportunity for medical review if required. They should be offered emotional support and also to consider how to reduce the chance of an incident like this from occurring again.

Staff are trained during Safety Intervention (previously MAPA) training in the IBERA Post-Crisis Debriefing Tool: 5 Simple Steps:

1. Introduction – Introduce yourself to the person and how long you have to spend with them.
2. Background - Find out about the event. Use open questions to get the person to tell you their view of the event.
3. Emotional Impact - Use questions which help the person to describe their emotional response to the event or circumstances.
4. Resourcefulness - Find out how the person is handling the event and show empathy. Assess the person's response to how they are dealing with the event.
5. Action & Close - End the debriefing by asking the person if there is anything they think they should now do.

A proforma for patient post incident review is available within the Rapid Tranquillisation Policy and Seclusion and Long-Term Segregation Policy.

When staff need a further debrief after an incident, this should be conducted using a recommended tool, for example, 6 C's (See Debrief flowchart in Restrictive Practices Policy).

For some incidents, there may be the need for a more formal debrief/reflect session to support the staff team. These will take part with support from the psychology team.

Staff also have access to AMICA, the Trust's counselling service to support with psychologically difficulties following an incident, as well as support from line management and Occupational Health. There may be a need to fast track trauma focused psychological therapies for some incidents. Further advice is available in the PIPPS Policy.

17 Zero Tolerance

We do not tolerate any form of abuse against our staff, volunteers, contractors, or students, from anyone who comes in to contact with our services; this includes hate incidents, physical abuse, and non-physical assault. We have a Zero Tolerance approach to abuse, which means:

1. Service users, or their family/friends/carers, who subject our staff to abuse will be written to by an appropriate manager to state that the behaviour is unacceptable

2. If abuse reoccurs or is significant enough to warrant immediate action at this stage, the patient will be discharged from LPT services and advised how they can access ongoing treatment.

3. If discharge is not possible (for instance, due to lack of capacity, or the need for emergency life-saving care), the abuse will be documented and discussed with the patient when they have capacity. Alternatives such as reassigning the patient to another member of staff, rotating care of the patient between multiple staff members, and other actions as part of a risk assessment, should be considered on a case-by-case basis depending on the needs of the staff member experiencing the abuse, and the wider team.

4. Abuse can be reported to our Police Partnership Officer, who can assist with making a report to Leicestershire Police (contact details on Staffnet).

5. In all cases, the victim of the abuse will be supported by their line manager as required and signposted to relevant internal and external support services. A list of support options is available on Staffnet.

It is expected that all incidents of abuse will be reported via Ulysses, although the report does not necessarily need to be made by the member of staff who has been the victim of abuse.

Zero Tolerance resources for teams can be found on Staffnet.

Zero Tolerance team training can be accessed from the Equality, Diversity & Inclusion team (LPT.EDI@nhs.net).

If abuse is perpetrated by a member of LPT staff (for example, bullying or harassment towards a colleague), staff can report this to their line manager, Freedom to Speak Up, or Human Resources. Further support can be found in the Dispute Resolution in the Workplace Policy.

18 Unacceptable behaviour and Withdrawal of Treatment

Under certain circumstances it may be necessary for LPT to modify, withdraw or refuse treatment of patients. LPT will support such action where it complies fully with the procedure detailed in Appendix D.

Withdrawal of treatment will only ever apply in extreme cases, after taking legal advice and should be seen as a last resort. However, there may be instances when the nature of the incident is so serious that LPT, having taken legal advice, will withhold treatment immediately. The procedure applies not only to violent or abusive patients aged 18 years or over, but to carers, visitors or family members whose behaviour poses a threat to staff.

Where a patient is under the age of 18 or deemed a vulnerable adult, any decision made must take into account a full clinical assessment of the patient's condition balanced against the nature of the incident (Refer to LPT Safeguarding).

Whilst not precluding individuals from the process, where a patient has a pre-existing mental health need or medical condition that can adversely affect their behaviour, it must be demonstrated and documented that a full account of that condition is taken into consideration before any action is taken.

Patients who are not competent to take responsibility for their actions will not be subject to the procedure. This will be based on the combined judgement of the relevant clinician and other medical experts and could include patients who become abusive as a result of an illness or injury.

19 Harassment, Stalking, Social Media, Defamation and Bullying of Staff

LPT has a Dispute Resolution in the Workplace Policy and a Social Media Policy which should be read in conjunction with this Policy. Members of staff should be aware that bullying by members of staff can involve violence, aggression and the sort of abuse described below. Members of staff subjected to such abuse are entitled to complain to the police in the same way as if they were abused by patients or other members of the public.

Whilst assault and abuse generally occur in physical confrontations between members of staff and others, aggression can be directed against members of staff in other, indirect, ways. This can involve activity using telephone calls, faxes, email, SMS and text messages, social media, and web pages. Behaviour of this type may incur criminal liability including offences listed below:

- **Harassment** - can include repeated attempts to impose unwanted communications and contact upon a victim in a manner that could be expected to cause distress or fear in any reasonable person (ss. 2 and 4, Protection from Harassment Act 1997).
- **Stalking** - acts or omissions which, in particular circumstances are ones associated with stalking. For example, following a person, watching, or spying on them or forcing contact with the victim through any means, including social media (ss. 2A and 4A, Protection from Harassment Act 1997).
- **Threats to Kill** – a threat, intending that the other would fear it would be carried out, to kill that other or a third person (s. 16, Offences Against the Person Act 1861).
- **Communications** – Improper uses of public electronic communications network such as sending grossly offensive, indecent, obscene, or menacing messages;

messages that cause annoyance, inconvenience or needless anxiety or messages that are known to be false (s. 127, Communications Act 2003).

- **Malicious Communications** – sending a message which conveys a message which is indecent or grossly offensive, a threat, false and known to be false by the sender (Malicious Communications Act 1988).
- **Postal Services** – sending indecent or obscene items by post (s. 85 Postal Services Act 2000).
- **Social Media Hate Crime** – covers offences and sentences that are aggravated by reason of the victim's race, religion, disability, sexual orientation, or transgender identity (ss. 145 and 146, Criminal Justice Act 2003).
- **Defamation** – some communications, particularly on social media or web pages, can involve false messages which affect the reputation of the individual. This is a difficult area as it affects the right of the individual to freedom of speech. In the first instance this should be dealt with at local level with advice from the SMA and Communications Team.

The above list is not exhaustive but includes the most common criminal offences used to tackle this type of abuse. Members of staff should be aware of their right to complain to the police about this type of activity and of the Trust's obligation to assist them to do this. Where a patient or other individual can reasonably be expected to understand the nature and consequences of their behaviour the victims should be encouraged to report the behaviour to the police without delay. However, many of our patients are acutely unwell so it may not be constructive to proceed against them via the criminal law without first considering local options.

The type of incidents listed above should be reported as shown in Appendix K. It may be more appropriate to deal with such incidents at a local level. Where appropriate the issues could be discussed with the multi-disciplinary team involved in the patient's care and the clinician/manager with overall responsibility. Advice can also be sought from the Bradgate Unit Police Officer and the SMA.

In the first instance, an immediate challenge to the alleged culprit, with a witness, may be sufficient.

The Manager may consider it appropriate to approach the alleged culprit and/or to discuss the situation with a carer or relative. A written note of any actions should be made.

If the behaviour persists or is unresolved a case conference should be arranged. Membership of this group must include either the Director or SMA depending on the severity of the behaviour but must initially include all Trust staff involved in the provision of care to the patient involved. This may be extended to include staff from external agencies that are also closely involved in providing care.

The case conference will take into account details of the incidents and the seriousness and urgency of the patient's health problems. It will consider taking formal action to prevent repetition of the patient's unacceptable behaviour.

Examples of the available options may include:

- Changing the member of staff providing care to that patient. This should never be implemented without the consultation of staff and certainly not without addressing the concerns with the patient/individual.

- The issuing of a verbal warning.
- A documented Acknowledgement of Responsibilities Agreement.
- A written warning.
- Reporting the incidents to the Police: these are potentially criminal offences.
- Exploring the potential to arrange counselling for the patient.
- Withdrawal of treatment in accordance with the relevant steps outlined in Appendix D.

20 Process for Review of this Document

This policy will be reviewed every three years or whenever there are changes to legislation, regulation, and standards relevant to this area.

21 Dissemination and Implementation

The policy is agreed by the Leicestershire Partnership NHS Trust Health and Safety Committee and is accepted as a Trust wide policy. This policy will be disseminated throughout the Trust following adoption.

The dissemination and implementation process is:

- The policy will be published and made available on Staffnet.
- Staff will be made aware of this policy using existing staff newsletters and team briefings.
- Managers will convey the contents of this policy to their staff.

22 Monitoring Compliance with and the Effectiveness of this Policy

The implementation of this policy will be monitored by the Health and Safety Committee.

Compliance with this policy will be measured through management of incidents relating to violence and aggression and the actions taken to address such incidents and recommendations from lessons learned.

The monitoring of this policy will be the responsibility of the Health and Safety Committee as stated in its Terms of Reference. Process for Monitoring Compliance and Effectiveness

- Audit of Policy by the SMA annually.
- Risk assessment reviewed at H&S Committee annually.
- Monitoring of reported violent incidents by SMA quarterly.
- Quarterly reporting to the Health and Safety Committee of safety audits e.g. alarms.
- Any issues of concern that are raised will be discussed at the Least Restrictive Practice Group and then taken to the relevant Trust Group, Health and Safety Committee and/or Patient Safety Improvement Group.

23 Reporting

The Health and Safety Committee will receive quarterly reports from Local Security Management Specialist on safety audit work undertaken, incident data, trends, and themes, RIDDOR incidents, lessons learned and recommendations from incident investigation, Police intervention and overview of training data.

The Workforce Wellbeing Group report on:

- Systems and risk assessments (workplace and workforce).
- Staff experiences (Causation themes, impact on Health & Wellbeing, consequences etc).
- Serious Incidents.
- Staff, Local or pulse surveys.
- Local HR intelligence (Staff recruitment and Leavers rates, absenteeism, or retention rates).

The Learning and Development Organisational Group report on training and development that refer to the management of violence and aggression within the Trust.

24 References and Bibliography

National Institute for Health and Care Excellence: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges: NICE guideline 11. May 2015. National Institute for Health and Care Excellence, London. nice.org.uk/guidance/ng11

National Institute for Health and Care Excellence: *Violence and Aggression: Short-Term Management in mental health, health and community settings*.

NICE Guideline 10. May 2015. National Institute for Health and Care Excellence, London. nice.org.uk/guidance/ng10

Positive and Proactive Care: reducing the need for restrictive interventions: Department of Health. April 2014

Least Restrictive Practice Group Terms of Reference

Mental Health Act, (1983)

Mental Health Act, Code of Practice, (2008)
Secretary of State Directions on work to tackle violence against staff and professionals who work in or provide services to the NHS. Counter Fraud and Security Management Service. (2003).
Mental health crisis care: physical restraint in crisis: A report on physical restraint in hospital settings in England. MIND June 2013.

A positive and proactive workforce: A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health. Skills for Care & Skills for Health 2014

National Institute for Health and Care Excellence: Violence and Aggression: Short-Term Management in mental health, health and community settings.

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The recognition, prevention and therapeutic management of violence in mental health care.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting, (2002)

Mental Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings. National Institute for Mental Health in England. (February 2004)

Code of Practice for Trainers in the use of Physical Interventions.

The British Institute of Learning Disabilities, (2004)

A safer place to Work: protecting NHS hospital and Ambulance staff from violence and aggression. National Audit Office. (2003).

Restraint Reduction Network (RRN) Training Standards 2019 First Edition

Guidance on Restrictive Physical Interventions for People with Learning Disabilities in Health, Education and Social Care Settings. Department of Health, (2002)

NHS Violence Prevention and Reduction Standard January 2021

25 Associated Policies and Procedures

Seclusion and Long-Term Segregation Policy
Searching of Inpatients and their Property Policy
Care Programme Approach Policy
Code of Conduct Policy
Police Liaison and guidelines for calling the police.
Personal Safety and Lone Worker Guidelines
Rapid Tranquillisation Policy
Dispute Resolution in the Workplace Policy
Health and Safety Policy
Incident Reporting and Management Policy
Supportive Observation and Engagement of Inpatients Policy
Guidelines for the provision of staff welfare and support following an incident of violence or aggression.
Social Media and Electronic Communications Policy
Privacy and Dignity Policy
Management of Sharps and Exposure to Blood Borne Viruses Policy
BILD Ethical Approaches to Physical Interventions Physical Interventions and the Law.
Escorting Patients Policy
Lone Worker Policy
First Aid at Work Policy
Additional local procedural documents may be produced for specific areas.

Leicestershire Partnership NHS Trust

GUIDELINES FOR THE

ALLOCATION, MONITORING AND RESPONDING OF

PERSONAL SAFETY ALARMS

INPATIENT/OUTPATIENT AND COMMUNITY SERVICES

(Insert unit name)

Standard Operating Procedure

- All alarms are to be clearly marked with the ward / area / department name and numbered.

- (Insert number) spare alarms to be kept on the ward / unit in the ward Matron's / Team manager's Office or identified safe place. This is to cover loss, damage and repair.

- **In Out patients, Community Bases and Non-Ward Areas that have personal safety alarms:**

  Alarms will be available from reception (Insert area) for anyone seeing a patient in interview/consulting rooms. Each individual will sign for the alarm when they collect the key for the room. It is the responsibility of the person using the room to collect an alarm when involved in any patient activity. Failure to return alarm to reception may lead to a charge being incurred.

- As there are a number of different alarm systems used in the Trust the potential cost for the replacement of alarms is likely to be in excess of £100. Any loss or damage of alarms should be investigated by the ward manager or matron. Where it is clear that the loss or damage is the result of a deliberate act or neglect on the part of the recipient, charging them the full cost of replacement should be considered. At no time should an alarm be refused to someone working in the area due to previous loss, damage or non-return.

- All substantive staff and junior doctors on rotation are to be issued with their own alarm after completion of a request form. (To include nursing, medical & Administration staff. Contracted Facilities Provider staff have their own system) ***(See A-4)***

- Student Nurses, Bank Staff, visiting professionals and any identified personnel are to be issued an alarm on a daily basis by the Nurse in Charge/identified person after signing an issue form, which includes Nerve Centre and keys and fobs or from the unit reception/Ward office. (***See A-5)***

- At the same time Student Nurses, Bank Staff & visiting professionals should be issued with a letter of instruction. ***(See A-6).***

- The Nurse in Charge/ Identified person is responsible for checking that spare alarms, keys and fobs are returned at the end of the shift/clinic. If equipment is not returned a letter is to be sent to the member of staff requesting its return. ***(See A-7)***

- **If an alarm is not returned following a letter (See A-7) then the local Manager must consider all circumstances around the failure to return the alarm before requesting payment for a replacement. At no time will this prevent an alarm being issued for the working hours.**

- Each individual member of staff is responsible for testing their alarm ***before*** the commencement of their shift/clinic. Although substantive staff are issued with their own alarm they must sign ***A-5*** to confirm testing when starting shift

- If, following testing of the alarm, it is found not to be working it is to be returned to the Nurse in Charge/ point of issue and a spare alarm issued. The faulty alarm should be sent for repair immediately and recorded on the sheet.

- All new staff, students and Bank Staff are to be shown how to test their alarm. ***(See A-8)***

- All new staff, students and Bank Staff are to be shown how to activate their alarm. ***(See A-10)***

- All new staff, students and Bank Staff are to be instructed on how to respond to the activation of an alarm. ***(See A-12)***

- A monthly audit is to be undertaken by the Ward Matron/Team Manager (or a nominated member of staff) to ensure that alarm testing is being undertaken by all members of staff on each shift. ***(See A-13)***

- SOP for LPT Staff, Enacting and Incident Response on a Mental Health Ward ***(See A-14)***

- This document to be incorporated into the local induction procedure for the ward/area/department.

LEICESTERSHIRE PARTNERSHIP NHS TRUST

(Ward/Unit Name)

ISSUE OF PERSONAL ALARM, KEYS AND FOB TO SUBSTANTIVE STAFF

Alarm number……

Key number……

Fob number……

Issued to…….

Declaration

I have received the above equipment and will ensure that the alarm is tested ***before*** the beginning of each shift/clinic and any fault reported immediately to the Nurse in Charge/point of issue/identified person.

I have been made aware of the charge that will be levied for non-return, loss or misuse of the alarm/equipment.

I confirm that I have received instructions on how to use, test and respond to alarm activation.

Signed…….. **Date……..**

Designation…….

A-4

PINPOINT/SAS, NERVE CENTRE AND KEY SIGN OUT SHEET **Ward:** _____ **Date:**_____

Details				Nerve Centre				Pinpoint Alarm			Keys		
No.	STAFF NAME	Shift	Phone number if not substantive	Device Number	Device cleaned prior to charging	Sign out	Sign in	Alarm number	Sign out (Test alarm)	Sign in	Key No.	Sign Out	Sign in
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													

Check that all staff have appropriate equipment to work on shift: Nurse in Charge sign at start of shift:_____

Check that all staff have returned appropriate equipment at the end of shift: Nurse in Charge sign at end of shift: _____

A-5

LEICESTERSHIRE PARTNERSHIP NHS TRUST

(Insert ward/unit name)

Instruction sheet to be handed to students, bank and medical staff on the issuing of key, alarm and fob

You have been allocated a set of equipment which includes (delete where not applicable) Keys, Alarm, Fob other ……. This has been allocated for your safety and for the duration of your shift/clinic/placement only.

You must return this to the Nurse in Charge/identified person at the end of your shift/clinic/placement. For your own protection, you **must not** give it to anyone else during or after your shift/clinic.

By signing for the equipment, you are accepting responsibility for the equipment and that you will return it at the end of your shift/clinic/allocation.

You need to be aware that a charge for the replacement will be levied for non-return, loss, or misuse of the alarm/equipment.

By signing for the equipment, you are agreeing to the Terms and conditions for use and return.

Thank you for respecting Trust property and keep safe.

(Name)
Ward Matron/Manager
(Ward/Clinical Service/Department/Area)

Leicestershire Partnership NHS
NHS Trust

A University Teaching Trust

Ward name
Address
Of the unit/ward
Tel: 0116 225 ….

Date
Address

Dear *(insert name)*

You recently worked on (Ward/area). At the beginning of the shift/clinic/placement, for your safety, you were supplied with a personal safety alarm/key/fob, which you signed for and agreed to return to the Nurse in Charge/point of issue after the shift/clinic/allocation.

We do not have a record that you returned this equipment and therefore the Ward/clinic will be expected to replace it at cost from the ward budget. We will look to recharge you for this cost as stated in the agreed terms and conditions you signed at the time of issue.

Please could you return this equipment as soon as possible (within 7 days?) to the (insert name) so that other staff members may benefit from the safety it offers.

Yours sincerely

Ward Matron/Manager
(Ward/Clinical Service)

(Ward Name)

TESTING OF PERSONAL ALARMS

(Add in relevant parts for local systems)

Pinpoint Energiser type

- Charge the alarm using the lead on the energiser box (If of this type)
- When this is done, put both hands in the box with the alarm held between them and pull the pin and/or the button is pressed.
- If fully charged the indicator will turn **RED**.
- If the indicator does not turn **RED** charge the alarm once more and repeat the procedure again. If it again fails to turn **RED**, take the alarm to the Nurse in Charge and ask to be issued with another whilst yours is sent for repair.
- If the alarm is used during your shift test and charge the alarm again using the procedure above.

Pinpoint PIT Battery type

- This type of device cannot be charged and has a replaceable battery.
- The blue Badge PIT has a battery test button whilst the black battery PIT has an audible alarm which sounds when the battery requires replacement.
- Test as per energizer PIT – put both hands in the box with the alarm held between them and pull the pin and/or the button is pressed.
- If the battery has adequate charge the indicator will turn **RED**.
- If the indicator does not turn **RED** charge the alarm once more and repeat the procedure again. If it again fails to turn **RED**, take the alarm to the Nurse in Charge and ask to be issued with another whilst yours is sent for battery replacement or repair.
- If the alarm is used during your shift test the alarm again using the procedure above.

Testing the alarm Guardian system (Evington Centre, Willows)

- Alarms should be tested at the start of each shift in an area which is not protected by the main alarm system.
- On some wards the sluice room has been specified for this.

- For non-ward areas, arrangements should be made with the nearest ward to use the identified room on a daily basis for clinical staff and weekly for administrative staff.
- To test: To test the button press and hold for 2 seconds while monitoring the **RED** confidence LED. Then pull pin and hold for 2 seconds while monitoring the **RED** confidence LED.
- If the LED fails to flash or flashes erratically then take the alarm to the Nurse in Charge/Point of issue immediately.
- There is no audible alarm or battery test button on the Guardian alarm device so you should retest your alarm during your shift if you are aware that the battery has not be changed for some or you are not aware when the last battery change took place.
- If the alarm is used during your shift test the alarm again using the procedure above.

SAS System (Belvoir/HPC)

- Individual SAS alarms are tested by the staff member allocating the devices at the commencement of every shift.
- The clear button at the bottom right hand side of the alarm is pressed whilst being pointed at an alarm sensor. At this point the sensor should flash **RED** with the SAS alarm battery lights flashing **GREEN** or **GREEN** / **AMBER**, this will indicate the system is active and the SAS Alarms battery is ok
- If SAS alarm battery indicates **RED** it will be immediately placed to one side for the battery to be changed and a functioning alarm will be provided.
- Alarms are attached to the belt loop and activated by either pulling the main body of the alarm away from the holding clip or by pressing the **RED** button on the front top of the alarm.
- **System Tests** are carried out by two (2) designated staff members (from each ward) on a weekly basis, covering 8 different pinpoints on each of the ward/building areas. This process will ensure that the entire HPC buildings alarm points are activated & logged over a 5-week period.

It is the responsibility of the person allocated the alarm to ensure that it is fully functional at the start of each shift.

INSTRUCTIONS FOR ACTIVATING PERSONAL ALARMS

Type of assistance required	Method of activation	Result
(PINPOINT ONLY) Low level assistance required, within same Ward, e.g. to diffuse potentially difficult situation	Press button on the bottom of the hand-held alarm	• Nearest sensor shows acknowledgement by displaying a red flashing light. • Nearest display panel sounds and indicates location of activation. • No other /wards/depts. are alerted. • You will receive assistance from staff in your area only. • All panels on the same area indicate 'Assistance?' and emit an audible signal.
Assistance required by entire response team, e.g. Physical Assault, absconding patient	Pull pin out of the alarm and retain alarm on person	• Nearest sensors acknowledge activation by displaying red flashing light. • All display panels sound and give location, indicating 'Psychiatric Emergency?' • Response team pagers are activated and indicate exact location and show 'Psychiatric Emergency?'. • You will receive assistance from other staff on the ward and other areas.

- The system has the capacity to handle multiple calls. If more than one alarm is activated at any one time, bleeps will be activated one after another and a second message will appear on the bleep and display panel.

- Each individual call will need to be cancelled in turn.

- The Nurse in Charge/ CDM / Coordinator will make the decision about how to respond to the second emergency.

- In the case of a patient absconding or moving around the unit, the nurse in pursuit holding the originally activated alarm will be tracked through the building by the other sensors around the unit. This information will be conveyed to the bleeps and control panels as the location changes. If the response team is not able to immediately locate the incident from the original message, the bleeps should be re-checked for a change in location. Once a pursuit leaves the unit this tracking facility fails to operate.

- Re-setting the system following an incident – when the Nurse in Charge / CDM / Coordinator is satisfied that the incident is over; the system can be reset by pressing the reset button on the display panel.

- Local response arrangements maybe different and may depend on the time of day/work activity. This will need to be made available for all staff working in the area and clearly documented.

Medical Emergency (see Resuscitation Policy for definition)

Safe system of work for responders

(*Can be used as a local induction checklist*)

Respond to activations by proceeding without delay to the exact stated location – Be mindful of factors and actions that may present risk to you or others i.e. moving quickly around corners and close to doorways. Do not run. Be mindful of the location of people and equipment when responding and act to reduce the risk of injury to yourself or others. Your objective is to arrive at the requesting location fit to deal with the situation you are presented with on arrival.

- Read and understand the Emergency response protocol.
- Take responsibility for the correct use of the pager when allocated.
- Understand the different levels of response required – Local Assistance or Full assistance.
- To ensure that the alarm is tested at the start of each shift - physical testing to be carried out and documented.
- Act to report / replace batteries when low battery indicators activate.

  Batteries can be obtained from……
- Take part in system testing and communicate with reception to confirm location signal.
- Report any loss, damage, or concerns to the nurse in charge/ identified person / point of issue.

(Name of Ward/outpatients/clinical area)

MONTHLY AUDIT OF ALARM TESTING

Date	Checked by	Issues identified	Actions	Actions completed on

A-13

STANDARD OPERATING PROCEDURE
For
LPT Staff, Enacting an Incident Response on a Mental Health Ward

	NAME	TITLE
Author(s)	Mike Ryan	Emergency Planning Manager

Effective Date:	**July 2019**
Review Date:	**July 2022**

In the event of a psychiatric incident, ensure the response team and ward staff undertake the following actions:-

1. Respond to activations by proceeding without delay to the exact stated location, your objective is to arrive at the requesting location fit to deal with the situation you are presented with on arrival.

2. Dynamically Risk asses the incident, take control of the situation

3. Consider the safety of staff, including domestics / hotel services and patients.

4. Consider the safety of non-ward personnel (Professional visitors, patient visitors, carers and contractors).

5. If required, move non-ward personnel to a safe space, in order to manage the incident safely.

6. If the incident requires the ward, or part of the ward to be isolated for a long period, ensure that all non-ward personnel are informed and are escorted from the ward/site, safely and securely.

7. Once the incident has been concluded, the response team leader should consider delivering a post incident de-brief at the earliest opportunity to all staff involved. If any staff sustained injuries during the response, asses if they are RIDDOR reportable, liaise with the Health and Safety Team for advice.

8. Submit an Electronic Incident Report Form (EIRF) on the Trust reporting system.

9. Communicate to the Clinical Duty Manager or Nurse in Charge that the ward is back to business as usual.

Appendix B

Leicestershire Partnership NHS
NHS Trust

Risk Assessment Environmental Guidance Notes

Contents

1 Introduction

The Least Restrictive Practice Group have reviewed the environmental risk assessment process relating to issues of violence and aggression within the Trust.

The duty imposed by the Management of Health and Safety at Work Regulations 1999 requires the trust to:

- Carry out a suitable and sufficient assessment of risk to both employees and others who may be affected by their work activities.
- Record the significant findings of assessments and identify any group of employees especially at risk.
- Review assessments when there is reason to suspect that they are no longer valid and when there has been a significant change in the matters to which they apply.

The Trusts Prevention and Management of Violence and Aggression policy acknowledges that risk assessment is an essential element of Health and Safety management.

The policy states that

5.4.2 All areas must have an assessment of their environment detailing measures to:

- Promote a safe environment.
- Demonstrate calming features within the environment, promoting the safety of staff and service users.

Violence has been defined by the NHS (NHS CFSMS 2003) as:

Physical Assault

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

Non-Physical Assault

The use of inappropriate words or behavior causing distress and / or constituting harassment.

Violence may be caused by staff, patients, relatives, and other visitors or by unwelcome guests such as intruders to the premises or grounds. This document should be read in conjunction with the following Trusts policies:

- Risk Assessment Policy and Procedures.
- Policy For Personal Protection for Staff.
- The Prevention and Management of Violence and Aggression Policy.
- The Fire Safety Management Policy.

2 Benefits of the Environmental Hazard Prompts

It is recognized that the environment is a major factor in the causation of violence and aggression. The introduction of the environmental hazard prompts will enable the following benefits: - (Royal College of Psychiatrist 2000)

- To ensure a standardized format is undertaken across the Trust.
- A consistent approach to identifying hazards in the environment, which would then aid finding control measures.
- An excellent communication tool for all the health care disciplines.

3 Prevention and Management of Aggression Environmental Hazard Guidance Notes

1	All areas should have Prevention And Management of Violence and Aggression environmental risk assessments.
2	It is the responsibility of the local manager to ensure that risk assessments at the local level are completed
3	The environmental hazard guidance provides an aid to assist in recognizing environmental issues that may be significant in preventing or managing risk of Violence and Aggression.
4	The hazards guidance notes concentrate on highlighting the more at-risk areas due to the activities that take place in those areas.
5	Involve as many staff working within that area as possible, when completing the paperwork, the more discussions regarding the subjects more possible solutions maybe identified.
6	Once the issues for concern have been identified and possible actions agreed this information should be placed on the current. Leicestershire partnership trust risk assessment paperwork as a means of recording what is required.
7	The decision of when to review the environmental risk assessment should be made in consultation with the manager of that clinical area

4 Environmental Considerations

Minimum expected requirements within in-patients settings:

- A designated area or room that may be used with the service users agreement to reduce arousal or agitation. This should be in addition to seclusion rooms.
- Secure lockable access to service user's room, bathroom and toilet area, with external staff override.
- Ward design should allow for observation, and lines of sight being unimpeded.
- There should be a separate area to receive service users with police escorts.
- Activity room and day room with Television.
- Single sex toilets, washing facilities, day areas and sleeping accommodation.
- Space for prayer and quiet reflection.
- Opportunities for daily exercise, group interaction, therapy and recreation.
- Access to day room at night for service users who cannot sleep.
- Easy access to daylight and fresh air.

- All areas should take account of the need for privacy, dignity, gender and cultural sensitivity and have sufficient physical space.
- Where possible service users should have privacy when making phone calls, receiving guests, and talking to members of staff.

4.1 Generally for the Department

ISSUES FOR CONCERN	RATIONALE	POSSIBLE SUGGESTED ACTION
Does CCTV cover any areas in the department?	May act as a deterrent possibility of obtaining information, but unless the station is manned this will be after the event.	If you feel that this would be advantageous provide a cost quote to management. Contact Estates or Security Management for assistance.
Is the procedure for managing visitors / contractors being applied? If the building is shared are all services aware of risk assessments?	This will assist in maintaining safety; also it highlights problems allowing action to be taken. Good audit tool. Uncontrolled access to all areas will expose staff to unnecessary risks.	Could have a notice / leaflet to read advising people to ask for the info (Beware of reading / language issues). Encourage staff / visitors to report incidents. If receptionist available could provide information verbally. Signing in and out book. Visitors not allowed to a room unescorted. Visitors to wear ID badges. Share Policies with other Services e.g. Social Services.
Are emergency / “zero tolerance” signs displayed?	Provides important information also informs people of behaviour the Trust is not willing to accept.	Contact the prevention and management of violence and aggression team regarding this.
Is the Prevention and Management of violence and aggression policy, the local risk assessments relating to violence and aggression accessible to staff.	Helps staff to acknowledge who is responsible for what, what’s expected of them, what commitment and support is available.	Provide policies, ensure staff have access to them and have read them.

Is the protocol for assessing external assistance if required e.g. police, available and accessible to staff?	Some incidents are outside of our control so links with the local police are useful.	Staff should be aware of the type of incidents that require police assistance. Ensure that all staff is aware of the procedure for contacting the police and how to report and record the incident. There are Guidelines of Police Response to Incidents.
Have all permanent staff received appropriate mandatory training to assist with prevention and management of aggression? Have agency and bank staff received appropriate training to assist with prevention and management of aggression?	Training is appropriate for all groups of employees at risk, as it will assist them to work safely by dealing with conflict resolution.	Identify different levels of training for staff members by risk assessment e.g. personal safety, breakaway, The Training Team may be able to assist with this. Line manager to ensure employees attend training / updates. The H&S training database records can assist with this.
Does your area indicate how members of the public can identify staff members?	Identifying people who can assist you in obtaining the information you require is vital and helps to reduce anxiety.	Risk assesses your environment to see what would be appropriate for your client group. Staff may need providing with ID badges that have different methods of being attached to clothing. Staff uniforms may need to be an option or some form of identification.

4.2 Lobby / Waiting Area

ISSUES FOR CONCERN	RATIONALE	POSSIBLE SUGGESTED ACTION
Is the area covered by an alarm call system? Are staff aware of how to use the alarm / panic button system? Is there a procedure for responding to the alarm. Are they tested daily? Is there a contingency plan for alarm system failure?	Allows help to be received quickly if required, notifies other staff members that there is a problem.	Choice of alarm system will depend on the nature of the work; check a variety in order to get the best suited. Do you require audible or visual. May need expert advice to assist with this decision e.g. local security management specialist. Provide training for the equipment provided. Ensure staff members are aware of the alarm response procedure. Document that the alarms are tested daily and by whom.
Is accessibility restricted to all 'staff only' areas? e.g. area available for the receptionist. If areas are restricted are suitable restrictions put in place i.e. coded locks, Are shutters or glass screens necessary for reception desks? Are reception areas designed with the safety of staff in mind?	Not all areas need to be open to the public; staff in these areas separated from other working areas leaving them vulnerable. It is also appropriate to restrict access for confidentiality and prevent members of the public or clients gaining access to dangerous substances.	Ensure reception area or desk is easily identifiable. Directional signs should be clear and concise. Staffing of a reception area needs to reflect the level of risk. Are there visitor panels fitted where appropriate? Ensure that this does not impede communication. Consider alternatives, would a wider desk be a more suitable alternative? Are there alternative exit routes?
Is there sufficient space to accommodate the activity or use of that particular area?	Layouts can be confrontational or intimidating. Areas need to be welcoming, informal clean and comfortable; this will	Are furniture and fittings appropriate for their use? Note whether they can be used as a potential weapon.

Is suitable seating provided? Is any information that has been provided for clients or visitors clear and current?	contribute to a relaxed environment.	Fixtures and fittings need to be securely fitted, including plants and pictures. Provide enough seats for people waiting if appropriate. Ensure that the temperature and lighting can be adjusted. Provide a system for informing clients of waiting times or any information they may need. Display posters and/or leaflets that maybe useful for clients and visitors. Possibly involve a visitor with the assessment as they could make suggestions based on their experiences.

a. Patient Living Space

ISSUES FOR CONCERN	RATIONALE	POSSIBLE SUGGESTED ACTION
Are all relevant staff aware of client's individual risk assessments for violence and aggression**?** Is there suitable space for the clients? Are essential amenities such as drinks, snacks, telephone, and television available?	This highlights the history and or knowledge of previous behaviour. There should be no ethical objection to recording factual information about the need for particular precautions in the client's care –plan.	All clients should have a care plan for violence and aggression if appropriate. Ensure there is a define criteria on the range of clients you can treat and can be accommodated in your workplace. A system should be in place e.g. Documentation for Plan of Care enabling staff to seek a full history of the client on admission.
Is there access to daily provision e.g. newspapers, sweets, cigarettes.	The Trust has a policy on confidentiality. People feel less crowed if they have sufficient personal space. Including space outdoors. This can help calm clients and reduce feelings of imprisonment. Providing activities helps to prevent boredom, frustration, and anxiety.	Shift handovers should provide relevant information on the risks as soon as possible. Remember to include other staff members e.g. Non-Clinical Staff. Involve clients in their care if possible. Provide suitable privacy arrangements for sleeping, bathing, eating, quiet areas etc. Is there separate sleeping, washing toilet areas for women? Try to provide a variety of activities, particularly if they are therapeutic in value. Ensure members of staff have access to alarm / panic button system in these areas? Are sight lines unimpeded? Ligature points removed / covered. Safe protected surfaces e.g. radiators.

		Ensure a good supply of hot and cold water. Are furniture and fittings appropriate? Consider door options, (In order to avoid barricade situations doors should open two ways). Do clients have access to other services e.g. the Chaplin, PAL's and independent advocacy or a counsellor?
Are there suitable facilities for isolating patients if necessary?	At times there may be a need for the client to have access to a private room, or staff may need to observe a client for their safety and the safety of others. The Trust has a Seclusion and Restrictive Practices policy for use if required.	Is there the facility of an observation or seclusion room? If so, environmental controls should be placed outside the room. Doors should be of suitable construction and wide enough for three-person access (wide). Seclusion mattress and tear proof blanket available. Suitable flooring (heat sealed corners). Appropriate viewing panel. Appropriate staffing levels to accommodate client observation. Assess to a trained physical intervention team if required.

4.4 Clinical / Interview Rooms / Therapeutic Facility

ISSUES FOR CONCERN	RATIONALE	POSSIBLE SUGGESTED ACTION
Are the treatment rooms, interview or clinic rooms suitably located in respect of other areas? Is the interview room or clinic room designed with personal safety in mind?	If a client's behaviour became violent or aggressive the incident could be prolonged if in the vicinity of others, so it is useful to provide separate rooms for clients and staff to talk about personal issues away from others. Communication between staff particularly in an emergency is vital. Design of the room should enable staff to make an easy exit or withdraw.	Try to locate a room that is not surrounded by other client areas. Is there control of unauthorized access e.g. coded system? Layout of room taken into account activity that will occur in that room. Any furnishings and fittings should be designed so that they cannot be used as weapons.
Has the client been clinically assessed for their suitability in the respect of safety?	The whole idea of environmental assessments is to ensure that the risks are reduced to the lowest possible level or removed.	The interviewer should be positioned closest to the exit. A telephone or panic button should be provided or suitable alarm. Is there an alternative access route staff members could use? Consider the need for easy communication between staff, while retaining privacy for patients e.g. vision panel. Clients should be assessed regarding access to the room. Staff members working in these environments should be familiar of what is in the room and which items need to remain inaccessible depending on the client.

4.5 Community Setting

ISSUES FOR CONCERN	RATIONALE	POSSIBLE SUGGESTED ACTION
Is there a system of collecting information on potential risks of violence and aggression pre-visit? Is there a system in place for establishing staff whereabouts, and arrangements for providing backup if required? Do staff members have information and training on how to deal with an emergency situation? Employee suitability. Are the vehicles used adequately maintained?	Other agencies may have already been involved – may indicate past issues, behaviour mood, medication of the client which is helpful. As it is difficult to modify the working environment, so it is important to consider working arrangements.	Should the visit be carried out at a particular time of day? Should first visits be carried out in pairs? Is there a possibility of combined visits? Is there a possibility of meeting the client elsewhere? Ensure communication and co-operation is maintained with other professionals this will assist in obtaining information about the site, lodgers, or pets. Periodically. Find the best system / procedure that will provide this for your service e.g. voice connect. A responsible person should keep movement plans, but that person should also know what to do if no contact has been made. Responsible person should arrange to inform senior management if communication is impeded. Provide provision of an alarm and or communication devices e.g. mobile phone if they are applicable for your area e.g. voice connect. Ensure maintenance of communication system e.g. charging up of the phones Training in use of equipment provided and in defusing. Access to a first aid kit.

		Is staff clothing appropriate for that area or individual client? Are there cultural, diversity or gender issues that may affect the client? Attitudes, traits, or mannerisms which can annoy the client. Parking - try to park close by and in a well-lit area, staff may want to keep a portable lighting tool with them. Staff should be made aware that they are responsible for maintaining their vehicles in a legal and roadworthy condition with insurance covering business risks.

Incapacitating Agents Administered by Local Police Authority

Introduction

Incapacitating agents used on individuals can lead to conditions requiring pre-hospital care. The aim of this guideline is to support clinical decision making for the management of patients following the deployment of: -

A Conducted Electrical Weapon (CEW) such as “Taser” or a stun gun
B Incapacitant sprays such as Pepper Spray and CS gas.

NB Not all patients exposed to incapacitating agents will require hospital care, but all patients must have a physical assessment.

A Conducted Electrical Weapon (CEW)

Conducted Electrical Weapon (CEW) are battery operated, hand-held devices that deliver up to 50,000 volts of electricity into skin or clothing. The voltage is delivered through two long copper wires that have an electrode attachment with a fishhook design at the end of the wires. The CEW results in pain, powerful muscle spasms and the loss of voluntary control of muscles.

SAFETY FIRST

- Ensure the wires are disconnected from the devise before touching the patient; the wires will easily break by cutting with scissors.
- There is a risk of combustion if the CEW is deployed immediately after the use of incapacitant sprays or following contact with a flammable liquid.

REMOVING THE ELECTRODE

1. Slightly stretch the skin around the electrode and pull sharply on the electrode. If it does not release or it breaks, or is in one of the places listed below, cut the wires 4cm from the electrode, cover and transfer to hospital care.
2. Dispose of the electrode as contaminated waste in a sharps bin.
3. Clean the area with an alcohol/antiseptic wipe.
4. Cover the site with a dressing.
5. Advise patient to have a tetanus booster within 72 hours.

DO NOT attempt to remove the electrode if it is attached to:

- the neck or groin or near blood vessels near the skin surface.
- one or both eyes or ears.
- the face or scalp.
- the mouth, throat or has been swallowed.
- Genitalia.
- a joint or over the spine.

PHYSICAL ASSESSMENT AND MANAGEMENT AFTER THE USE OF A CEW

Most patients will not require hospital care, but the physical assessment should identify the presence of:

Effects of the use of a CEW	**Management of a patient**
Pain	Follow guidance on the use of pain management.
Superficial burns	Follow guidance on the management of burns.
Soft tissue injuries such as contusions, tendon damage, abrasions, lacerations, puncture wounds	Clean the area. Cover with a dressing. Advise tetanus booster within 72 hours. Seek medical advice.
Cardiac symptoms such as increased heart rate, cardiac arrhythmia and cardiac arrest	Monitor blood pressure. Monitor oxygen saturation. Identify individuals' cardiac history. Seek medical advice.
Secondary head, neck and back injuries caused by the fall or the powerful muscle contractions resulting from the use of a CEW	Assess levels of consciousness. Monitor blood pressure. Monitor oxygen saturation. Identify individuals medical history. Seek medical advice.
Convulsions	Monitor blood pressure. Monitor oxygen saturation. Identify individuals medical history. Seek medical advice.
Obstetric and gynaecological conditions	Monitor blood pressure. Monitor oxygen saturation. Identify individuals medical history. Seek medical advice.
Head injury caused by intracranial penetration	Assess levels of consciousness. Seek medical advice.

B Incapacitant Sprays (Inc Spray) such as “CS gas” and “Pepper spray”.

Incapacitant sprays cause irritation (burning sensation) when in contact with the exposed skin and mucous membranes causing lacrimation (tears); rhinorrhoea (runny nose); sialorrhoea (excessive salivation); disorientation; dizziness; breathing difficulties; coughing and vomiting.

SAFETY FIRST

- Do not enter a contaminated area unless it is absolutely necessary for the safety of patients or staff.
- Gloves, aprons, and masks if necessary are to be worn to prevent cross contamination.
- Staff must not touch their eyes nose or mouth as incapacitant sprays are a liquid not a gas and can be spread by contact.

PHYSICAL ASSESSMENT AND MANAGEMENT AFTER THE USE OF AN INCAPACITANT SPRAY

Most patients will not require hospital care, but the physical assessment should identify the presence of:

Effects of the use of an Incapacitant Spray	**Management of a patient**
Lacrimation Rhinorrhoea Sialorrhoea	Move the patient away from the source of the contaminant and expose to fresh air. Heavy contamination can be irrigated with tap water. If symptoms persist after 15 minutes transfer to further care.
Breathing difficulties Coughing	Use of oxygen as required. If symptoms persist seek medical advice.
Disorientation	Remain with the patient and manage their safety, privacy, and dignity appropriately.
Dizziness	Check blood pressure. Keep seated or lying down as appropriate.
Vomiting	Maintain airway. Manage their safety, privacy, and dignity appropriately.

Always identify how the patient was behaving prior to the deployment of the Inc Spray and assess for:

- drug and alcohol use
- bizarre behaviour
- physical aggression and abnormal physical strength
- an aroused state sometimes called “excited delirium”.

These behaviours place the patient at increased risk of secondary physical conditions such as cardio-pulmonary collapse.

IF THERE IS ANY DOUBT ABOUT THE HEALTH OF THE PATIENT SEEK MEDICAL ADVICE

Appendix D

PROCEDURE FOR WITHDRAWAL OR REFUSAL OF TREATMENT

To ascertain the reason for the behaviour, in order to prevent further incidents, or reduce the risk of them reoccurring, there are several steps that must be taken before withdrawal of treatment can be considered.

All key stakeholders and relevant personnel, including staff union or professional representatives, the SMA and Director must attend a pre-meet to discuss the situation where a decision will be made as to the most appropriate course of action or relevant stage of the policy to implement. For patients who have a pre-existing mental disability or medical condition that can adversely affect their behaviour or are not deemed competent to take responsibility for their actions, medical advice must be obtained – this can include advice from the individuals GP or other medical expert e.g. psychiatrist or mental health nurse.

The steps below refer to document templates which are included at Appendices E-H. Editable versions of these templates are available on the Health, Safety and Security eSource page.

Step 1 Verbal Warning

When a violent or abusive incident occurs or when there is evidence of continued and serious inappropriate behaviour by an individual, a verbal warning should be given to the patient concerned by a senior member of staff.

Verbal warnings may not always be appropriate and should only be attempted when it is safe to do so with at least two members of staff present.

The aim of the verbal warning is twofold:

- To ensure that the patient, relative or visitor is made aware that their conduct is not acceptable.
- To ensure that the patient, relative or visitor is aware of the consequence of further unacceptable behaviour.

In the interim, where on-going care is necessary, Managers should ensure that suitable contingency arrangements are made to ensure this is delivered in a safe environment.

Where possible a meeting should be arranged with the person concerned and conducted in a fair and objective manner where they should be informed of staff concerns. A formal record should be made and maintained and also copied to the Incident Team. Any verbal warning should also be noted in the patient's notes.

Where the process has no affect and unacceptable behaviour continues, alternative action must be considered.

In serious cases it may be appropriate to issue a final warning without the need for a verbal warning or ARA process.

Step 2 **Acknowledgement of Responsibilities Agreement (ARA) (Behaviour Agreement)**

ARAs are an option that can be considered for individuals to address unacceptable behaviour where verbal warnings have failed, or as an immediate intervention, depending on circumstances. An ARA is a written agreement between parties aimed at addressing and preventing the recurrence of unacceptable behaviour. They can also be used as an early intervention process to staff unacceptable behaviour from escalating.

Where it is safe to do so, the perpetrator should be invited to attend a meeting where the agreement is made (**If not considered safe communication to the service user should be made in writing using Appendix E**). Consideration should be given to a suitable venue taking into account any specific access difficulties for the persons concern. Appropriate persons should attend this meeting, but careful consideration should be given to the number of staff attending as the situation could be perceived as intimidating. The individual should also be given the opportunity of representation or support.

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

Terms of the ARA should be confirmed in a formal written document (**Appendix F**) delivered to the individual concerned and any agreement should be for at least a period of six months.

Monitoring is essential if the ARA is to be effective and roles and responsibilities in respect of monitoring must be clearly understood so that further unacceptable behaviour is recorded, and appropriate action can be escalated if necessary. Agreement will be made at the outset on who will undertake responsibility for monitoring compliance with the ARA. The SMA must be kept updated on the monitoring process.

Step 3 **Written Warning**

Before withholding treatment is instigated, a final written warning should be issued to the patient by a senior member of staff (either the Chief Executive Officer or Director) and must be copied to the patient's GP.

The letter or written warning should explain the reasons why the withholding of treatment is being considered (including relevant information, dates and times of incidents) and give details of the mechanism for seeking a review of the issue e.g. via local patient complaints procedures (**Appendix G**).

There may be instances however where the nature of any assault is so serious the Trust, having obtained legal advice, can decide to withhold treatment immediately.

Step 4 Withdrawing of Treatment

Having obtained legal advice and where it is decided that there is no other alternative but to withhold treatment, a written explanation must be provided to the patient or patient's representative.

This letter (**Appendix H**) will be signed by the Chief Executive Officer of the Trust and copied to the SMA, the patients GP and relevant key worker / staff group. Copies of all relevant letters and documentation will be held by the SMA.

The letter must state:

- The reason why treatment is being withheld (including specific information, dates, and times of incidents).
- The period of the exclusion (this will not normally exceed 12 months).
- Details of the mechanism for seeking a review of the decision to withhold treatment.
- The process the individual must undertake to obtain further NHS treatment in the event of an emergency.
- The action the Trust intends to take if an excluded individual returns to the Trust for any reason other than a medical emergency.

Treatment could be withheld from a patient as a result of the behaviour of a person accompanying or visiting a patient. However, LPT will seek to establish alternative arrangements to deliver care in a safe environment.

Appendix E

<Date>

Dear

Acknowledgement of Responsibilities Agreement between <insert name of patient, visitor, or member of the public> and Leicestershire Partnership NHS Trust.

It is alleged that on the <insert date> you <insert name> used /threatened unlawful violence/racial abuse/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 our meeting:

<list of example conditions – You are prohibited from entering the premises or grounds of [insert name of premises or refer to map etc.] except in the following circumstances –

- Where you or a member of your immediate family require urgent or emergency medical treatment.
- To attend yourself, or to accompany a member of your immediate family, at a pre-arranged appointment.
- To attend yourself as an in-patient, or to visit a member of your immediate family who is an in-patient.
- To attend for non-medical purposes any meeting previously arranged in writing.)>

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 may be reported to the police with a view to this health body supporting a criminal prosecution by the Crown Prosecution Service.

- Consideration may be given to obtaining a civil injunction or Anti-Social Behaviour Order. 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 a senior staff member.

Date

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

Signed

Date

Appendix F

<Date>

Dear

Acknowledgement of Responsibilities Agreement between <insert name of patient, visitor or member of the public> and Leicestershire Partnership NHS Trust

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/racial abuse/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 <insert name of Trust/location> in the future and comply with the following conditions as discussed at our meeting:

<list of conditions – can include all/any one of the conditions listed on the Behaviour Agreement (Appendix 3)>

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

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

- Consideration may be given to obtaining a civil injunction or Anti-Social Behaviour Order. 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 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 faithfully

Signed by a senior staff member.

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

Signed

Dated

Appendix G

<Date>

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/racial abuse/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 organisation 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. A copy of this health body's policy on the withholding of treatment from patients is enclosed for your attention.

If you act in accordance with what this organisation considers to be acceptable behaviour, your care will not be affected. However, if there is a repetition of your unacceptable behaviour, this warning will remain on your medical records and will be taken into consideration with one or more of the following actions:

(to be adjusted as appropriate)

- The withdrawal of NHS Care and Treatment, subject to clinical advice.
- The matter may be reported to the police with a view to this health body supporting a criminal prosecution by the Crown Prosecution Service.
- Consideration may be given to obtaining a civil injunction or Anti-Social Behaviour Order. Any legal costs incurred will be sought from yourself.

In considering withholding treatment this organisation considers cases on an individual basis to ensure that the need to protect staff is balanced against the need to provide health care to patients. An exclusion from NHS premises would mean that you would not receive care at this organisation and (title i.e. clinician) would make alternative arrangement for you to receive treatment elsewhere.

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 the decision in light of your account of the incident(s).

A copy of this letter has been issued to your GP and consultant.

Yours faithfully

Signed by a senior staff member

Dated

Appendix H

<Date>

Dear

Withholding of Treatment

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/racial abuse/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 organisation 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>. A copy of this health body's policy on the withholding of treatment from patients is enclosed for your attention.

Following a number of warnings <insert details of correspondence and meetings> where this has been made clear to you, and following clinical assessment and appropriate consultation, it has been decided that you should be excluded from health body premises. The period of this exclusion is <insert number of weeks/months> and comes into effect from the date of this letter
As part of this exclusion notice you are not to attend health body premises at any time except:

- In a medical emergency; or
- Where you are invited to attend as a pre-arranged appointment.

Contravention of this notice will result in one or more of the following actions being taken (to be adjusted as appropriate):

- Consideration may be given to obtaining a civil injunction or Anti-Social Behaviour Order. Any legal costs incurred will be sought from yourself.
- The matter may be reported to the police with a view to this health body supporting a criminal prosecution by the Crown Prosecution Service.

The matter may 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.
During the period of your exclusion the following arrangement must be followed in order for you to receive treatment <list arrangements>.

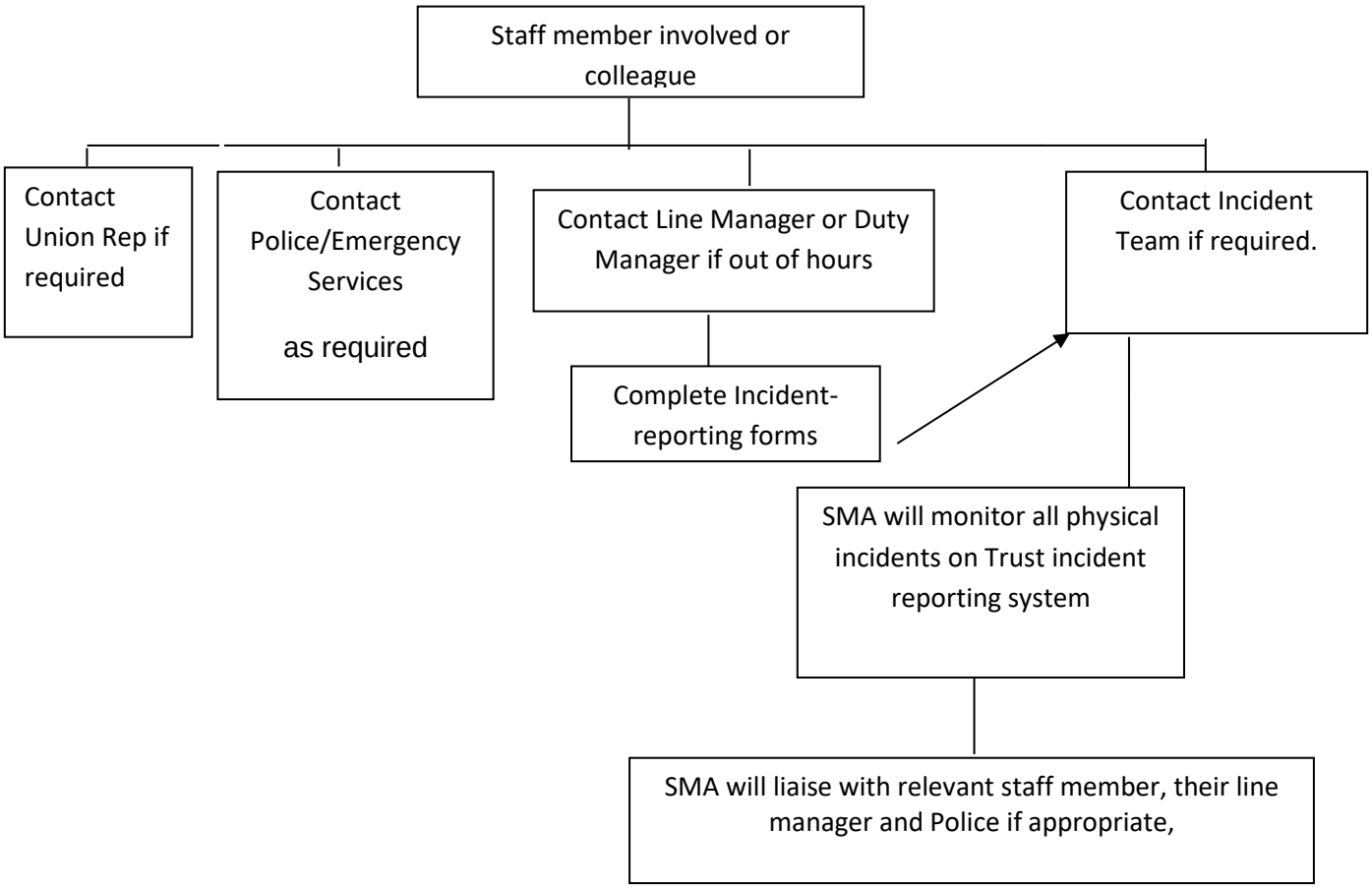
In considering withholding treatment this organisation considers cases on an individual basis to ensure that the need to protect staff is balanced against the need to provide health care to patients. If you consider that your alleged behaviour has been misrepresented or that this action is unwarranted, please contact in writing <insert details of local complaints procedure> who will review the decision in light of your account of the incident(s).
A copy of this letter has been issued to your GP and consultant.
Yours faithfully

Signed by a senior staff member

Dated

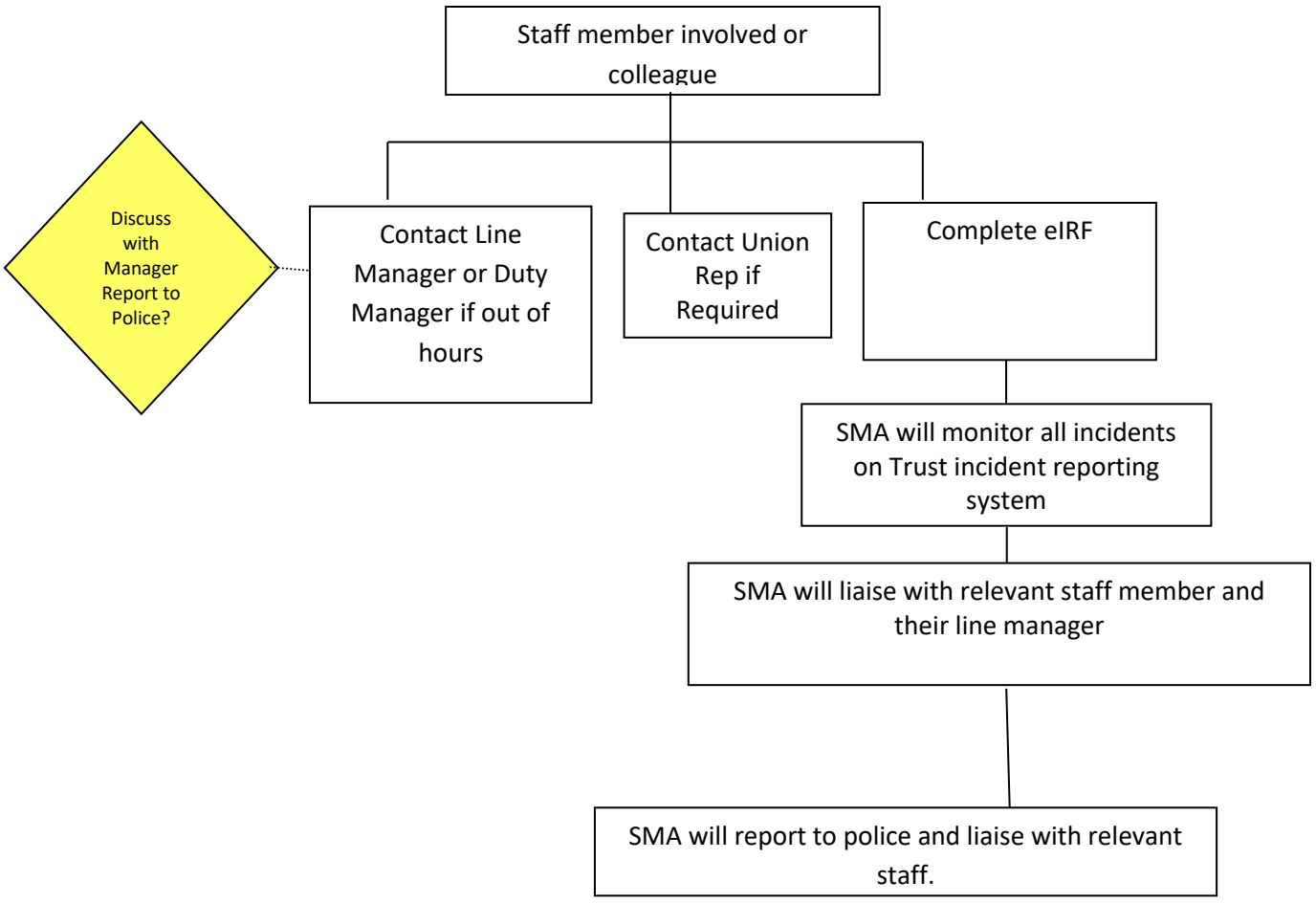
Appendix I

Reporting Intentional Physical Assaults



When reporting incidents to the Police use either the emergency (9) 999 or (9) 101 depending on the response needed. (9) 999 should be used when immediate action to a situation is needed.

Reporting Non-Intentional Physical Assault

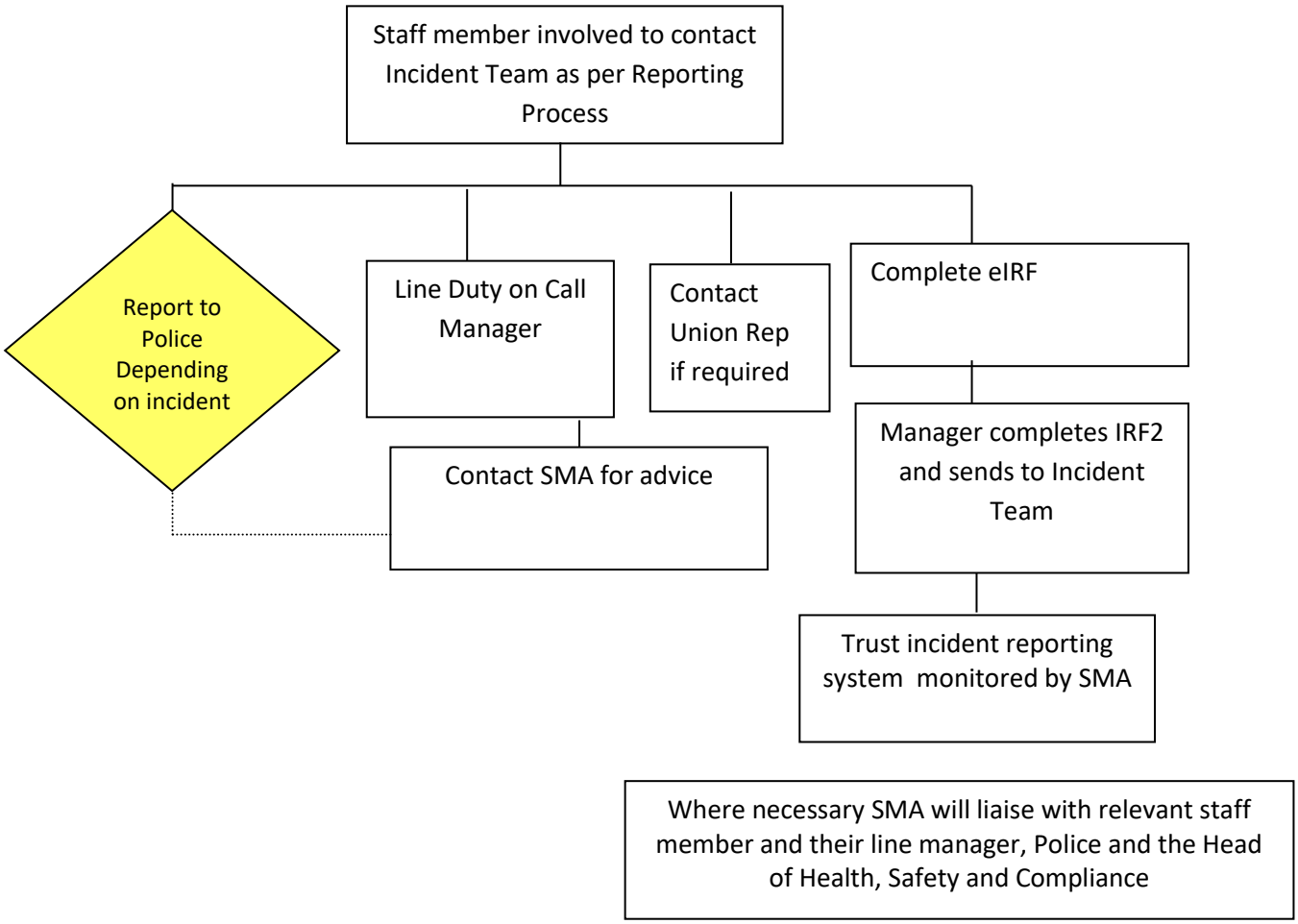


Consideration should be given to circumstances:

- Patients on some medications
- Patients with Dementia/Alzheimer's
- Patients with Mental Health issues
- Patients with Learning Disabilities
- Some incidents involving children's behaviour/reactions

Appendix K

Reporting Unacceptable Behaviour, Actions or Comments



Examples of unacceptable behaviour are

•Threats or threatening behaviour
•Offensive sexual gestures or behaviour
•Derogatory remarks e.g. racial, sexual or personal
•Malicious allegations
•Excessive noise such as shouting
•Harassment, Stalking, abuse on social media
•Threatening or abusive language including excessive swearing or offensive remarks

When reporting incidents to the Police use either the emergency (9) 999 or 0116 2222222 or 101 depending on the response needed. (9) 999 should only be used when there is immediate danger and an urgent action is essential.


NHS
Leicestershire Partnership
NHS Trust
ZERO
TOLERANCE
Do not abuse our staff.
#RedCardToAbuse
We will seek to prosecute those who are violent and abusive to our staff, and may restrict or exclude them from our services.

Appendix M

Policy Monitoring Section

Duties outlined in this Policy will be evidenced through monitoring of the other minimum requirements.

Where monitoring identifies any shortfall in compliance the group responsible for the Policy (as identified on the policy cover) shall be responsible for developing and monitoring any action plans to ensure future compliance.

Reference	Minimum Requirements to be monitored	Evidence for self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
5.3	Ensure that all operational risks relating to violence and aggression are identified and written risk assessments are completed to address these risks which are reviewed in line with the Risk Management Strategy.	Section 19 page 14	Risk assessment reviewed at H&S Committee annually Annual Health & Safety Audit	Trust Health and Safety Committee	Annual
5.8 13	All incidents of violence and aggression relating to their staff are reported in accordance with the Incident Reporting Policy	Section 19 page 14	SMA quarterly reports. Incidents reviewed at the Least Restrictive Practice Group	Trust Health and Safety Committee Least Restrictive Practice Group	Quarterly Monthly
9	All patients receiving care from LPT Staff will be assessed for violence and aggression as part of their initial clinical risk assessment	Section 19 page 14	Audit of care plans and Clinical Risk assessments	Least Restrictive Practice Group	Annual
4	Reporting on the compliance against Violence Prevention and Reduction Standards		Review undertaken of compliance	Health and Safety Committee	Every six months via the quarterly reports

Appendix N

Due Regard Screening Template

Section 1	
Name of activity/proposal	Violence Reduction and Prevention Policy
Date Screening commenced	November 2022
Directorate / Service carrying out the Assessment	Workforce
Name and role of person undertaking this Due Regard (Equality Analysis)	Andy Lee
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: This policy provides a framework for the management of violence and aggression directed at staff and service users.	
OBJECTIVES: To ensure that the Trust has in place adequate arrangements to monitor the implementation and effectiveness of controls required to reduce the risk of violence and aggression to staff	
PURPOSE: To protect service users, staff and visitors within the Trust from incidents of violence and aggression and to prevent, minimise and reduce the risk of such incidents occurring	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	No
Disability	Yes
Gender reassignment	No
Marriage & Civil Partnership	No
Pregnancy & Maternity	No
Race	No
Religion and Belief	No
Sex	No
Sexual Orientation	No
Other equality groups?	No

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	**X**

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Signed by reviewer/assessor	Andy Lee	**Date**	December 2023
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Samantha Roost	**Date**	December 2023

The NHS Constitution

NHS Core Principles – Checklist

Please tick below those principles that apply to this policy

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	X
Respond to different needs of different sectors of the population	☐
Work continuously to improve quality services and to minimise errors	X
Support and value its staff	X
Work together with others to ensure a seamless service for patients	X
Help keep people healthy and work to reduce health inequalities	X
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	X

Appendix P

Policy Training Requirements

The purpose of this template is to provide assurance that any training implications have been considered

Training Required	YES	
Training topic:	Prevention and Management of Aggression Conflict Resolution Training	
Type of training: (see study leave policy)	X Mandatory (must be on mandatory training register) ☐ Role specific ☐ Personal development	
Division(s) to which the training is applicable:	X Adult Mental Health & Learning Disability Services X Community Health Services X Enabling Services X Families Young People Children ☐ Hosted Services	
Staff groups who require the training:	*Please specify…* *All front line staff* *Individuals identified by training needs analysis*	
Regularity of Update requirement:	Safety Intervention (previously MAPA) Training Annual update CRT 3-yearly via mandatory training update	
Who is responsible for delivery of this training?	Learning & Development Team	
Have resources been identified?	Yes	
Has a training plan been agreed?	Yes	
Where will completion of this training be recorded?	X ULearn ☐ Other (please specify)	
How is this training going to be monitored?	LPT Health & Safety Committee	

PRIVACY IMPACT ASSESSMENT SCREENING

Privacy impact assessment (PIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the PIA process is identifying the need for an assessment.

The following screening questions will help decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise and requires senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	Violence Reduction and Prevention Policy		
Completed by:	Andy Lee		
Job title	Security Management Advisor	**Date**	December 2023

	Yes / No
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	**No**
2. Will the process described in the document compel individuals to provide information about themselves? This is information in excess of what is required to carry out the process described within the document.	**No**
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	**No**
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**No**
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	**No**
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	**No**
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	**No**
8. Will the process require you to contact individuals in ways which they may find intrusive?	**No**

If the answer to any of these questions is 'Yes' please contact the Head of Data Privacy Tel: 0116 2950997 Mobile: 07825 947786
Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, adoption n of a procedural document will not take place until approved by the Head of Data Privacy.

IG Manager approval name:	
Date of approval	

Acknowledgement: Princess Alexandra Hospital NHS Trust