Violence Prevention and Reduction Policy

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What is in this policy?

The Trust recognises its duty of care to ensure colleagues feel safe in their working environment and that the trust has effective measures and practices in place to prevent or address violent or aggressive behaviour towards staff and also that violent behaviour can be distressing and disturbing for patients and their visitors who witness incidents.

This policy provides a framework for the prevention and management of violence and aggression directed at staff and service users across University Hospital Bristol and Weston NHS Foundation Trust (the Trust).

It provides detailed guidance on the Trust's approach and arrangements for violence prevention and reduction across its hospitals and services in line with best practice guidance from NHS England Violence Prevention and Reduction Standard

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
June 2002	1	Head of Security		Policy development
Oct 2005	2	Head of Security & Head of H&S	Revision	Amendments
April 2008	3	Senior H&S Advisor	Revision	Amendments
November 2013	4	Local Security Management Specialist (LSMS)	Major	Simplification and combination of three related policies. Renaming policy from 'Procedures for the Prevention and Management of Violence and Aggression in the Workplace' to 'Conflict Resolution Policy'.
September 2018	5	Local Security Management Specialist (LSMS)	Major	Renaming of policy from ***Conflict Resolution Policy*** to **Zero Tolerance Policy** with major revisions and additions to all sections following consultation with stakeholders.
June 2023	6	Head of Security, Head of Health and Safety Services, Conflict Resolution Corporate Trainer	Major	Moving away from a Zero tolerance approach to reflect requirements of the NHS England Violence Prevention and Reduction Standard

Sign off Process and Dates	
Groups consulted	**Date agreed**
Management of Violence and Aggression Committee (MVAC)	09/10/2023
Policy Assurance Group	16/10/2023
Approval Authority: People and Learning Development Group	25/10/2023

- **Stakeholder Group** can include any group that has been consulted over the content or requirement for this policy.
- **Steering Group** can include any meeting of professionals who has been involved in agreeing specific content relating to this policy.
- **Other Groups** include any meetings consulted over this policy.
- **Policy Assurance Group** must agree this document before it is sent to the **Approval Authority** for final sign off before upload to the DMS.

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Do I need to read this Policy?

All Staff

Are required to be aware of sections 5 to 13, with emphasis placed on sections 8, 11 and 13 with regard to incident reporting, support for staff and training.

Managers, Supervisors or Risk Assessors

Are required to read, understand, and apply the requirements of the whole document to provide a secure and safe environment for staff, patients and others. Particular emphasis should be placed on duties, roles and responsibilities, risk assessment, supporting staff and training.

1. Introduction

This policy is concerned with violent, aggressive, and challenging behaviour, both physical and verbal, towards employees of University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) from patients, relatives, visitors or other members of the public. Working in an atmosphere of continuing threat is profoundly damaging to the confidence and morale of colleagues and may have associated outcomes in terms of reduced efficiency, sickness or absence.

The Trust recognises that as an employer, it has a duty of care towards its staff and that reasonable steps should be taken to ensure their health and safety at all times.

The Trust recognises it may not be able to reduce incidents of physical or non-physical aggression, including harassment, to zero, however effective control, management and ways of working can reduce this number significantly. We aim to provide as safe a working environment as possible and this policy should be used to promote safer working practices in relation to violent or aggressive behaviour. On occasions when there will be violent or abusive incidents when the person exhibiting challenging behaviour is unable to control their actions due to medical factors, we will provide colleagues with the correct training and support to ensure both staff and service user safety.

The Trust's 'It Stops with Me' campaign aligns to our Trust values where respecting everyone is at the heart of everything we do. We are supportive and respectful and aim to empower all staff who witness or experience unacceptable behaviour to take action: respectfully challenge; de-escalate; report incidents; and support victims.

The Trust reserves the right to implement a range of sanctions against persons using intentional violence and aggression including the right to exclude any person who in the considered opinion of the Trust threatens the safety and or security of the Trust employees, patients, visitors or property. For further information and guidance refer to Section 12, Sanctions and Management of Unacceptable Behaviour.

The Trust also acknowledges the need for relevant staff roles to be skilled in the de-escalation of aggressive and violent behaviour. Additionally, some identified colleagues will require accredited training in restrictive practices. (Refer to Section 13: Training.)

2. Purpose

This policy will provide guidance and advice for all employees of the Trust and persons providing services on the management of intentional violence and aggression and challenging behaviour due to medical factors.

It is important that all staff feel safe in their working environment. Violent behaviour not only affects staff personally, but it also has a negative impact on the standard of services and the delivery of patient care. In terms of tackling violence against staff, this policy provides information and guidance on a range of measures introduced to make the NHS a safer place to work.

3. Scope

This policy relates to all permanent and temporary employees, volunteers, agencies, and agency staff working for and on behalf of the Trust.

4. Definitions

1. Violence at work

Any incident in which a person is abused, threatened, or assaulted in circumstances relating to their work (HSE England.) This definition includes both physical and verbal abuse experienced by staff.

2. Physical assaults or abuse

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

3. Verbal abuse

Verbal abuse or threats can include those which are face-to-face, over the telephone, via letter, email or social media that cause distress and or constitute harassment. This abuse may include inappropriate words or behaviours which imply or directly threaten an individual or individuals.

4. Emergency Worker

Is defined within section 3(1) of the Assaults on Emergency Workers (Offences) Act 2018. This definition relating to a health service is a "person employed for the purposes of providing, or engaged to provide NHS health services, or services in the support of the provision of NHS health services, and whose general activities in doing so involve face to face interaction with individuals receiving the services or with other members of the public."

5. Clinically Related Challenging Behaviour

Clinically related challenging behaviour is often a manifestation of a patient's illness and an attempt by the person to communicate their unmet needs. For further advice and guidance see Appendix C – Clinically Related Challenging Behaviour.

6. Restrictive Practices

In accordance with NHS England: Restrictive interventions are defined as:
1. Planned or reactive 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

2. End or reduce significantly, the danger to the person or others

3. Contain or limit the person's freedom.

4. Restraint - The Mental Capacity Act 2005 provides a legal definition of restraint which is "the use or threat of force to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist."

For any use of restrictive practices, reference must be made to the "*Restrictive Interventions (restraint and clinical holding) for all Patients*" Policy.

5. Duties, Roles and Responsibilities

5.1 Chief Executive

The Chief Executive has overall responsibility for ensuring a safe and secure environment. The Chief executive and Trust board of directors have overall responsibility for violence reduction strategy and policy. The Chief Executive has delegated the day-to-day responsibility to the Chief People Officer.

5.2 Role of the Chief People Officer as the Executive Violence and Reduction Lead

The Chief People Officer is the Trusts nominated Executive Violence & Reduction lead. The Chief People Officer is responsible for the following:

- Security of hospital premises as far as is reasonably practicable
- To support and promote the Violence Prevention and Reduction Policy
- To ensure the trust provides the resources required to deliver the violence prevention and reduction objectives
- To meet the aims set out in the people strategy to reduce violence and aggression across the trust, taking a collaborative approach to engage and draw on the expertise of multidisciplinary stakeholders
- To ensure the trust is meeting its legislative requirements regarding violence and aggression and provide assurance of this to the Trust Board

5.3 Managing violence and aggression committee (MVAC)

The Managing of Violence and Aggression Committee is responsible for the oversight of learning from violent or aggressive incidents. An action log of learnings and changes implemented to reduce violence and aggression is kept for submission to the board for oversight every 6 months to ensure continuous learning is taking place across the organisation to stop incidents repeating in line with the NHS Violence Prevention and Reduction Standard which the trust uses as it's framework for managing violence and aggression.

- Monitor data and analyse
- Agree work programmes to reduce violence and aggression
- Review appropriateness of training interventions
- Ensure compliance with relevant legislation relating to violence and aggression throughout the trust
- Engage with key stakeholders to ensure the violence reduction strategy is working and effective
- Promote a culture where continuous improvement is standard, lessons learnt from incidents and action taken to prevent them re-occurring
- Ensure compliance with the violence prevention and reduction standard

- Ensure associated sub-groups and divisions are meeting their local responsibilities to reduce violence and aggression and providing accurate data on incidents and corrective actions taken

5.4 Role of the Divisional MVAC sub-groups

- Divisional MVAC sub-groups are responsible for identifying and initiating reviews of violent and aggressive incidents in their area of work
- Any incidents where physical violence has occurred or incidents which have resulted with lost time at work must be reviewed to:
    - Ensure the health and wellbeing of all colleagues directly and indirectly affected
    - Check policies, procedures and training were followed
    - Identify areas for improvement and make feedback for departments to implement them
    - Keep a record of incidents reviewed and improvements made
    - Report back to MVAC action log of improvements made to reduce chance of re-occurrence of incidents
- Ensure incidents are being reported on Datix with enough accurate information to support continuous learning
- Ensure colleagues who have been subjected to an incident of violence and aggression have access to and are offered appropriate support
- De-brief colleagues following incidents in a reasonable timeframe and if delayed communicate to those involved

5.5 Role of Head of Security

- The Head of Security is responsible for strategy and planning within the Trust, as well as the co-ordination of people, structures, and procedures, to systematically prevent, deter, detect, and respond to security threats and acts of violence and aggression.
- The head of security will manage the Security and Violence Reduction Teams

5.6 Role of Head of Health and Safety

- Manage and provide a risk assessment template for violence and aggression
- Ensure training and support is provided on how to complete risk assessments and implement control measures
- Coordinate storage and audit of completed risk assessments ensuring compliance with the violence reduction standard guidelines
- Report to the Health and Safety Executive, incidents meeting the reporting criteria under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- Ensure incidents reported on Datix have accurate categories assigned
- Summarise Trust data to identify trends

5.7 Role of Senior Managers and Line Managers

Senior managers and line managers will:

- Be aware of 'it stops with me' Trust campaign to support and empower staff by encouraging them to utilise the respecting everyone resources
- Ensure colleagues work in an environment that is as safe as possible which includes community visits to a patient's home and other partner locations within the 'Healthier Together' Integrated Care System (ICS) for Bristol, North Somerset and South Gloucestershire
- Be aware of the Trust campaign `it stops with me` to support the management and response to unwanted incidents.
- Support colleagues to implement the Red Card procedure with confidence
- Address issues that could lead to incidents escalating which we are able to control such as local policies, individual/team behaviour or culture which could be a trigger for clinical conditions or adversely affect the patient experience
- Complete violence and aggression risk assessments and reduce the risks identified
- Ensure [redacted] is offered to colleagues following violent or distressing incidents
- Ensure that safety measures are reviewed following an incident
- Ensure staff are appropriately trained in local procedures and incident reporting requirements
- Ensure patient facing staff including non-clinical roles receive the appropriate level of conflict resolution training
- Ensure all staff are risk assessed where appropriate for the requirement and attend the appropriate training defined in this policy's training section
- Challenge all harassment or inappropriate behaviour and offer all appropriate protection and support to the victim. In cases where colleagues are victims, this may include referral to [redacted]
- Where incidents of violence, aggression, or challenging behaviour occur, the line manager must conduct a full debriefing of all colleagues involved.
- The Line Manager of the colleague involved in the incident should ensure it is reported on the Trust incident reporting system, Datix, to enable central monitoring of incidents and responses. This may also support equality monitoring

5.8 Role of Employees

- Employees should ensure the health, safety and welfare of themselves and other persons by being vigilant in respect of themselves and others
- The Trust do not expect colleagues to intervene in episodes where they will compromise their personal safety or that of others
- All employees should role model Trust values and behaviours in line with the Trust Respecting Everyone Policy and framework

- Attend appropriate training and ensure that they act in accordance with the training they have received
- Utilise the red card procedure to support the management and response to unwanted incidents.
- Colleagues are responsible for adhering to and cooperating with procedures within this policy and help address the issues of violence and aggression by reporting incidents via DATIX and where appropriate, support de briefing meetings

5.9 Role of Security

All Security Officers will maintain a professional trained presence across the Trust. The Security Officers' main function is to provide a safe and secure environment that supports positive patient outcomes. Security Officers assist in safeguarding the safety and well-being of staff, patient and their visitors. They will provide assistance and support to staff of the Trust, and others, with regard to incidents of violence and aggression. The Security Manager and Security Officers will use their skills and training to defuse potentially violent situations and use the minimal appropriate force when de-escalation techniques have not worked.

6. Violence and Aggression Risk Assessment

6.1 Risk Assessments for teams/departments

Risk assessments relating to potential violence and aggression, or challenging behaviour are the responsibility of local managers and are intended to identify risks, threats and vulnerabilities, record the existing control measures and the additional actions required to mitigate uncontrolled risks to acceptable levels.

Risk assessments must be reviewed periodically as per the Trust [redacted] when a new risk or threat is identified or when working practices change.
A risk assessment tool has been developed to support departmental risk assessors in completing the assessment.
Risk assessments should be based on the scenarios faced. This may include assessments for working in the community, home visits and lone workers.

Templates for risk assessment are available on the [redacted]. Corporate Education will work with senior managers and ward managers to complete a training needs analysis for each area of work to determine the risks faced from violence and aggression based on the risk assessments completed. Each ward will be offered training appropriate for the risks and tasks carried out. The training required is defined in section 13 of this policy

6.2 Risk Assessments for individual patients who are violent and aggressive

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

The sharing of and disclosure of information to other organisations may occur for the purposes of staff safety. This is achieved via the alert system within Careflow.

Risk assessments, where appropriate, will support existing patient care plans for a patient presenting with challenging behaviour. Where it is identified that a patient may present a risk to staff or others, the appropriate health care professional must ensure that:

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

7. Lone Working

Lone working can be defined as any situation, or location, in which someone works without close or direct supervision; without a colleague nearby or is out of sight or earshot of another colleague. University Hospitals Bristol & Weston NHS Foundation Trust, as a healthcare provider has a duty of care to its lone working staff, both in the community and on its properties.

Risk assessments are undertaken within departments or services where it is identified that colleagues may be lone working. Violence and aggression towards colleagues is recognised as a risk to be included within assessments and measures will be identified to manage, control and mitigate risks to lone workers.

Management instructions to colleagues make it clear that they should not enter into lone working situations where they feel their safety, or the safety of their colleagues could be compromised. Written systems of work have been developed for many high risk services including where colleagues work within the community. These systems of work will also identify any escalation processes to be followed.

Specific training for 'Safer Lone Working' is provided within the range of eLearning courses available to colleagues. This eLearning should be completed in addition to role relevant Maybo training

8. Incident Reporting

All incidents of physical or verbal abuse including unwanted or unacceptable behaviour should be recorded on [redacted]. The immediate supervisor and/or line manager must also be informed at the first available opportunity.

Physical assault: Examples could include:	Verbal abuse (non-physical assault): Examples could include:
• Intentional physical contact on a person that has resulted in bodily harm and injury such as a bite, scratch, bruise, reddening of the skin etc • An intentional, unlawful threat to cause bodily harm or injury • A circumstance which creates in the other person a well-founded fear of imminent peril or danger • Battery – the wilful or intentional touching of a person against that person's will by another person • Offensive touching • Sexual Assault – sexual contact against a person's consent or will • Unwanted physical contact by another • Spitting	• Offensive language, verbal abuse and swearing which prevents staff from doing their job or makes them feel unsafe. • Threatening, abusive or insulting words or behaviour, or display of visible representations, which intentionally cause harassment, alarm, or distress • Abusive telephone calls • Derogatory racial or sexual remarks, verbal or written • Offensive sexual gestures or behaviours

The Datix incident reporting system has a category of 'Violence and Aggression' and further sub-categories to distinguish 'verbal abuse' or 'physical assault'. In addition, further information requested will permit more accurate contributory factors to be identified and assist with targeted actions to reduce incidents

The manager allocated to the incident (via DATIX) is responsible for ensuring an investigation is conducted in a manner proportionate to the incident with advice, support, and assistance provided where required by the Security Department or Violence Reduction Team.

During the management of incidents, it may be established that an assault was not intentional. Contributory factors for non-intentional assaults may include:

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

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

The violence reduction officers, divisional leads and MVAC will review incidents of violence and aggression recorded on Datix to inform ongoing strategy and ensure plans are effective in reducing incidents.

9. Contacting Security

Where staff are unable to manage risks of violence and aggression, Security can be contacted via the emergency switchboard number of 2222 or 3333 for the Weston hospital site

10. Contacting the Police

Report a crime directly to the Avon and Somerset Police using a dedicated UHBW form
https://www.avonandsomerset.police.uk/forms/raa

Contact the Violence Reduction Team on [redacted] to get help and advice on reporting crimes to the police.

Advice for calling 999: Dial 9 (internal) followed by 999.

- call when it's an emergency.
- a crime is in progress.
- someone suspected of a crime is nearby.
- when there is danger to life
- when violence is being used or threatened

Also, alert security via [redacted] (Bristol) [redacted] (Weston)

For non-urgent enquiries, contact the Trust Police Liaison Officer [redacted]

11. Support for Staff

11.1 Trauma Risk Management (TRiM)

Colleagues may need to be supported following a traumatic event. A traumatic event is an experience that can have a significant effect on individuals and groups. Examples of these events are physical assault, verbal assault, bullying/harassment and traumatic and/or shocking events, but the cause can be unique to each person.

TRiM is a peer-delivered risk assessment and ongoing support system, designed specifically to help in the management of traumatic or potentially traumatic events. TRiM helps peers to understand likely reactions to traumatic incidents and to conduct structured risk assessments, aiming to identify people needing early referral to qualified medical support.

TRiM Practitioners are situated in Adults and Childrens' Emergency Departments. In addition to this, Psychological Health Services (PHS) have developed an internal approach aligned to TRiM that is available Trust wide; however, this offer requires commissioning from relevant Divisions or departments if this intervention is required. Contact email address - [redacted]

11.2 Violence Reduction Team

The Violence Reduction Team, work in partnership with the police to investigate crimes committed against UHBW employees.

This will include assaults, threats, and abuse, including when incidents occur on the grounds of a persons protected characteristics

The violence reduction team will ensure that all investigations are dealt with in a timely and efficient manner communicating to all involved if there is a delay in the process any reasons why

The Violence Reduction Officer will ensure that all investigations are dealt with a timely and efficient manner and will;

- Gather evidence, take witness statements
- Support the victim throughout the process (including attendance at court)
- Identify and save CCTV and Bodycam footage
- Preserve and secure evidence

- Update the Security Management Team throughout the investigation process.
- Prepare comprehensive evidential case files
- Work in partnership with the Police
- Work in partnership with wellbeing support

11.3 Workplace Wellbeing Services and Intervention

The Trust workplace wellbeing offer comprises a number of free, confidential resources, services and interventions inclusive to all colleagues whenever needed including a 24/7 support service.
This ranges from guidance on dealing with traumatic events to access to accredited counselling or professional support from our Psychological Health Service - staff support team.

Further information on all Wellbeing services available in the trust can be found on the [redacted] or contact the corporate team via [redacted]

11.4 Preventing incidents recurring

In line with our duty of care it would be unreasonable to put staff into situations which we can foresee an incident of violence or aggression recurring, colleagues who have been subjected to an incident of violence, aggression, or abuse may no longer be comfortable dealing with the patient. In consultation with the staff member, it may be appropriate to rotate them to other patients/duties, so they are no longer exposed to the risk of an incident recurring. It is important managers take care to ensure staff do not feel pressured to continue dealing with a person who has subjected them to violence or aggressive behaviour previously.

11.5 Freedom to Speak Up

As a Trust, we positively encourage any member of staff to raise concerns. By doing this, we all play a vital role in helping to improve the working environment for colleagues and services for patients.
If you feel unable to raise concerns with a manager, then [redacted] are in place to provide guidance and advice including signposting to appropriate support available

11.6 'It Stops with me' Trust campaign

'It Stops with Me' is a campaign aligned to the Trust values of being supportive and respectful, introduced in October 2023.

In support of encouraging staff to take positive action to prevent recurrence of poor behaviours, the campaign aims to;

- Empower all colleagues who either witness or experience unacceptable behaviour to take action: respectfully challenge; de-escalate; report incidents; and support victims

- Make it easier for colleagues to understand the options available to them if they have experienced or witnessed violence, aggression or other type of unacceptable behaviour at work

- Raise awareness of the role of leaders and managers in managing and resolving conflict in teams by promoting training opportunities and support available

- Raise awareness of protected characteristic violence, aggression and poor behaviour and the support available, including from Staff Network Groups

- Share real examples of, and the steps the Trust is taking to reduce incidents to demonstrate the organisation commitment to take this seriously and that patients and the public understand we will take action

11.7 Trade Union Support

The Trust has a number of health and safety union representatives from recognised Trade Unions who can represent, support and provide guidance to colleagues. [redacted]

12. Sanctions and Management of Unacceptable Behaviour

A wide range of sanctions can be taken for physical assaults and verbal abuse dependent on the severity of the incident and persons capacity. These measures may include:

- Verbal Warning
- Warning Letter*
- Withdrawal of care
- Exclusion from premises
- Criminal Prosecution
- Management of behaviour through restriction of freedoms or liberty

**See section 12 for link to letter templates*

A [redacted] has been developed to provide an overall introduction and overview of the pathways available to deal with conflict and unacceptable behaviour

12.1 Withholding Treatment

A standard operating procedure (SOP) is in place and is consistent with Department of Health guidance regarding the withholding of NHS treatment from violent and abusive patients and from those whose behaviour is otherwise unacceptable, in an inpatient setting.

The SOP is for use with patients who are *not* medically fit, have capacity and have repeatedly displayed unacceptable behaviour, including breaking their 'acceptable behaviour contract' that had been agreed at admission.

Treatment can only be withheld in circumstances where a patient has committed - or it is felt they pose a significant and imminent risk of committing - violent or abusive behaviour AND such behaviour;

- is **not** a manifestation of a current clinical condition requiring urgent treatment
- is committed by a person **not** requiring emergency treatment

- is committed by a person deemed to have capacity to make decisions around their treatment and to take responsibility for their actions
- is committed by a person over the age of 18

Withholding treatment from violent or abusive patients can only be considered;

- As a last resort (where no other reasonable course of action is possible).
- After a full and proper clinical assessment has been undertaken by a senior member of Medical staff

Full guidance on application and authorisation of sanction management and guidance on what constitutes unacceptable behaviour can be found within the [redacted]

13. Conflict Resolution Training

A comprehensive training package from an accredited provider (Maybo) is available to keep staff safe from violence and aggression. Face to face training is identified as a requirement of some roles, including updates sessions based on the accreditation requirements. All face-to-face training for UHBW staff (including Bank) can be booked by contacting [redacted]

13.1 Agency Workers

Agency workers will need to have completed the relevant level of training for the duties they are expected to cover. For example, if the agency worker is treating patients detained under the mental health act where Use of Force Act (2018) applies they must have completed the relevant RRN standard of training to be involved in restrictive interventions. The agency is responsible for ensuring their staff have the appropriate training. Managers hiring agency workers should check they have the appropriate level of training.

13.2 E-Learning

NHS Conflict resolution training (available through Kallidus) - Must be completed by all employees that interact with the public. This will include;

- Safer Lone Working
- Dealing with abusive telephone calls

13.3 Face to face training

The trust offers accredited training in the following modules to meet the needs of higher risk areas:

- Positive approaches to behaviour
- Safer de-escalation
- Personal safety and disengagement
- Redirection and guiding
- Safer holding
- Clinical holding

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

The HSE – **Violence in health and social care** states:
Employees involved in the following activities are at increased risk of violence and aggressive behaviour:

- working alone;
- working after normal working hours;
- working and travelling in the community;
- handling valuables or medication;
- providing or withholding a service;
- exercising authority;
- working with people who are emotionally or mentally unstable;
- working with people who are under the influence of drink or drugs;
- working with people under stress.

Managers should pay particular attention to these groups as well as regularly monitoring violence and aggression and identifying colleagues who require additional training to manage the risk for the type of work they complete.

Specific training will be given for specialist areas to support different population groups such as care of the elderly, children, and others with additional needs. This may include Safeguarding and Mental Capacity Act training

13.4 Restrictive intervention training

To meet compliance with the Use of Force Act (2018), maintain patient and staff safety the trust requires colleagues who need to undertake any [redacted] as part of their job to have completed the relevant accredited training. Managers can book training by contacting corporate education. ([redacted])

14. Standards and Key Performance Indicators (KPI's)

14.1 Applicable Standards

The Trust uses the violence prevention and reduction standards as it's framework for keeping staff safe and reducing incidents of violence or aggression. In line with the standard, the KPI's defined for reducing violent or aggressive incidents are set out below.

14.2 Measurement and Key Performance Indicators

As part of a 5-year action plan, a target has been set to reduce incidents of violence and aggression by 10% per year and is published in the annual Health and Safety report. The Trusts KPI's for violence or aggression are as follows:

Reducing by 10% reported cases of violence and aggression by improving mechanisms to manage violent and/or aggressive patients and members of the public and by ensuring staff feel the systems, processes and working environment are sufficient that they feel 'safe' whilst at work.
Overall, embedding a positive health and safety culture

The following are measurements used to monitor effectiveness of the violence reduction strategy:

- Number of incidents being reported
- Number of significant event reports
- Number of serious investigations
- NHS Staff Survey results (Violence and Aggression section)

15. References

- National Institute for Health and Care Excellence (NICE) (2015): Violence and aggression: short-term management in mental health, health and community settings (NICE Guidance NG10). [online]. Available at: https://www.nice.org.uk/guidance/ng10
- The Nursing and Midwifery Council (NMC) (2010). Code of professional conduct. London: CMC. [online]. Available at; https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
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- Mental Capacity Act 2005 [online]. Available at: http://www.legislation.gov.uk/ukpga/2005/9/contents
- The Mental Health Act 1983 Code of Practice [online]. Available at: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
- Criminal Law Act 1967 [online]. Available at: http://www.legislation.gov.uk/ukpga/1967/58
- Criminal Justice and Immigration Act 2008http://www.legislation.gov.uk/ukpga/2008/4/contents

16. Associated Internal Documentation

- Restrictive Interventions (restraint and clinical holding) for all patients policy
- Withholding treatment from patients displaying unacceptable behaviour
- Domestic Violence and Abuse Trust Policy
- Freedom to Speak Up Policy
- Respecting Everyone Policy
- Dignity at Work Policy (incorporating Bullying & Harassment at Work)

17. Appendix A: Department Risk Assessment Template

University Hospitals Bristol and Weston
Violence Prevention and Reduction Risk Assessment

Guidance Notes

The purpose of this document is to aid department risk assessors and managers to assess the risks of violence and aggression within their work areas.
The document should be read in conjunction with the Trust Prevention and Management of Violence and Aggression Policy.
The information below will support completion of the assessment.

The assessment tool is general guidance to both managers and staff of various issues relating to violence and aggression that may foreseeably arise whilst working in the Trust. This tool is unlikely to cover every issue relating to a particular area or activity; therefore, consideration should be given to specific tasks or activities undertaken in the department. Such an assessment is a legal requirement under health and safety legislation.
The assessment can be undertaken by more than person as we all have subjective opinions about violence, and it is important to obtain a balanced view. Consider asking somebody from outside of your work area to support with the assessment to gain a different perspective.

Any actions identified to reduce risk should be documented within the assessment and discussed with the department manager to ensure that support and assistance are available to deliver the actions identified.

When risk assessing the likelihood of work-related violence, it is important to consider the following:

- Possible assailants
- The tasks and work practices that might put staff at risk
- The workplace or working environment (both internal and external)
- Existing security and response strategies in place, and the need for improvements
- Staff training and competence in dealing with a violent or potentially violent situation

You may need to consider additional risk for day or night, or for different seasons of the year, as the risks and risk reduction measures may be different.

You will need to differentiate between patients, who behave violently because of their clinical condition, and patients and other members of the public who **choose** to behave violently within the assessment.

Identify the hazards in your work environment to see whether they increase the likelihood that violence may occur.

Please note the information below is not an exhaustive list and departments may have specific hazards that should be documented within the risk assessment.

INTERNAL ENVIRONMENT	PUBLIC WAITING AREAS
• Any environmental factors that may create or promote violence or aggression e.g., is the area to cold/hot/dark/bright/dirty/unpleasant?	• Is sufficient personal space provided?
• Can staff conversations be overheard?	• Do furniture or fixings provide potential missiles or weapons?
• Can phone conversations be overheard?	• Is there a means of ensuring the public are kept in designated? areas?
• Does the reception have some form of barrier?	• Are there diversions/activities to prevent boredom?
• Are all doors within your area locked out of hours?	• Can staff rest areas be seen/accessed by the public?
• Does the method of locking provide adequate security?	
• Is it difficult to summon help from any areas in your department?	
• Are there corridors/areas where aggressors could hide/congregate e.g., unlocked store cupboards/unoccupied offices?	
• Does the layout of the room position patients between staff members and the door?	
• Are access functions in good working order e.g., swipe access?	
• Is there adequate signage to direct patients/visitors to where they need to go?	

PATIENT SITUATION:	VISITOR SITUATION
• Clinical condition causing predisposition to violence	• Dealing with patient's family (inc. at patient/family home)
• Confused due to clinical condition	• In traumatic situation
• History of self-harm	• In unfamiliar surroundings
• Illegal/recreational drug or alcohol dependent	• Misunderstanding due to language barrier
• Learning difficulties	• Not being allowed to visit a patient
• Mental illness	• Receiving bad news
• Misunderstanding due to language barrier	• Is tailgating prohibited?
• Not wanting to be in hospital	• Could prohibited or dangerous items be passed over during visits?
• Not wanting to receive treatment	
• Receiving bad news	
• Recovering from anaesthesia	
• Side effects of medication	

Consider existing measures (controls) in place to reduce the risk of violence – general examples are below.

RISK REDUCTION MEASURES (CONTROLS) - GENERAL
• Can your area/ward be completely locked down?
• Have you and your staff read the relevant sections of the Trust Violence, Prevention and Reduction Policy?
• Are you and your staff aware of Trust/Local evacuation procedures?
• Would all staff have a clear route of escape?
• Is there a protocol specific to your area describing how a violent incident must be handled?
• In an emergency, do you have a means of summoning help OTHER THAN THE PHONE e.g., panic buttons, attack alarms, code words?
• In an emergency, is sufficient help available at the time it is needed?
• Do staff record all incidents involving violence or aggression (Datix)?
• Do you inform other Trust wards & departments, or follow up care in the community, of past problems with individual patients' behaviour when you transfer them e.g., notes added to electronic records?
• Do your staff receive regular Prevention and Management of Violence and Aggression training e.g., personal safety, clinical holding
• Has staff eligibility been assessed for any additional training relating to clinically related challenging behaviours?
• Where locum/bank/agency working takes place are there protocols for sharing information regarding known risks of violence and aggression?

STAFF PROFILE/TRAINING

Think about groups of staff who are at risk of violence in your area (e.g., junior doctors, nurses, receptionists etc.) and indicate within the assessment whether they have received any training on dealing with violence and aggression and clinically related challenging behaviour. Further details regarding training options can be found in Section 12 of the Prevention and Management of Violence and Aggression Policy.

RISK REDUCTION OPPORTUNITIES

Consider if any tasks can be eliminated and if not currently adequately controlled identify actions with the aim to reduce the risk.

Areas to consider are below:

Is there a way to reduce risk by changing any of the following:
• The way the job is done e.g., are there any local ways of working that could reduce a risk of conflict?
• The workplace (refer to environment section of this assessment)
• The information given
• The way information is communicated
• The system for sharing information on patients
• The response to incidents and follow up action on incidents

University Hospitals Bristol and Weston NHS Foundation Trust

Risk Assessment Form

Link to risk matrix and consequence table

Title	
Department & Site	
Risk Assessor/s	
Date of Assessment	
Managers Name / Signature	

Consequence > Likelihood	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
5 Very Likely	5 - Yellow	10 - Amber	15 - Red	20 - Red	25 - Red
4 Likely	4 - Yellow	8 - Amber	12 - Amber	16 - Red	20 - Red
3 Possible	3 - Green	6 – Yellow	9 - Amber	12 - Amber	15 - Red
2 Unlikely	2 - Green	4 – Yellow	6 - Yellow	8 - Amber	10 - Amber
1 Rare	1 - Green	2 - Green	3 - Green	4 - Yellow	5 - Yellow
Review Date (s)					

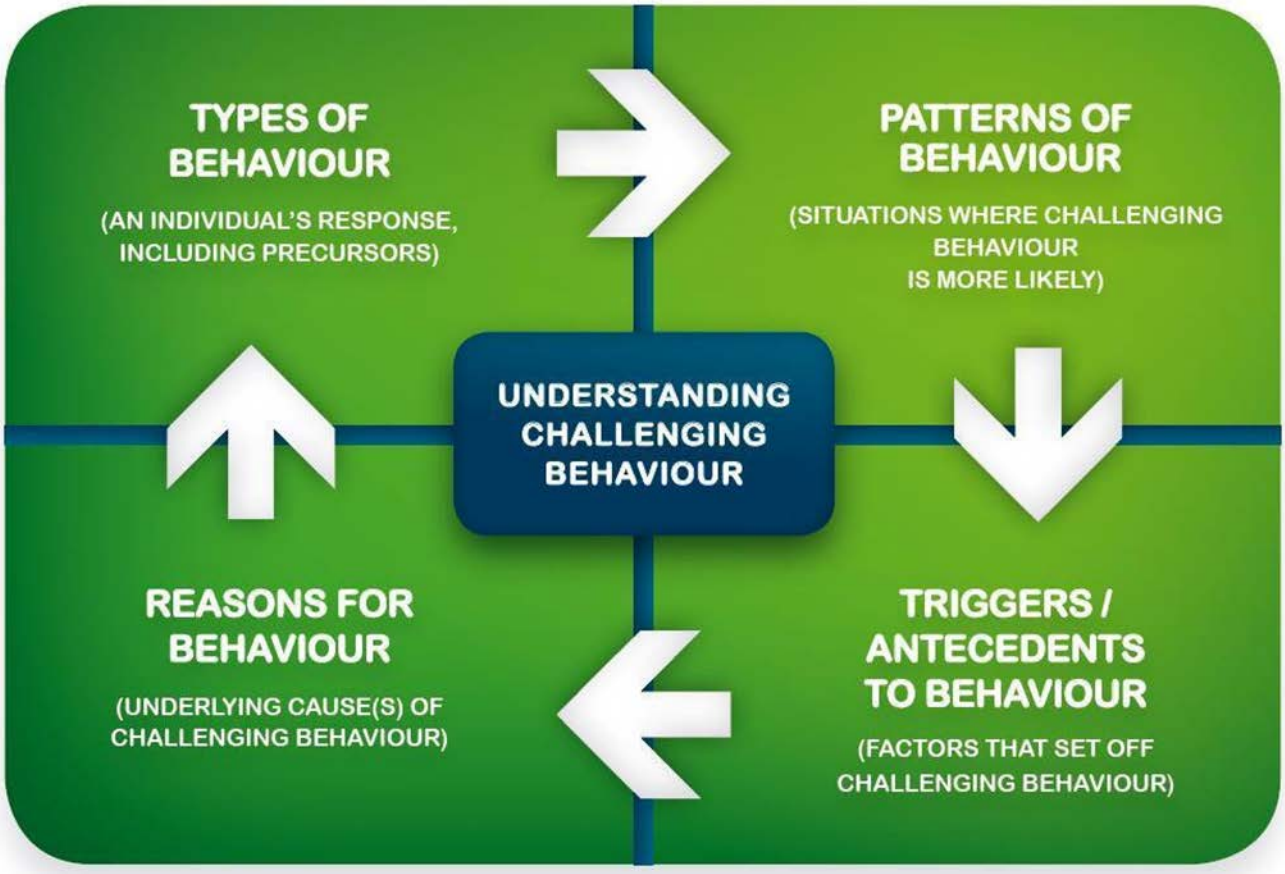
Summary description of task/activity/environment

Include: *Description of main activities undertaken in the department, number of patients/beds, patient group, service coverage e.g., 24 hours, staffing numbers, specifics relating to the department environment / location. The aim here is to build a picture of the type of issues faced in relation to behavioural incidents.*

Hazard Category Hazards *(Something with the potential to cause harm)*	**Who could be harmed and how?** *(Risk – the potential for that harm to be realised)*	**What are you already doing to control the risk(s)?**	**Current risk score** *Consequence x Likelihood*	**What further action do you need to take to control the risk(s)?**	**Target risk score** *Consequence x Likelihood*	**Who will carry out the action and by when ?** *(When actions are complete, they become 'existing controls')*
Example *Patients with clinically related challenging behaviours due to chronic or acute cognitive impairment.*	*Staff/Visitors/Patients/Contractors* *Risk of violent or aggressive behaviours from patients as a direct result of their clinical condition. This could lead to physical injury through an assault or psychological harm through physical or verbal abuse.*	• *Individual patient risk assessments completed where it is identified a patient may present a risk to staff or others* • *Violence Prevention and Reduction Policy in place* • *Restrictive Interventions for all patients policy in place* • *Patient records updated should an aggressive event occur* • *Adverse incidents recorded onto Datix* • *Security support available if required.* • *Prevention and Management of Violence and Aggression Training available* • *Wellbeing support available for colleagues* • *Violence Reduction Officer support post incident* • *Non-essential items that could be used as weapons removed from the patients room/bed space* • *2:1 staff to patient ratio at all times with challenging patients* • *Phone lines/emergency call systems available*	*Moderate (3) x Possible (3) = 9*	*Ensure team members have attended Prevention and Management of Violence and Aggression Training including clinical holding where applicable* *Reminder to be given to staff in relation to wearing of lanyards with aggressive patients and to ensure sharp items such as scissors are not within patient reach* *Consideration to bed location for patients with challenging behaviours*	*Minor (2) x Unlikely (2) = 4*	*Manager Within 6 months* *Manager & Ward staff Within the next week* *Manager - ongoing*

Manager/Risk Owners section	
Are additional control measures to be implemented?	
Date actions complete	
Does this risk need to be escalated? [redacted]	

18. Appendix B: Clinically Related Challenging Behaviour and Managing Risk



1. Common Characteristics

1.1 Individuals who manifest challenging behaviour often have some degree of cognitive impairment, either chronic (e.g., dementia or a learning disability) or acute (e.g., delirium, head or brain injury, drug or alcohol intoxication). It may also be seen in other mental health conditions such as psychosis or personality disorder.

1.2 Care is needed that the behaviour is not as a result of an underlying illness or injury which needs urgent attention.

2. Types of Behaviour

2.1 Challenging behaviour may describe many kinds of deliberate or non-deliberate non- verbal, verbal or physical behaviour. Some of these behaviours (e.g., staring, crying and shouting) may represent legitimate expressions of distress.

2.2 It can include behaviours which may be less risky, such as apathy, lethargy, fatigue, hyperactivity, hypo activity, being non-compliant or withdrawn, if staff need to intervene because the behaviour poses a safety risk to staff, patients and service users or others, e.g., an individual trying to get out of bed when they cannot stand and may fall.

2.3 There is no continuum of behaviour and where someone is sufficiently distressed or alarmed; their behaviour may instantly result in a physical action.

3. Patterns of Challenging Behaviour

3.1 Identifying patterns to predict when challenging behaviour is more likely to occur can assist when planning, preventing and preparing for it. Challenging behaviour tends to occur in response to:

- Unmet care needs (e.g., toilet, pain, thirst, hunger)
- Care tasks, including intimate procedures
- Administering medication (especially where the patient has to wait for pain relief)
- Pre-operative period (waiting, nil-by-mouth, clinical interventions and procedures)
- Post-operative period
- Gender issues (preferences for male or female carer)
- Pressure on staff time (i.e., staff not being on the 'shop floor')
- Lack of engagement by staff
- Times when staff are otherwise engaged (mealtimes, medication, handovers etc.)
- Areas where there are less experienced staff (e.g., less aware of psychological issues)
- 'Sun downing' (i.e., behaviours are more prevalent during afternoon and evenings, due to factors such as tiredness and changes in levels of light, or sensory deprivation)
- Nighttime disturbance
- Over-stimulating or under-stimulating environments
- Heightened activity (e.g., mealtimes)
- Lack of meaningful activity
- Relatives leaving
- Cultural, religious or spiritual needs
- Individuals feeling that staff are not hearing or listening to what they are saying
- Staff hostility
- Inconsistent rule setting
- Provocation by other individuals, distress in other individuals

4. Types of Behaviour

Non-verbal	Verbal	Physical
Agitation Wandering, pacing, following Intimidating facial expressions, staring Intimidating body posture Cornering, invading personal space Interference with equipment or property Being withdrawn, extreme passivity, refusal to move	Shouting Swearing Crying Screaming Repetitive statements or questions Personal comments or questions Racist, sexist, offensive speech Bizarre, psychotic content, not based on known reality	Scratching Grabbing, hair pulling Biting Hitting, slapping, punching Pinching Spitting Kicking Pushing, shoving, knocking into someone Striking or throwing objects Inappropriate touching (self or others) Urinating, smearing Undressing Self-harm Absconding Removal of lines, masks, catheters, dressings, incontinence pads Non-compliance, resistive behaviour (e.g., refusing medication, blood tests)

5. Triggers and Antecedents

5.1 Triggers and antecedents are factors which occur prior to an individual's challenging behaviour. These factors may include the care environment or setting, individuals or interventions, activities or objects, thoughts or feelings, pain or discomfort.

5.2 For example a person may become overwhelmed, when a high number of healthcare professionals undertake a care intervention in close proximity to them.

5.3 Observing, identifying and documenting triggers and antecedents is the first part of a proactive strategy for minimising an individual's stress or distress. This is because, once identified, many of these situations can be avoided or changed.

6. Precursors

6.1 Challenging behaviours can occur without warning and staff need to be aware of, recognise and identify precursors. Precursors are behaviours and are different to triggers, which are factors that can lead to challenging behaviour.

6.2 Precursors can often be very subtle and leave staff feeling 'uncomfortable', or they may signpost the onset of challenging behaviour.

6.3 Common recognisable cues include:

- Tense and angry facial expressions
- Increased and prolonged restlessness, pacing, body tension
- Increased breathing, muscle twitching and dilated pupils
- Increased volume of speech and swearing
- Refusal to communicate, withdrawal, irritability
- Prolonged eye contact
- Confusion of thought processes, poor Concentration
- Delusions or hallucinations
- Verbal threats or gestures
- Verbalising an intention that suggests distress, e.g. 'I want to go…'
- Replicating behaviour which preceded earlier disturbed or challenging episodes
- Reporting anger or violent feelings
- Generally, anything that seems out of character, e.g. excessive crying or laughing hysterically.

7. Reasons for Challenging Behaviour

7.1 There is always a cause of clinically related challenging behaviour, even if it is not evident at the time. An overall approach that looks to prevent distress by identifying, categorising and understanding its reasons should reduce the likelihood of these potentially 'unforeseen' events occurring. The main categories are:

- Physical factors
- Cognitive factors
- Psychological and emotional factors
- Environmental or social factors

8. Reasons for Challenging Behaviour – Summary

This table is not exhaustive and is only examples of what may cause challenging behaviour.

Physical	Cognitive	Psychological/Emotional	Environmental/Social
Hypoxia Hyperglycaemia Hypoglycaemia Electrolyte abnormality Dehydration Constipation Infection Pain Visual or hearing impairment Sleep deprivation Medication (effects) Illicit drugs or alcohol Drug or alcohol withdrawal Pre or postoperative Hunger, thirst Incontinence, urgent toilet needs Earache Epilepsy	Communication problems (expression and understanding) Memory loss Difficulty with language or dialect Reduced spatial awareness Learning disabilities Disorientation Poor executive function (reasoning, planning, foresight) Loss of insight Autism	Fear Anxiety Anger Depression Social isolation Mania Fixed beliefs or current thinking Separation anxiety Loss of self-worth	Noise Lights Temperature Overcrowding, or busy environment Inappropriate signage Lack of information Long waiting times Cultural factors Lack of continuity of staffing, or care Loss of routine Unfamiliar surroundings Pace of surroundings Lack of meaningful activity Over-stimulation Under-stimulation Imposed boundaries or routine Stopping a habit/behaviour (e.g., smoking)

9. Physical Factors

9.1 The physical causes which may lead to challenging behaviour include features of an individual's condition that pre-dispose him or her to distress (such as sensory impairments e.g., a loss of sight, hearing) unpleasant symptoms, pain and discomfort. They can all cause irritability and agitation or trigger distress.

9.2 Patho-physiological changes that cause delirium can be a significant factor and it is worth mentioning them specifically. Delirium is a short term confused state, or worsening of pre-existing confusion, due to a physical cause. It comes on suddenly (days to hours), fluctuates with time and is characterised by cognitive impairment and inattentiveness (distractibility) or drowsiness. Delusions, hallucinations and emotional changes (fear, anger) are common, and symptoms are often worse at night. Delirium usually resolves with treatment of the underlying cause, but it may persist and rarely does not always recover. Suspicion of delirium requires assessment by a suitably skilled doctor. Supporting information can be found in the Alcohol Withdrawal Guidelines.

9.3 Poor sleep is common in illness and in hospital, and leaves people fatigued and irritable. Hunger, thirst and urinary symptoms are associated with strong urges in an individual and may manifest as challenging behaviours if they cannot be communicated.

10. Cognitive Factors

10.1 Cognitive factors include the inability to remember new information, explanations or instructions, the loss of inhibitions, poor judgment and planning and importantly communication problems.

10.2 They often result in an inability to articulate needs or a difficulty in understanding and interpreting the communication of those around them (both verbal and non-verbal) and can all lead to distress or difficult behaviours.

10.3 Staff need to translate the reasons for challenging behaviour into unmet needs before identifying strategies to meet these needs.

10.4 Staff and carers can sometimes lack an understanding of communication impairment and overestimate a person's ability to understand information and make choices.

11. Psychological and Emotional Factors

11.1 Individuals suffering from delusions, especially paranoid, can feel they are being threatened and this can lead to defensive and challenging responses on their part. People with personality disorders may have difficulty foreseeing the consequences on others of their actions and may become acutely distressed. Fear is powerful in provoking difficult or aggressive behaviours. Anger can arise at a time of threat, as part of bereavement, or if needs are not being met.

12. Environmental or Social Factors

12.1 Factors relating to an individual's surroundings (e.g., excessive noise) can be provocative particularly if they are prolonged or persistent and may also interfere with the individual's rest and sleep. People with cognitive impairment often find care surroundings overwhelming and over-stimulating and may not keep up with the speed or volume of information or activity they are exposed to.

12.2 A lack of stimulation and activity, engaging in meaningless activity or over-activity can lead to frustration in individuals. This may be exacerbated by a lack of communication and dialogue between staff and patients or service users, poor care planning and a lack of coordination of activities between multi-disciplinary teams (MDTs).

12.3 Finally, a lack of understanding of an individual's culture and related behaviour can lead to frustration and agitation on their part. This can lead to a lack of trust, misinterpretation of their behaviour and miscommunication. Cultural sensitivity is important in dealing with this kind of challenging behaviour.

13. Managing risk and assessing behaviours

13.1 Risk Factors

Risk factors increase the likelihood of challenging behaviour and require quick management decisions. Risk factors may include a person's previous history and current clinical presentations. Historical and current factors may operate independently or interact together, and they may combine with environmental and situational triggers to heighten the risk of challenging behaviour.

The following factors point to an increased risk of challenging behaviour:

Person	Environment	Situational
Historical factors History of aggressive/violent behaviour History of intent to harm others History of mental condition(s)/self-harm/suicide attempts Cognitive impairment Previously detained under a section of the Mental Health Act Forensic, criminal related history, e.g., prisoners in hospital etc. History of abuse or trauma History of substance and alcohol abuse or withdrawal History of disruption to service delivery and resources, e.g., damage to property, equipment, disruption to staffing levels etc. **Current presentation** Specific diagnoses, physical, cognitive, (especially communication) and psychological/emotional factors.	Environmental factors, e.g., new environments, busy, active, crowded treatment Areas Other agitated or distressed patients or service users Lack of meaningful activities.	Activities being undertaken, e.g., washing, dressing, giving medications etc. Services being provided and the client group Staff member, e.g., inconsistent staff attitudes, awareness and approach Staffing, e.g., staffing levels, skill levels and training Certain times of day Patient, e.g., mix/tensions, patient on patient incidents Restrictions, denial or confrontation, e.g., a person wanting to leave, cigarette requests.

13.2 Preventing the Risk of Challenging Behaviour

Preventing the risk of challenging behaviour relies on meeting personalised care needs: '*Care where the patient is an equal partner with the healthcare professional and where both parties work together to make an assessment, identify options for the delivery of the most appropriate care. The care provided is holistic and the 'whole person' sits at the centre of the care package, which may be delivered by a range of health and social care professionals.*' (NHS Education for Scotland, 2010).

This approach is based on positive staff attitudes, high levels of tolerance, compassion and empathy. Dignity is important and requires that the individual is kept comfortable, valued, respected, is in control, and that they have choices in their treatment and care.

Empathic understanding means seeing problems from the perspective of the patient or service user.

It requires strong leadership, skilled staff confident in their own abilities and adequate resources. It requires training, practice and often role-modelling by people who know how to do it and can share their expertise.

In acute health settings, staff are often instilled with the belief that they need to work quickly in order to be effective. However, the approach presented here relies on staff being able to talk to the patient or service user and understand their psychological, emotional and physical care needs.

Personalised care means staff building positive relationships with the person being cared for, their family and carers. The rewards equally apply to those delivering the care as well as the person being cared for, as staff tend to feel empowered and supported by this approach.

Staff should understand that the way they interact is vital in helping the patient communicate the reasons for their distress and their unmet needs. They also need to be aware (and this should be reiterated through training) of how their interaction with the patient can positively or negatively reinforce challenging behaviours and of the need to communicate with them in a sensitive way.

A collaborative approach is the most effective way of preventing a person's challenging behaviour, which involves all staff having a unified understanding of an individual's behaviours, antecedents, triggers, reinforces and consequences and what everyone needs to do to prevent the behaviours. This understanding requires developing a personal profile and wherever possible observing and analysing what is happening and designing effective interventions – a functional assessment can assist where possible.

13.3 Management Tools and Techniques

Aggressive behaviour can nearly always be explained by the "fight or flight" reaction to a situation that is deemed "dangerous" by the victim. In such situations, the following points need to be remembered (however where a diagnosis of delirium has been made, refer also to the Clinical Guidelines for the Diagnosis and Management of Delirium):

- Reduce noise and stimulation
- Allow patients to "wander" safely
- Do not physically restrain patients unless they are a real danger to themselves or others. If absolutely necessary, use the minimal force possible.
- Remember that a uniform may not inspire confidence and may have the reverse effect
- Provide 1:1 care. Use friends or relatives if they are happy to come in; usually relatives are more than happy to be involved in the care, but additional staff may be needed, particularly over the first 24 hours
- Ensure adequate hydration, nutrition and comfort
- Do not be offended if the patient takes a dislike to you. Do not argue with the patient. Find someone that has a good rapport to do the bulk of the care; but make sure that they are supported and have regular breaks during an acute confusion period, as this is very energy demanding
- Use of bed rails. This may increase the patient's feeling of being trapped or held against their will. All relevant UHBW staff must read the [redacted] which details the process for bed rail risk assessment completion. The registered nurse will determine if a standard hospital bed with bed rails is inappropriate and therefore recommend that a floor-level bed is rented with accompanying crash mats.
- Use a calm but firm approach so that the patient feels there is someone in control of the situation. Keep the voice calm and reassuring; do not shout or speak
- Unnecessarily loudly. Keep commands/information short and concise; the patient will not be able to deal with too much information at once.
- Maintain consistency of approach by the whole team by through good handovers.
- Avoid the use of sedatives if at all possible. If this is the only safe way of managing the patient it should be used as a last resort and expert advice should be sought regarding appropriate drugs and dosage.

13.4 Keeping Patients and Visitors Informed

The provision of information to patients, their relatives and friends and ensuring that patients' concerns and complaints are dealt with quickly and fairly is extremely important and can prevent the risk of violence. This is particularly the case in situations of acute distress and/or long waiting periods and is more relevant to areas such as the Emergency Department and Outpatients.

13.5 Keeping Staff Informed

Staff involved with patient care should ensure information is communicated to relevant staff, e.g., at handover, particularly when the following applies:

- New members of staff are involved
- New patients are admitted
- There has been a change in the patient's medical/physical state, medication, behaviour or mood, etc.
- Known violent patients/clients are being transferred from one department to another
- Where domiciliary visits are made to patients with a known or suspected history of aggressive or violent behaviour. Further details are available in the separate Lone Working Policy.

13.6 Environment

It is important that the workplace environment and surroundings are considered within the assessment of risk.

The patient's environment can have a significant impact on their behaviour, specialty areas, mobility, etc. Items available to them within their environment may also become a hazard to others and/or a means to facilitate self-harm.

As part of the assessment, consideration should be given to:

- Bed location – can the patient be managed in a bay or is a side room more appropriate, will their behaviour impact on the care and/or recovery of other patients including demands on nursing time
- Potential weapons – remove any non-essential items that may be used to strike and/or be thrown including patients personal property, consider using plastic cutlery and non-ceramic crockery, ensure that "hot drinks" are not hot enough to scald or injure
- If appropriate, remove sharps bins from the immediate vicinity of the patient, be aware of items on your person such as scissors
- Ensure the patient's visitors do not compromise safety by passing unsuitable items or substances during visits. Consider checking patient's property and local environment following visits.
- Giving each patient a defined personal space
- Providing distraction activities where appropriate
- Encouraging play areas and activities for younger patients with challenging behaviour
- Providing activities and safe wandering space for patients with dementia
- Monitoring the mix of patients
- Removing aggressive patients to a single room or cubicle to protect both the health and safety of other patients and that of the aggressor himself/herself
- For patients with dementia and delirium there is also an argument for cohorting patients to reduce the risk of incidents of falls and aggression
- Request check of personal belongings for offensive weapon(s) and potential incendiary devices (matches, cigarette lighters).

13.7 Personal Safety of Staff

As well as managing the care of the patient concerned, the personal safety of all disciplines and groups of staff must be ensured as far as is reasonably practicable. Although patient care is the primary focus this must not be at the expense or risk of personal injury where the task being attempted is not of an essential and/or life preserving nature.

- Routine, non- essential tasks - bed making, room cleaning, patient hygiene etc. should not be undertaken or attempted when the patient is showing challenging behaviour (unless there is a risk to skin breakdown leading to pain and further aggression)
- Ensure that all staff that may have reason to have contact with the patient – doctors, nurses, (including departments such as x-ray, fracture clinic, cardiology),
- Housekeepers, porters, chaplain – are aware of the potential or actual risk/s in dealing with the patient
- To avoid a one on one confrontation situation consider setting a minimum 2:1 staff to patient ratio at all times and document this in the patient care plan
- Report all challenging behaviour incidents involving the patient by completing a Trust incident report on Datix and ensure new and/or revised information is communicated to all relevant staff
- Line managers should be aware that caring for challenging behaviour patients can be demanding and stressful and staff caring for challenging patients may require additional management support.
- In more serious or traumatic cases line managers should ensure staff are debriefed and if necessary, counselling should be offered to staff.

13.8 Care Planning

Risk assessment and management should inform the care plan as to whether specific interventions are required to manage challenging behaviour. The risk assessment documentation should sit alongside the care plan and should be cross-referenced and updated accordingly if new risks emerge.

13.9 De-escalation

If prevention has failed, is failing or has never had a chance to work, staff need to be skilled in de-escalation. This is based around highly developed communication skills, fostering good relationships, empathy, calming, non-confrontation, minimising threat, negotiation, compromise, agreeing to any reasonable requests, distraction, activities and changes of staffing which are all key here.

13.10 Doing Nothing/ Watch and Wait

Doing nothing and 'watch and wait' are important strategies in high risk situations where it is safe to apply them, although they require staff confidence as they may seem counter- intuitive. Challenging behaviour around the time of transition (e.g., hospital or care home admission, or ward or bed moves) often settles down within 2 or 3 days without intervention other than trying to keep the individual, staff and other people safe and offering comfort and reassurance. The latter meets psychological and emotional needs and improves the individual's experience of care.

13.11 Leave and Return

'Leave and return' is a strategy when someone is resisting care. Staff need to employ good judgment here. If a patient or service user absolutely needs medical intervention or another essential intervention (e.g., a soiled incontinence pad needs changing), brief physical interventions may be necessary. But in the majority of cases things can wait (washing or shaving, for example). Constant informal risk assessment is needed, along with adequate supervision, opportunities to discuss and debrief dilemmas and staff being trusted to use their judgment.

13.12 Better Understanding and Tolerance

Some challenging behaviours may be difficult, or unnecessary, to stop (e.g., wandering or persistent 'vocalisation'). It is important for staff to be able to understand these behaviours, tolerate them (where they are not offensive), accommodate them within the confines of the care environment, keep the patient or service user and others safe and sometimes mitigate effects. For example, someone who is persistently shouting may have to be isolated to reduce stimulation and keep the environment tolerable for others, as well as to avoid provoking others or 'setting them off'.

13.13 Observation

Observation that goes beyond normal therapeutic engagement and assists in building relationships with patients or service users should be considered for the immediate and long term prevention and management of challenging behaviour. It must not be intrusive, should respect dignity and privacy and must be conducted safely. Organisations

should have an action plan for checking availability of internal staff for observation (e.g., staff bank, temporary staff, central response team, movement of staff from other areas). An observation policy should clarify observation levels according to risk and what is expected of staff (a prior knowledge of the person's history is desirable) and how to initiate or discontinue higher level support.

13.14 Physical Intervention and Rapid Tranquillisation

It is important for staff to be able to recognise situations where physical intervention and/or rapid tranquillisation (refer to Clinical Guidelines for Rapid Tranquilisation of Adults and / or Pharmacological Management of Disturbed Young People including Rapid Tranquilisation are required. Clinical staff need to be confident about when these short-term intervention strategies are required, e.g., immediate control of a dangerous situation and when they are not required, i.e., where de- escalation, non-pharmacological means, or use of more routine medication (e.g., pain relief) should be attempted first.

During care planning, 'advance directives' (decisions) may be considered by asking a person to indicate what forms of treatment they would or would not prefer, should they lack capacity to refuse or consent in the future. This includes any treatment preferences that they may have in the event that they become challenging. Where a person has memory/understanding issues a formal capacity assessment is necessary, and a plan made in their best interest following the process set out in the MCA Code of Practice taking into account views of relatives and those close to the patient.

Full guidance on these issues should be sought from Safeguarding and the Restrictive Interventions Restraint and Clinical Holding policy.

19. Appendix C – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this policy. Please ensure any possible means of monitoring this policy to ensure all parts are fulfilled are included in this table.

Objective	Evidence	Method	Frequency	Responsible	Committee
Monitoring of incidents to identify learning.	Incident reports from Datix Incident Reporting System	Data extraction from incident reporting system.	Quarterly, Annually and Ad hoc as required.	Divisional Health and Safety Leads/Divisional H&S (site/service) Advisors. Safety Department	Trust Health and Safety Committee/Divisional H&S Forums. Managing Violence and Aggression Committee (MVAC)
Review of policy to ensure relevance	In date policy and associated documents	Reading /review	In line with policy review or major changes	Policy author	Managing Violence and Aggression Committee (MVAC)
Essential training compliance monitoring for Conflict Resolution	Reports for essential training topics	Data extraction from Kallidus training system	Monthly	Kallidus Administrators	Managing Violence and Aggression Committee (MVAC)

20. Appendix D – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Head of Security
Is this document: A – replacing the same titled, expired policy, B – replacing an alternative policy, C – a new policy:	B
If answer above is B: Alternative documentation this policy will replace (if applicable):	This policy will replace the previous titled Zero Tolerance Policy
This document is to be disseminated to:	All staff
Method of dissemination:	Available via the Document Management System (DMS) and promoted via the H&S Committee and Managing Violence and Aggression Committee (MVAC)
Is Training required:	[DITP - Training is required]
The Training Lead is:	Corporate Education Team

Additional Comments	

Plan Elements	Plan Details

21. Appendix E– Equality Impact Assessment (EIA) Screening Tool

Further information and guidance about Equality Impact Assessments is available here:

[redacted]

Query	Response
What is the main purpose of the document?	To ensure staff are aware of roles, responsibilities and arrangements in place in relation to the prevention and management of violence and aggression and to be aware of the support available to them
Who is the target audience of the document? Who is it likely to impact on? (Please tick all that apply.)	Add ☑ or ☒ **Staff ✓ Patients Visitors Carers Others**

Could the document have a significant **negative** impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment in relation to your response.
Age (including younger and older people)		X	No age related restrictions within the policy
Disability (including physical and sensory impairments, learning disabilities, mental health)		X	No disability restrictions within the policy
Gender reassignment		X	There is no reference to gender reassignment in this policy so no negative impact found
Pregnancy and maternity		X	
Race (includes ethnicity as well as gypsy travelers)		X	No race related restrictions within the policy
Religion and belief (includes non-belief)		X	No religion or belief (or non-belief) restrictions within the policy
Sex (male and female)		X	No reference to gender creating restrictions within the policy
Sexual Orientation (lesbian, gay, bisexual, other)		X	No reference to sexual orientation within the policy so negative impact found
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		X	No reference to any possibility of social exclusion found.
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		X	Even situations where treatment is withheld, or security called there remains an expectation of respectful treatment

Could the document have a significant **positive** impact on inclusion by reducing inequalities?	YES	NO	If yes, please explain why, and what evidence supports this assessment.

Will it promote equal opportunities for people from all groups?	X		Procedures in place will ensure that staff and others are treated in a fair and equitable manner
Will it help to get rid of discrimination?	X		The policy supports the same level of acceptable behaviour towards everyone
Will it help to get rid of harassment?	X		As above
Will it promote good relations between people from all groups?	X		By expecting that everyone displays acceptable behaviours there is no reason to suspect that good relations would not be promoted
Will it promote and protect human rights?	X		The policy addresses unacceptable behaviour to ensure safety

On the basis of the information/evidence so far, do you believe that the document will have a positive or negative impact on equality? (Please rate by circling the level of impact, below.)

Positive impact				**Negative Impact**		
Significant	**Some**	Very Little	NONE	Very Little	Some	Significant

Will the document create any problems or barriers to any community or group? ~~YES~~ / NO

Will any group be excluded because of this document? ~~YES~~ / NO

Will the document result in discrimination against any group? ~~YES~~ / NO

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment.

Is a full equality impact assessment required? ~~YES~~ / NO

Date assessment completed: 14/09/2023

Person completing the assessment: Head of Health and Safety Services