Policy Document

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NHS
University Hospitals of North Midlands
NHS Trust

Violence Prevention & Reduction

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Version Control Schedule

Version	Issue Date	Comments
1		
2		
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4		
5	April 2015	Integrated Policy with County Hospital
6	June 2018	3 year review
7	July 2021	3 year review Renamed policy from: 'Management of Violence and Aggression at Work' to 'Violence Prevention & Reduction' in line with new Violence Prevention & Reduction standards. Updated terminology in line with change of standards Inclusion of search guidance at Appendix I Inclusion of Freedom to Speak up Guardian and Raising Concerns & Workforce Equality Manager

Statement on Trust Policies

The latest version of 'Statement on Trust Policies' applies to this policy and can be accessed here

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1. INTRODUCTION

The University Hospitals of North Midlands NHS Trust recognises the need to have effective security measures and practices in place to prevent and reduce violence towards staff. This policy forms the basis for the development of security procedures, based on the recommendations and requirements set out by NHS England & NHS Improvement, in the 'Violence Prevention & Reduction Standards' December 2020.

The provision of a safe and secure environment is recognised in this policy and accepted by the Trust as a statutory requirement of health and safety legislation, and in particular compliance with the Violence Prevention & Reduction Standards that have been incorporated into the NHS Standard Contract. The organisation is required to review their status against these standards and provide board assurance that they have been met twice a year.

A pro-security culture amongst staff, patients, visitors and members of the public is one where the responsibility for security is accepted by all and the actions of a small anti-social minority who breach security is not conducive to a safe and secure environment. In order to build a pro-security culture, it is essential that security awareness is communicated to all staff and members of the public that it is necessary that they should be vigilant and that they report all potential breaches of security. A key element of pro-security culture is to encourage staff to take an active part in delivering a safe and secure environment within the Trust and effectively prevent and reduce violence at work.

An "Equality Impact Assessment" has been undertaken and no actual or potential discriminatory impact has been identified relating to this document.

This policy aims to protect Trust staff and where necessary, patients and visitors from violence and to minimise the risks of any incidents occurring.

2. SCOPE

This policy covers all employees of the Trust, any persons acting on the Trust's behalf, its service users and the Trust as an organisational body. Staff employed by the Trust includes full-time and part-time employees, contractors, sub-contractors, locum and agency workers, students and volunteers, although this list is not exhaustive. The policy applies to all Trust premises, property and assets.

3. DEFINITIONS

Violence, both physical and non-physical (including racially or homophobic motivated), aimed at health care staff continues to be present in Hospitals and domiciliary settings. The appropriate and proportionate response to incidents will depend on the individual circumstances.

To comply with the Violence Prevention & Reduction Standards, the Trust will use the World Health Organizations definition of violence:

"The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either result in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation"

Where such assaults, physical or non-physical, are directed at staff by another member of staff, the incident should be referred to the relevant Human Resources Policy.

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Below is a list of the most common abbreviations used in this policy.

ASMS **Accredited Security Management Specialist**

ARA **Acknowledgement of Responsibilities Agreement**

CICA **Criminal Injuries Compensation Authority**

PACE **Police and Criminal Evidence Act 1984**

DPA **The Data Protection Act 2018**

4. ROLES AND RESPONSIBILITIES

The roles and responsibilities within this section should be referenced to those contained in the Trust Policy EF02, Security Policy.

4.1 The **Chief Executive** has overall responsibility for ensuring that corporate decisions in respect of general security management, organisation and training are implemented with specific action for the prevention and reduction of violence at work.

The senior management (the chief executive and the board) is accountable for the violence prevention and reduction strategy and policy.

4.2 **Violence Prevention & Reduction Executive Director** is the Executive Director nominated by the Chief Executive, with responsibility for managing the violence prevention and reduction work stream and ensures appropriate and sufficient resources are allocated to the function, which is underpinned by an organisational risk assessment.

4.3 **Violence Prevention and Reduction Lead** - Trust Security Manager (ASMS)

- The role and responsibilities of the Violence Prevention & Reduction Lead/Trust Security Manager are specified in the Violence Prevention & Reduction Standards.
- The Violence Prevention and Reduction Lead/Trust Security Manager reports directly to the designated Executive Director in addition to any operational line management facilities in place locally.
- To take the day to day lead in violence prevention and reduction work, implementing the work of the violence prevention and reduction standards at a local level.
- Establish and promote measures to prevent and reduce violence, within the overall promotion and implementation of a Trust pro-security culture.
- Monitor reported incidents of violence and security incident trends and report twice a year to senior management.
- To ensure that details of the incidents of all violent incidents are recorded in accordance with the Datix Incident reporting system.
- Liaise with the Police, other NHS Bodies and other interested stakeholders to secure appropriate sanctions and redress for incidents of crime and disorder, with particular regard to incidents of violence against Trust staff.
- Monitor the effectiveness of any security arrangements, especially those aimed at preventing and reducing violence at work.

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- Develop and advise on Trust training programmes in respect of preventing and reducing violence at work.

4.4 **Operational Security**

Royal Stoke University Hospital:

The Sodexo Security Service is responsible for operational security matters at the Royal Stoke University Hospital site. Additionally Sodexo Security advise on security requirements, in liaison with the Violence Prevention & Reduction Lead/Trust Security Manager and Police as required.

Sodexo Security will refer all security incidents to the Trust's Violence Prevention & Reduction Lead/Trust Security Manager who will advise on the relevant actions to be taken. Sodexo Security will work closely with the Trust's Violence Prevention & Reduction Lead/Trust Security Manager in the promotion and provision of a pro-security culture within the Trust.

In exceptional circumstances security can provide a dedicated presence, where an inpatient is deemed a high risk of violence see appendix G for further guidance

County Hospital:

The **Operational Car Parks and Security Manager** is responsible for operational security matters at the County Hospital site, liaising with the Trust Violence Prevention & Reduction Lead/Trust Security Manager on all relevant issues. Additionally the Operational Car Parks and Security Manager can advise on security requirements, in liaison with the Violence Prevention & Reduction Lead/Trust Security Manager and Police as required.

The Operational Car Parks and Security Manager and the Violence Prevention & Reduction Lead/Trust Security Manager roles are closely interlinked. Operational Security oversees operational security whilst the Violence Prevention & Reduction Lead/Trust Security Manager has additional security management roles and responsibilities on behalf of the Trust.

Operational Security will be responsible for advising on security incidents and to liaise regularly with the Violence Prevention & Reduction Lead/Trust Security Manager and the Police on security issues regarding the development of operational procedures for the prevention and reduction of violence aimed at staff.

Operational Security will work closely with the Trust's Violence Prevention & Reduction Lead/Trust Security Manager in the promotion and provision of a pro-security culture within the Trust.

4.5 **Clinical Directors / Associate Directors / Directorate Managers** have responsibility for the following areas;

- To implement this Policy and Procedure within Divisions.
- To ensure risk assessments of all wards and departments are undertaken and departmental protocols/plans for the prevention and reduction of violence are developed.
- To ensure all staff groups working within the Divisions are aware of this Policy and Procedure and the Divisional arrangements for the prevention and reduction of violence.
- To ensure Trust adverse incident reporting procedures are implemented.
- To allocate appropriate resources, time and training to the prevention and reduction of violence in the Divisions.

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4.6 **Ward/Department/Line Managers** hold responsibility;

- To increase awareness to mitigate the risk of violence. It is essential to involve the whole team closely in determining local management arrangements.

- To assess Departmental risks of violence using the Violence Risk Assessment Form (Appendix C), considering any seasonal or weekly variations in risk and any vulnerable staff such as lone workers or staff that do not have direct contact with colleagues, such as community staff. Managers should, if possible, reorganise the work in such a way that individuals are less isolated, or install appropriate security measures.

- To develop and review local lone worker procedure as required. Further guidance is available in HS21 Loneworking Policy and Guidance

- To review security risk assessments on an annual basis.

- To review the risk assessment following any major departmental changes or significant aggressive or violent incidents. Specialist advice from the Violence Prevention & Reduction Lead/Trust Security Manager, Health & Safety Department or other source should be obtained, if appropriate.

- To develop, implement and review action plans following the completion of a risk assessment, as required.

- To identify and review the training needs of all staff as part of the risk assessment process and arrange appropriate training to ensure staff working across all service hours are appropriately trained. Full participation of staff in the risk assessment is a key part of their training.

- To report all actual violent incidents via the Datix Incident Reporting System.

- To report, where appropriate, violent incidents to the Police. In most circumstances, it will normally be the decision of the individual (or advocate representing the patient) who has suffered an attack whether or not they wish to press charges but this should not prevent the matter being reported to the Police.

- To ensure the preservation of any evidence by minimising the handling of any weapons or disturbing the scene until the Police arrive. Personal details of witnesses should be taken at once. If possible, witnesses should be encouraged to stay until the Police arrive.

- To ensure the department resumes normal operation and that the care of patients continues as soon as is reasonably practicable after the violent incident.

- To provide immediate support to the individual concerned following a violent incident. Debriefing of all staff should occur as soon as possible and staff should be advised of the Staff Support Services available.

- Local induction should include awareness of any local risk assessments concerned with the security of staff, patients, visitors and the environment.

- Referral of staff to occupational health or support network from BAME wellbeing leads.

4.7 **Trust Staff**

- Staff of all disciplines has a responsibility to the Trust and their colleagues to ensure they comply with the Trust's Violence Prevention and Reduction Policy and procedures, associated duties and local protocols. Every individual has a responsibility to follow safe working practices and co-

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operate with the Trust to promote safety at work whilst following good professional practice at all times.

- The Trust does not expect staff to place themselves at risk of violence to protect or prevent damage to or theft of property. All staff have a duty of care to themselves.

- To report all violent incidents to their line manager or the person in charge. It is vital to forewarn colleagues about potentially violent individuals. Violent incidents should be reported on Datix incident reporting system.

- Wherever possible, staff are to withdraw from a violent situation rather than try to defend themselves or subdue the attacker.

- Staff must attend all mandatory training and any other training that has been identified in their training needs analysis (violence) informed by the risk assessment.

4.8 Staff Support Services

- To provide confidential counselling following violent incidents, at individual request.

4.9 Freedom to Speak up Guardian

- To support staff who want to speak up about concerns that may have led to the incident of violence occurring.

4.10 Raising Concerns & Workforce Equality Manager

- To collaborate with the Violence Prevention and Reduction Lead/Trust Security Manager when implementing the Workforce Race Equality Standards

4.11 Other Arrangements

- Where appropriate, assistance will be sought from other bodies such as the Police, Crown Prosecution Service and the Trust Solicitors.

- The Policy will be monitored in collaboration with Health & Safety Colleagues as described in the Monitoring Table at paragraph 7.1

5. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

5.1 Training

- **Conflict Resolution Training** – It is a requirement that all Trust front line staff attend this training in line with Trust Policy all training should be recorded on ESR (See Appendix F).

- Clinical Holding – where an area has been risk assessed and the requirement is found for provision of training in interventions and disengagement, this extended course equips individuals with enhanced skills. The identification of the requirement for Clinical Holding training via risk assessment, its provision and funding is the responsibility of individual Trust Divisions. Where it is identified that clinical holding instructors are required Divisions should approach the Senior Nurse, Safeguarding for on-going advice.

5.2 Information

Advice and information on aspects on personal safety and security, including lone working, is provided by Security Management and Health & Safety departments, and is also available on the Trust's Intranet.

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6. MONITORING AND REVIEW ARRANGEMENTS

6.1 Monitoring Arrangements

Risk Assessment

All foreseeable areas of violence and lone working arrangements will be subject to risk assessment, using the Trust's risk assessment process. Control measures identified by risk assessment should be implemented to reduce risk. All assessments that do not eliminate, reduce or manage violence hazards should be reviewed by the relevant department and may, if deficiencies are identified, be added to the Trust's Risk Register with an accompanying action plan. The Trust risk assessment process must be enforced, regularly reviewed and acted upon within every local Ward/Department/Area.

Incidents of violence must be reported and monitored as soon as practicable to ensure there is co-ordination and sharing of good practice between staff on all Trust sites and between Trusts where applicable.

This should be completed through:

- the Trust's Risk Management department via the Datix Incident Reporting process,
- the Violence Prevention & Reduction Lead/Trust Security Manager

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Violence Prevention & Reduction Monitoring Table					
Aspect of compliance or effectiveness being monitored	Monitoring method	Individual or department responsible for the monitoring	Frequency of the monitoring activity	Group/committee/ forum which will receive the findings/monitoring report	Committee/ individual responsible for ensuring that the actions are completed
Requirement to undertake appropriate risk assessments for the prevention and reduction of violence	• Risk assessments on local levels (departmental/Directorate/ Divisional) • Risk assessments - corporate level • Adverse incident reports (Datix) • Risk register reports / escalation	• Local level – ward/department, Directorate, Division • Corporate level – LSMS, Division	Yearly	• Divisional Health and Safety Meeting • Executive Health and Safety Group	– Local managers – Executive Health and Safety Group Violence Prevention & Reduction Lead/ASMS
Timescales for review of risk assessments	• Risk assessments on local levels (departmental/Directorate/ Divisional) • Risk assessments - corporate level • Adverse incident reports (Datix) • Risk register reports / escalation	• Local level – ward/department, Directorate, Division • Corporate level – ASMS, Division	Yearly	• Divisional Health and Safety Meeting • Executive Health and Safety Group	Local managers LSMS – Executive Health and Safety Group Violence Prevention & Reduction Lead/ASMS
How action plans are developed as a result of risk assessments	• Risk assessments on local levels (departmental/Directorate/ Divisional)	• Local level – ward/department, Directorate, Division	Yearly	• Divisional Health and Safety Meeting, by exception	Local managers LSMS – Executive Health and Safety Group Violence Prevention & Reduction Lead/ASMS
How action plans are followed up	• Risk assessments on local levels (departmental/Directorate/ Divisional) •	• Local level – ward/department, Directorate, Division •	Yearly	• Divisional Health and Safety Meeting	– Local managers LSMS – Executive Health and Safety Group Violence Prevention & Reduction Lead/ASMS
Arrangements for ensuring the safety of lone workers	• Risk assessments on local levels (departmental/Directorate/ Divisional) • Adverse incident reports (Datix) •	• Local level – ward/department, Directorate, Division	Yearly	• Divisional Health and Safety Meeting	Local managers – Executive Health and Safety Group Violence Prevention & Reduction Lead/ASMS
Organisation's expectations in relation to staff training, as identified in the training needs analysis (violence)	• compliance statutory & mandatory training reports	• Local level – ward/department, Directorate, Division	At least twice a year	• Divisional Health and Safety Meeting /Divisional Governance Group	Local managers LSMS – Executive Health and Safety Group Violence Prevention & Reduction Lead/ASMS

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6.2 Review

This Policy will be reviewed following any major change in statute or local pressures or after any national guidance updates. A review will be undertaken 3 yearly, whether or not any major changes in statute or guidance have been issued.

The responsibility for this policy's review falls under the remit of the Trust's Violence Prevention and Reduction Lead/Trust Security Manager, in conjunction with the Trust's Executive Director, Security, Health and Safety and Governance and Risk Departments. Other personnel or departments may also be consulted and contribute as necessary, dependent on the Trust's security standing at the time of this policy's next review.

7. REFERENCES

This Trust Security Policy should be implemented in conjunction with other security related policies providing for the safety and security of staff, patients, visitors, premises, equipment, data and other assets. Below is a list, not exhaustive, of associated strategies, policies and legislation from Trust, regional and national sources.

- NHS Standard Contract
- Health and Safety at Work etc Act 1974
- Management of Health and Safety at Work Regulations, 1999
- Criminal Justice and Immigration Act 2008
- The Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000
- Freedom of Information Act 2000
- Data Protection Act 2018
- General Data Protection Regulations, 2018
- EF02 Security Policy
- HR38 Emotional Wellbeing & Mental Health Policy
- HR02 Dignity at Work Policy and Procedure
- HR03 Grievance and Disputes Policy
- RM02 Policy and Procedure for Handling Complaints and concerns
- HS01 Health and Safety Policy
- HR22 Supporting Staff Involved in An Incident, Complaint or Claim
- HS21 Loneworking Policy and Guidance
- C08 Therapeutic observation of adult patients who are considered at risk of harm to themselves or others
- C44 Trust Policy on Chaperoning
- C33 Trust Policy for the use and reduction of restrictive interventions including the use of clinical holding
- C36 Protection of Adults from Abuse & Neglect who have care and support needs
- RM07 Trust Policy for Reporting and Management of Incidents including SIRI and STEIS reportable incidents
- Any other legal statute which is applicable

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Appendix A: Management of Violence Procedure

1. Introduction

The Trust is committed to the wellbeing and safety of all those employed within the service and those who use its services, in line with the Health & Safety at Work Act 1974, Management of Health, Safety & Welfare Regulations 1999 and other associated statute.

The Trust is committed to providing a safe and healthy working and treatment environment for staff, service users and all visitors that is free, so far as is reasonably practicable, from violence. All staff, including agency and bank staff, service users and visitors will be supported when they have been subjected to, or have observed, any violent, behaviour. All concerns will be taken seriously and the relevant actions taken.

The Trust is committed to the training and development of its entire staff to recognise potential violence, be skilled in its diffusion, and have knowledge of effective procedures for managing any unavoidable incidents of violence in a manner that is safe and respectful for patients and staff.

The Trust will address such violence through programmes of conflict resolution training for staff and other recognised models of conflict management, including Clinical Holding training programmed for appropriate staff groups. The primary purpose of clinical holding is for patients that are being resistive to care and treatment and not for violent patients, however the same techniques taught can be applied.

The Trust is committed to raising the awareness of all Trust service users to this issue and enlisting their support for staff in the provision of a therapeutic environment.

It is accepted that there will be times when despite every precaution employees will, due to the nature of their work, be faced with potentially violent incidents. The Trust will support any individual who acts reasonably and legally in good faith and with due professional standards in accordance with Trust practice when dealing with such difficulties.

The Trust cannot guard against all eventualities, nor can action taken by the Trust alone bring the problem of violence under control. All employees have an important part to play in raising security awareness and reducing risks of violence.

In order to prevent staff being confronted at their place of work by persistently violent individuals, the Trust will consider the use of the following legal actions where **physical assault** has occurred:

- Civil proceedings based on the tort of Battery.
- Criminal prosecutions for anti-social behaviour which can prevent an individual from attending specified premises or being disruptive in a given locality.
- Criminal prosecutions in relation to assault, actual bodily harm, wounding or inflicting grievous bodily harm **AND** racially or religiously aggravated forms of these offences and wounding with intent to cause grievous bodily harm.

Whilst there are difficulties in denying access of treatment for patients, if certain circumstances dictate the Trust will make arrangements for those identified as particularly violent or potentially violent patients to receive treatment at locations where they can best be managed and the potential for harm minimised.

The Trust may also refuse treatment, if this is the only option available other than in the case of a life threatening emergency. The decision to refuse treatment lies only with the Chief Executive and this decision must not be taken locally.

Where a particular risk of violence has been identified, the Trust will also consider the provision of security personnel or other actions to minimise the risk towards those using the premises.

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Whilst the Trust will monitor all reported cases of violence and continuously review their response in line with history and current experience, it is appreciated that all employees have an important role to play in raising awareness and preventing and reducing the risk of violence in the workplace. The timely and accurate reporting of all actual or potential incidents is essential in order to monitor risk and plan preventative actions.

The Trust will evaluate all reports through the Executive Health and Safety Group and in conjunction with the Violence Prevention and Reduction Lead / Trust Security Manager review all cases and take suitable action.

2. Principles of Handling Aggression and Violence

The Trust recognises that there are two separate real or potentially aggressive or violent situations encountered by staff:-

I. The sick patient requires the application of therapeutic interventions in order to safely and skilfully care for them without causing injury to either themselves, other patients or members of staff.

II. Patients, visitors and others deliberately act aggressively or violently towards staff.

The first situation is a recognised medical state, which requires appropriate intervention.

The second will not be tolerated and this form of violence is not acceptable in circumstances where the application of force is intentional.

In identifying words, actions and conduct that cause harassment, alarm or distress, staff should use careful judgement and a sense of reasonableness and proportion but the use or threat of, violence or personal abuse is never acceptable.

Wherever possible, staff members are instructed to withdraw from an aggressive or violent situation rather than try to defend themselves or subdue the attacker.

However, the Trust recognises that there will be situations when caring for the sick patient where staff may have to intervene to protect the patient who is displaying behavioural problems. In these situations **the first principle must always be for staff not to expose themselves to any unnecessary risk.**

Therefore due account should always be paid to the individual's experience, training, confidence and knowledge of the patient's behaviour.

Providing the policy is followed in good faith, staff will not be held responsible in any way for an act of violence, which they could neither foresee, prevent nor control. The Trust would support and advise a member of staff wishing to press charges with the provisos made above.

Communication - it is vital to forewarn appropriate managers and colleagues about potentially violent individuals. Departments will provide information concerning violent patients, clients and relatives to staff and colleagues, this could be through the application and management of risk markers to the patient records.

Any acts of violence between members of staff are considered unacceptable by the Trust. Action will be taken, as appropriate, according to the relevant Human Resources Policies.

3. Reporting Of Incidents

The Trust requires all employees to report all violent incidents and fears of potential violence, whether or not there is an injury, adhering to the Trust Adverse Incident Reporting Policy, RM07.

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A Datix Incident Report must be completed. The Police must be called for all incidents requiring a physical response.

The victim of the incident will be kept fully informed of the progress of any investigation or action taken and will be offered the full support of the Trust such as debriefing, counselling services or other appropriate support that would be considered necessary or desirable in the circumstances.

4. Reporting to the Police

Criminal acts should be reported to the Police as soon as practicable and the appropriate information included on the Datix incident report. The Violence Prevention & Reduction Lead / Trust Security Manager can be contacted to assist in this process.

With the exception of the reporting of incidents, all Police contact should be through the Violence Prevention & Reduction Lead / Trust Security Manager or Security.

5. Counselling & Support

As soon as possible following a violent incident, the line manager should provide immediate support to the injured party.

Continual debriefing of all staff will also occur as soon as possible and staff will be reminded of the counselling facilities available by the Staff Support Service.

Other staff may experience a reaction to the incident and they may also require support and guidance in addition to training to help them manage future situations effectively. Involving all staff in any review of departmental risk assessments and safety procedures soon after the incident and periodically thereafter will help to allay any anxieties staff groups may feel in relation to particular incidents.

Further information and guidance can be found in Policy H38, Emotional wellbeing and Mental Health Policy and Policy HR22 Supporting Staff involved in an incident, complaint or claim.

Staff support can come in many forms and may include:

a) Clinical supervision
b) Counselling
c) Training
d) Incident de-brief

6. Criminal Injuries Compensation Authority

In the event of injury to a member of staff during the course of their duty, staff may be entitled to benefits under the relevant terms and conditions of service. Advice on this can be obtained from the Violence Prevention and Reduction Lead/Trust Security Manager, an HR Manager, the Payroll Department or a staff representative.

Additionally, there may be a further right to compensation from the Criminal Injuries Compensation Authority if any member of staff sustains personal injury -

- directly attributable to a criminal offence or
- when trying to prevent someone from committing a crime or
- when trying to arrest a suspected offender or
- when helping the Police to prevent a crime being committed or arresting a suspected offender

Staff should be aware that to obtain an award from the Criminal Injuries Compensation Authority, any incident resulting in physical or psychological injury needs to have been reported to the Police.

Further information can be found at: https://www.gov.uk/claim-compensation-criminal-injury

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7. Legal Advice

The Trust may be asked for assistance to obtain legal advice, but members of staff may also wish to consult their staff side organisation, the local Citizens' Advice Bureau or a Solicitor. Staff representatives shall be offered full opportunities for explaining legal support and assistance offered to their members who have been victims of violence.

8. NHS Injury Benefits Scheme

The NHS Injury Benefits Scheme changed on 31 March 2013. Employees who sustain an injury or contract a disease due to NHS employment on or before 30 March 2013 can still access the NHS Injury Benefits Scheme until 30 March 2038 under new transitional arrangements.

For further advice and guidance visit: https://www.nhsbsa.nhs.uk/nhs-injury-benefits-scheme

9. Risk Assessments

Risk assessments of each workplace will be carried out in line with the Trust's Health & Safety Policy. These are to be supported, where necessary, by clinical based assessments linked to individual patient's care plans. Staff must be involved in the identification of problems and suitable control measures such as training and the review of their effectiveness.

10. Provision of Appropriate Environment

Every effort will be made to minimise the likelihood of a violent incident by providing a pleasant, comfortable and therapeutic environment designed to reduce stress and anxiety. Due care will be taken with regard to individual patient's clinical conditions and to any triggers to violence which may be associated with these. This should also result in benefits regarding patient satisfaction and service to the public.

In order that all authorised staff can be readily identified and to prevent potential intruders, the Trust provides its entire staff with identification badges. The authorised identification must be carried by all staff whilst in their working environment, see Policy EF21 for further guidance.

Appropriate measures commensurate with the risk assessment will be taken to adapt the working environment to reduce, eradicate or manage identified risks of violence toward staff. This will be especially relevant to any new capital programmes or redesign of services.

11. Measures

A range of measures can be taken depending on the severity of the incident, to assist in the management of unacceptable behaviour by seeking to reduce the risks and demonstrate acceptable standards of behaviour. These include;

- Verbal warnings
- Acknowledgement of Responsibilities Agreements (ARA)
- Withholding treatment
- Civil injunctions, Community Protection Notice (CPN) and Criminal Behaviour Order (CBO)
- Criminal prosecution.

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

There is no requirement to escalate the response in any particular order if the situation warrants immediate action.

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11.1 Verbal Warnings

Verbal Warnings are an effective method of addressing unacceptable behaviour with a view to achieving realistic and workable solutions.

They are not a method of appeasing difficult patients, relatives or visitors in an attempt to modify their behaviour, or to punish them, but instead to determine the cause of the behaviour so that the problem can be addressed or the risk of it reoccurring minimised.

It is important that patients, relatives, and visitors are dealt with in a demonstrably fair and objective manner. However, whilst staff have a duty of care, this does not include accepting abusive behaviour. Every attempt should be made to de-escalate a situation that could potentially become abusive. Where de-escalation fails, the patient, relative or visitor should be warned of the consequences of future unacceptable behaviour. The incident should also be reported and recorded via the Datix Incident Reporting procedure.

Where it is deemed appropriate to approach a patient, relative or visitor in respect of their behaviour, this should (where practicable) be done informally, privately and at a time when all parties involved are composed.

The aim of the verbal warning process is;

- To ascertain the reason for the behaviour as a means of preventing further incidents or reducing the risk of them reoccurring,
- To ensure that the patient, relative or visitor is aware of the consequences of further unacceptable behaviour.

A meeting should be arranged and conducted in a fair and objective manner. A formal record should be made and maintained, utilising the Datix incident reporting system. Due consideration by senior Trust personnel prior to the meeting must be given to;

- The meeting's desired outcome
- Appropriate conditions of the ARA.

Verbal warnings will not always be appropriate and should only be attempted when it is safe to do so with relevant and appropriate staff present (including Security Staff if necessary). If a risk of violence is identified, consideration must be given to conducting this interview within a safe environment.

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

In the rare circumstances where a person who has not yet reached the age of 16 is to be interviewed, they must be accompanied by an appropriate adult (i.e. parent, guardian), to whom all correspondence must be issued.

Where the process has no affect and unacceptable behaviour continues, alternative action must be considered including procedural, civil or criminal action with advice from the Violence Prevention and Reduction Lead / Trust Security Manager in specific cases when necessary.

11.2 Acknowledgement of Responsibilities Agreements (ARA)

ARAs are an option to be considered for individuals, such as patients, relatives or visitors, to address unacceptable behaviour where verbal warnings have failed, or as an immediate intervention depending on the circumstances. Acknowledgement of Responsibilities Agreement (ARA) is a

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written agreement between parties aimed at addressing and preventing the recurrence of unacceptable behaviour and can be used as an early intervention process to stop unacceptable behaviour from escalating into more serious behaviour.

All relevant personnel, (i.e. Staff, Social Services), should organise and attend a pre-meeting to discuss conditions. Where it is considered safe to do so, the perpetrator should then be invited to attend a meeting where the agreement is made. Appropriate persons should attend, but careful consideration should be given to the number of staff attending as the situation could be perceived as intimidating and threatening to the perpetrator if too many are present. Involving the perpetrator in the process is important as it may encourage recognition of the impact of unacceptable behaviour, the need to take responsibility for their actions, and a subsequent improvement in their conduct.

The agreement itself should specify a list of acts or behaviours which an individual (either patient, relative or visitor) has been involved in with a view to obtaining agreement and cooperation with regard to improvement in their behaviour.

ARAs should last for a period of at least six months. However, any reasonable period can be specified depending on the nature of the behaviour to be addressed, with a balance of both general and specific recommendations.

The terms of the ARA should be outlined formally in a written document to the perpetrator See Appendix B for a flowchart of the verbal and written warning process together with the ARA process.

If an ARA is required please contact the LSMS for further advice and guidance in the process.

If the individual complies with the terms of the agreement they can expect the following:

- their clinical care or access to the Trust will not be affected in any way.
- where substance abuse has been identified, appropriate assistance will be provided.
- a copy of the Confirmation of the Acknowledgement of Responsibilities Agreement will be kept on file and a copy will also be kept in the patient's notes, if the perpetrator is a patient.
- the LSMS and other appropriate personnel / departments will be informed.
- the Trust will fully investigate all valid concerns raised by the patient.
- the ARA will be reviewed after an appropriate time period and at least within one year of issue of the ARA.

The use of ARA would not be appropriate in the following circumstances:

- Where the Violence Prevention and Reduction Executive Director , having consulted with relevant staff and obtained clinical advice, has reached the conclusion that the incident was clinically induced, and where an ARA could adversely affect the patient's well-being or recovery. However, the presence of a mental health issue should not preclude appropriate action from being taken

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

Failure to comply with the ARA may, at the request of the relevant Divisional Manager and the Violence Prevention and Reduction Executive Director (or their nominated deputies) result in exclusion from the Trust via a final warning letter.

Such exclusion will be reviewed after one year, subject to alternative care arrangements being made; the provision of such arrangements will be pursued by the relevant clinician if the excluded individual is a patient. In the event of an excluded individual presenting at the Trust's Emergency Department for emergency treatment, that individual will be treated and stabilised with, if necessary, Security Staff in attendance. However, if admission is unavoidable, Security Staff will, if necessary, remain in attendance. The need for security attendance will be determined by an appropriate

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member of clinical staff. The Trust may subsequently seek legal redress to prevent the individual from returning to Trust property.

11.3 Withholding Treatment

Any decision to withhold treatment must be based on an accurate clinical assessment and the advice of the patient's Consultant or senior member of the medical team (on call team for Out of Hours) in consultation with the relevant Divisional Manager on a case by case basis. Under no circumstances should it be inferred to a patient that treatment may be withheld without appropriate consultation taking place. **The withholding of treatment should always be seen as a last resort, and only after taking legal advice.** This does not preclude the relevant clinician discharging a patient who no long requires inpatient care in the normal manner.

There may be instances where the nature of the assault is so serious that the Trust, having obtained legal advice, can decide to withhold treatment immediately. Where it is decided that a patient should be excluded from the Trust premises and treatment withheld, a written explanation for the exclusion must be provided.

This letter should be signed by the Chief Executive of the Trust and be copied to all relevant personnel / departments. This letter must state:

- the reason why treatment is being withheld (including specific information, dates and times of incidents)
- the period of the exclusion (the period of exclusion should normally not exceed 12 months, after which the decision must be reviewed)
- details of the mechanism for seeking a review of a decision to withhold treatment e.g. via local patient complaints procedures
- the action that the Trust intends to take if an excluded individual returns to health body premises for any reason other than a medical emergency (these could range from criminal prosecution and civil injunctions)
- that each case is judged on its own merits to ensure that the need to protect and ensure the safety of staff is properly balanced against the need to provide health care to individuals
- that the GP and Consultant will be notified in writing of the decision
- a detailed record of the rationale for exclusion and of the alternate arrangement for care should be kept in the patient's medical and nursing documentation and copied to the LSMS and documented via the Datix Incident Reporting system
- The Trust must also consider if it will share the details of the incident(s) with other Hospitals which may receive or already have received this patient.

11.4 Civil Injunctions and Criminal Prosecution

Any person behaving unlawfully will be reported to the Police and The Trust will seek the application of the maximum penalties available in law. The Trust will prosecute all perpetrators of crime on or against Trust staff, property and assets.

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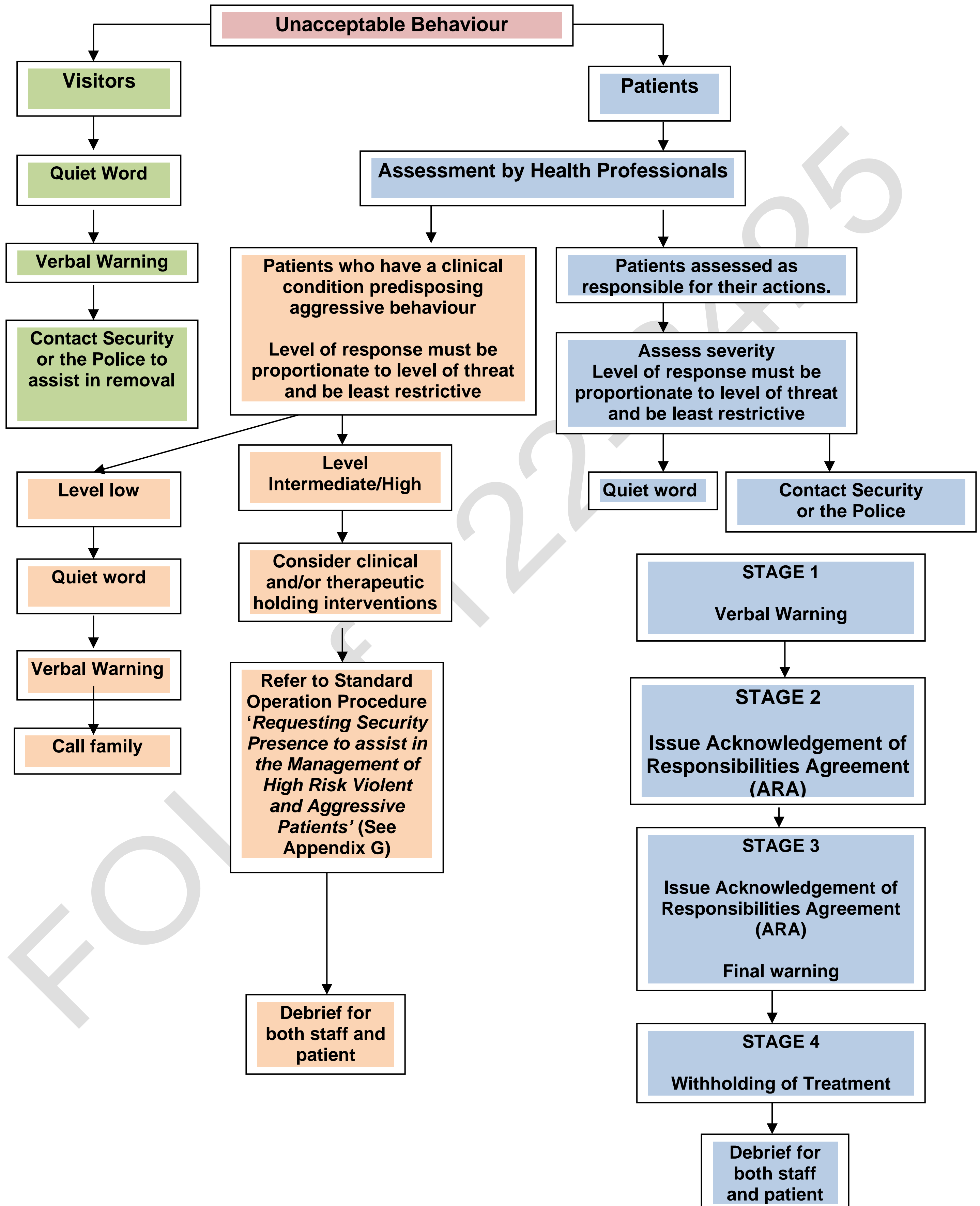
Appendix B: Management of Violence And Aggression In The Workplace

Unacceptable Behaviour Flowchart



Appendix C: Work Related Security And Violence Risk Assessment

WORK RELATED SECURITY AND VIOLENCE RISK ASSESSMENT

WARD/DEPT/AREA	
DIRECTORATE/DIVISION	
DATE OF ASSESSMENT	
DATE OF RE-ASSESSMENT	

GUIDANCE NOTES

1. This assessment should be undertaken by more than person. We all have subjective opinions about violence, and it is important to obtain a balanced view. Consider taking somebody from outside of your work area to gain a different perspective.

2. The manager of the area is responsible for implementing any actions arising from this risk assessment. The action plan should be discussed with the line manager to ensure that support and assistance are available to deliver the action plan.

3. In order to risk assess the likelihood of security breaches and 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.

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

5. 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.

6. All improvements to the existing situation should be reflected in the action plan at the end of this document.

Name of Person(s) Undertaking this Risk Assessment	
(1)	**(2)**
Position:	**Position:**
Signature:	**Signature:**

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A: PHYSICAL SECURITY

Look at the risks in the working environment that affect the security of the building/area, the staff working there and the physical assets that are within that area.

ACCESS	Yes/No
Is the work area completely securable, can all the doors be secured?	
Do you know who has entry and exit rights to Access Controlled doors in your work area?	
Are any Access Controlled doors set up for timed opening?	
Do you have a means of controlling access and exit within your work area?	
If "yes", do you always use it?	
Do you change the codes of the keycode locks regularly?	
Do all windows have locks and opening restriction devices?	
Is any part of your work area covered by CCTV?	
If Yes; Does it cover the main entrance point?	

Does the area remain open and staffed 24/7?	
If No; Does this area have an intruder alarm when it is closed?	
If there is an alarm, does it get tested regularly?	
Does this alarm sound in the security office?	
Is there a security response to the sounding of the alarm?	
Is there a procedure for locking up the area at the end of work?	
Are the handling of keys for this area recorded as procedure?	

Do all staff wear clearly visible and up to date ID badges?	
Are people NOT wearing badges challenged?	
Are all staff aware of or reminded of personal security procedures?	
Do the staff have secure changing areas?	
Do the staff have secure lockers?	
Do patients have secure lockers/drawers?	
Are staff fully aware of patient property policy?	
Are you aware of all valuable physical assets in your work area?	

Are Controlled Drugs handled in this area?	
If yes; are all staff aware of CD Policy?	
Are CDs held in a secure area?	
Are the CD keys managed with policy?	

LOCKDOWN PROCEDURE	Yes/No
Are you aware of the UHNM Lockdown policy and procedures and how they affect your work area?	
Have you completed a local **Lockdown Risk Profile***?	
If yes, Are all staff aware of it?	
And is it practiced?	
Can a lockdown be activated and completed with your own staff, not requiring additional security staff?	
Do you have a local evacuation process and plan for fire and other events?	
If yes, Are all staff aware of it?	
And is it practiced?	

NOTE: IF YOU HAVE ANSWERED "NO" TO ANY OF THE ABOVE QUESTIONS, YOU NEED TO TAKE ACTION AND NOTE THIS IN YOUR ACTION PLAN.

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B: ENVIRONMENT

Look at the risks in your working environment to see whether they increase the likelihood that security may be breached or violence may occur.

EXTERNAL ENVIRONMENT	Yes, No N/A
Is the lighting adequate?	
Does the lighting work?	
Is the lighting in the right place?	
Is the area visited by lone workers?	
Do walls, bushes or trees provide cover for an attacker?	
Is the area quiet/unfrequented?	
Is the area in use at weekends?	
Is it a place where the public is known to loiter?	
Is it used as a public thoroughfare?	
Are there secure and safe routes from your building to another place of safety?	
Are Security escorts available to the car parks after dark?	
Is all refuse stored correctly according to Trust Policy (Potential Arson Risk)?	
Are all stores deliveries unloaded and stored quickly and effectively (Potential Arson, Theft or Tampering Risk)?	

INTERNAL ENVIRONMENT	Yes, No N/A
With the potential to create or promote violence or aggression, Is the area:	
Too dark	
Too bright	
Too cold	
Too hot	
Too noisy	
Dull	
Unpleasant	
Untidy/dirty	
Adequately sign-posted?	
Can staff conversations be overheard?	
Can phone conversations be overheard?	
Does the reception have some form of barrier?	
Are all doors within your area locked out of hours?	
Does the method of locking provide adequate security?	
Is all refuse stored correctly according to Trust Policy (Potential Arson Risk)?	
Are all stores deliveries unloaded and stored quickly and effectively (Potential Arson, Theft or Tampering Risk)?	

In public waiting areas:	
Is sufficient personal space provided?	
Does furniture or fixings provide potential missiles or weapons?	
Is it stuffy?	
Is there a means of ensuring the public are kept in designated areas?	
Are there diversions/activities to prevent boredom?	
Can staff rest areas be seen by the public?	
Is it difficult to summon help from any areas in your department?	
Are there any obstructions in your way if you need to escape from your work area in an emergency?	
Is all refuse stored correctly according to Trust Policy (Potential Arson Risk)?	

C: CONTACT WITH PATIENTS AND THE PUBLIC

Please identify possible violent assailants by ticking against the lists below. Add other headings that are particular to your environment.

EXTERNAL ENVIRONMENT	✓
PATIENTS (Draw information from the clinical risk assessment)	
Confused due to clinical condition	
Mental illness	
Recovering from anaesthesia	
Learning difficulties	
History of self-harm	
Illegal/recreational drug or alcohol dependent	
Clinical condition causing predisposition to violence	
Receiving bad news	
Side effects of medication	
Misunderstanding due to ethnic origin	
Not wanting to receive treatment	
Not wanting to be in hospital	

VISITORS	✓
In traumatic situation	
In unfamiliar surroundings	
Not being allowed to visit a patient	
Receiving bad news	
Misunderstanding due to ethnic origin	
Dealing with patient's family in their home	

Now identify which of the activities listed below could put members of staff **or other patients** at risk. Add others as necessary.

HIGH RISK ACTIVITIES (Please tick)	✓
Working alone-either inside or outside buildings	
Carrying drugs/money or other attractive items	
Treating patients with a predominantly female workforce.	
Long waiting time potential	
Delivering bad news	
Carrying out potentially painful procedures	
Treating patients without information about their previous behaviour	
Caring for outlying patients	
Notifying a patient that their operation has been cancelled	
Working off site	
Working with patients whose clinical condition predisposes towards violence	
Working with illegal/recreational drug or alcohol dependent patients	
Working with patients with a history of self-harm	
Administering medication	
Refusing a patient an appointment	
Response time from medical staff is inadequate	
Treating patients with underlying psychiatric conditions	
Unfamiliar with Ward/Dept/patients	

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D: CURRENT RISK REDUCTION MEASURES

Now consider the existing measures in place to reduce the risk of security and violence by answering the following questions.

GENERAL	Yes/No
Can your area/ward be completely locked down	
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?	
Do your staff receive regular Conflict Resolution Training?	

LONE WORKING ON OR OFF SITE	Yes/No
Do you have written procedures to protect staff, who work alone, off site or in vulnerable areas?	
If yes, are all staff aware of them; and are they followed at all times?	
Are lone workers issued with personal attack alarms or other means of summoning help?	
Are mobile phones or other means of summoning assistance issued to staff, who work off site?	
Are records kept of offsite staff and their work plans and locations?	

NOTE: IF YOU HAVE ANSWERED "NO" TO ANY OF THE ABOVE QUESTIONS, YOU NEED TO TAKE ACTION AND NOTE THIS IN YOUR ACTION PLAN.

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E: STAFF PROFILE

List the groups of staff who are at risk of violence in your area (e.g. junior doctors, nurses, receptionists etc) and indicate whether they have received any training on dealing with violence and aggression (CRT).
Are these staff regarded as public frontline staff?

STAFF GROUPS	TRAINED? YES/NO

Please detail the training each group has received for dealing with violence.

<u>NOTE</u>: IF YOU HAVE ANSWERED <u>"NO"</u> AGAINST ANY STAFF GROUP LISTED ABOVE, YOU NEED TO TAKE ACTION AND NOTE THIS IN YOUR ACTION PLAN.

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F: RISK REDUCTION OPPORTUNITIES

Are there any tasks that can be eliminated? YES/NO
If "yes", please list below and add to the action plan

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

Is there a way to reduce risk by the changing any of the following:

	Yes/No
The job	
The circumstances	
The way the job is done	
The workplace (refer to the environmental 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	

NOTE: IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, YOU NEED TO TAKE ACTION AND NOTE THIS IN YOUR ACTION PLAN

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G: MANAGEMENT ACTION PLAN

Please discuss this action plan with your line manager

NO	ACTION	LEAD PERSON	ACTION DATE	COMPLETION /COMMENTS

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H: RE-ASSESSMENT DETAILS

	Non-Completed Action	Reason for Non-completion	Further Action	Person Responsible	Date to be completed by
1					
2					
3					
4					
5					
6					
7					

Does the Non-completion of any of the control measures, require the action to be added to the Trust's Risk Register? □ Yes □ No
Has there been any MAJOR changes affecting HAZARDS and RISKS? □ Yes □ No
If **YES** - Complete new assessment and action plan for this changed work process

This Risk Assessment will need - i) no further action - MONITOR system for safety annually □
ii) a further REVIEW following action taken □ Date of further review ____________

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Appendix D: Unacceptable Standards of Behaviour

The following are examples of behaviour that are not considered acceptable on Trust premises:

- Excessive noise e.g. loud or intrusive conversation or shouting.
- Threatening or abusive language involving excessive swearing or offensive remarks.
- Derogatory, racial, homophobic or sexual remarks.
- Malicious allegations relating to members of staff, other patients or visitors.
- Offensive sexual gestures or behaviours.
- Abusing alcohol or drugs in Hospitals (however, all medically identified substance abuse problems will be treated appropriately).
- Drug dealing.
- Wilful damage to Trust property.
- Theft.
- Threats or threatening behaviour.
- Violence.

SANCTIONS

Visitors (anyone who is not a patient or staff member):

- visitors who display any of the above behaviour will be asked to desist and offered the opportunity to explain their actions;
- continued failure to comply with the required standard of behaviour will result in Security Staff and the On Call Manager being bleeped and the removal of the offending individual from Trust property. The excluded individual may request an immediate review of the exclusion by the On Call Manager and should be informed of this
- any visitor behaving in an unlawful manner will be reported to the Police and the Trust will seek the application of the maximum penalties available in law.
- the relevant directorate manager / clinical director or matron may decide to continue to exclude any individual removed from the premises or restrict their visiting only to specific times and, if necessary, under escort from Security Staff.

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Appendix E: Record of Verbally Abusive, Suspicious or Nuisance Phone Calls

DIVISION……………………… SITE……………………… WARD / UNIT…………………

RECEIVED BY………………………….. ON TELEPHONE No ………………………………….

DATE……………………… TIME ………………… DURATION OF CALL ……………..........

CALLER ? MALE / FEMALE YOUNG / OLD ANGRY / EXCITED / NERVOUS

WHAT ACCENT ? ……………………………………………………………………………………

DETAILS OF CALL (Use actual words if possible) …………………………………………………

…….. (Continue overleaf if necessary)

WAS THERE ANYTHING MENTIONED IN THE CALL TO CONNECT IT TO YOU, YOUR STAFF OR DEPT ? ……………………………………………………………………………………..

……..

WHAT BACKGROUND NOISES DID YOU HEAR ? ……………………………………………….

WAS THE CALL RECORDED ? ……………………………………………………………………

HOW WERE YOU AFFECTED BY THE CALL ? …………………………………………………..

IF THE CALL WAS A REQUEST FOR PATIENT DETAILS:

WHAT IS THE PATIENTS NAME AND NUMBER ? ………………………………….................

WHAT INFORMATION WAS REQUESTED ? ……………………………………………………....

WHAT NAME AND ORGANISATION DID THE CALLER GIVE ? ....

……..

WHAT TELEPHONE / BLEEP No DID THEY GIVE ? ……………………………………………...

DID YOU OFFER TO CALL BACK AND WHAT WAS THEIR REACTION ? ……………………

……..

ANY OTHER COMMENTS : ………………………………………………………………………..

IF THE CALL IS A BOMB THREAT, REFER TO BOMB THREAT AND SUSPECT PACKAGES PROCEDURE.

PLEASE FORWARD TO TRUST SECURITY

Appendix F: Conflict Resolution Training

FOI ref 122-2425

It is a Trust requirement that all frontline staff in the NHS receive Conflict Resolution Training. There is a compliance target of 95%; this is monitored at the Executive Health & Safety Group.

The course has been designed for all frontline NHS staff and professionals whose work brings them into regular face to face contact with members of the public. Their work may result in exposure to situations that may become volatile and confrontational, resulting in violence and abuse.

Examples of staff considered to be frontline (list not exhaustive)

- Nurses on wards/community teams
- Medical staff on wards/community teams
- Psychologists/occupational therapists and other relevant professionals on wards/community teams
- Clinical staff in A&E mental health liaison services
- Support staff on wards – administrators/domestic staff
- Staff (clinical and non-clinical) in out–patient departments, based on risk assessment and training needs analysis
- Non-clinical staff in community teams, based on training needs analysis and risk assessment

Conflict Resolution Training consists of a standard national syllabus for NHS staff in non-physical intervention techniques and managing and de-escalating potentially violent incidents within the work environment.

At the end of the course delegates will be able to:

- Describe common causes of conflict
- Describe the two forms of 'communication'
- Give examples of how communication can break down
- Explain 3 examples of communication models that can assist in conflict resolution
- Describe patterns of behaviour that may be encountered during different interactions
- Give examples of the different warning and danger signs
- Give examples of impact factors
- Describe the use of distance when dealing with conflict
- Explain the use of 'reasonable force' as it applies to conflict resolution
- Describe different methods for dealing with possible conflict situations

Initial Conflict Resolution Training consists of a half day face to face training session. Conflict Resolution Training Refresher sessions should be completed three years after the original Conflict Resolution Training has been completed; this is available via an elearning package. Further, ongoing Conflict Resolution Training Refresher sessions should be completed once every three years in order to update, review and consolidate previous learning, skills and experiences related to conflict resolution.

For further advice and guidance please contact the Violence Prevention and Reduction Lead / Trust Security Manager.

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Appendix G: Requesting Security Presence to Assist in the Management of High Risk Violent and Aggressive In-Patients

Introduction

This Standard Operating Procedure should be read in conjunction with the Trust Policies:-
- Violence Prevention & Reduction Policy (EF15)
- Security (EF02)
- Trust Policy on Chaperoning (C44)
- Trust Policy for the use and reduction of restrictive interventions including the use of clinical holding (C33)
- Therapeutic Observation (Specialling) of Patients Who are Considered at Risk of Harm to Themselves or Others (C08)

Definition of High Risk

Patient presents an extreme risk of physical violence or threat to the life of themselves or others.

Requesting Security presence

The assistance of Security must be considered on an individual case basis by a multidisciplinary clinical team and should be seen as a last resort once all other factors have been considered.

A 'Violent Patient Risk Assessment' must be undertaken by the Ward Sister / Charge Nurse or Nurse in Charge to establish the level of risk and the requirement for Security presence (see page 36) **(NB patient must be risk level 3/4 to request Security).**

The Ward Sister / Charge Nurse or Nurse in Charge will seek authorisation for Security presence from those listed on Page 37. Out of hours, they will seek authorisation from the Nurse Practitioner (out of hours) who will inform either the Site Matron or the Silver on Call.

Once authorised, the Ward Sister / Charge Nurse or Nurse in Charge will contact Security or the Trust Violence Prevention & Reduction Lead / Trust Security Manager (RSUH) to arrange a face to face on the Ward and jointly finalise the completion of the Security Presence Request Form (**see page 37-38).**

Once completed and authorised, the original copy of the completed Security Presence Request Form must be retained on the patient's case notes and a photocopy provided to Security.

The requirement for on-going security presence should be reviewed by the Ward Sister / Charge Nurse **at least** every 4 hours and at the nursing staff shift changeover times. The section for handover information should be completed on Security Presence Request Form.

The presence of Security staff does not negate the roles and responsibilities of clinical staff. Security staff **must not** under any circumstances provide supervision in isolation from clinical staff i.e. they should be able to be observed by clinical staff, not behind curtains or closed doors. They should not be involved in the delivery of intimate care, or undertake any care usually in the roles and responsibilities of nursing staff. Their role is to be present to provide support to clinical staff (refer to Trust Policy for Chaperoning C44). The nurse in charge remains accountable for any care provided to the patient, including that provided by the Security Officer.

Violent and aggressive behaviour may be as a result of the patient's illness, reaction to medications and alcohol or drug withdrawal.

If the cause of violence is of a non-clinical origin and the patient is fully aware of his/her actions and if the patient does not refrain from violent behaviour, the Police must be contacted immediately.

Even when a Security Officer is present, the patient must have an identified nurse who is responsible and undertakes the supervision of the patient, providing all required clinical care. Based on a risk assessment, a

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short comfort break can be taken by the Security Officer in liaison with the Ward Sister / Charge Nurse, who must ensure that additional cover is provided. For breaks of longer duration the Security Manager or Security CCTV Control (out of hours) must be contacted by the Nurse in Charge to arrange replacement cover.

Authorised Signatories

	Job Title
Normal Working Hours 0800hrs – 1700hrs Monday – Friday	Associate Chief Nurse
	Deputy Associate Chief Nurse
Outside of Normal Working Hours	Nurse Practitioner (out of hours)

Incident Reporting

A Datix incident report must be completed by the clinical staff for all requests for Security to assist in the management of all high risk patients which must be updated with the outcome and include details of any delays in response for security assistance.

Use of Radio Handsets

Radio handsets pose a high risk to medical equipment due to their relatively high-transmitted power. They must not normally be used in clinical areas, especially areas such as intensive care or theatres, where there is likely to be a high concentration of equipment with a critical function.

Security Officers should use the normal telephone network to communicate with colleagues. However, in an emergency, any overt risk due to fire, physical violence or serious criminal activity must take priority over the risk of interference with medical equipment.

Where a Security Officer needs to make an urgent call for assistance, he/she should move as far as practicable from any active medical equipment before initiating a call and ensure that clinical staff in the vicinity are aware of the use of the radio. Staff in clinical areas must ensure that Security Officers are aware of these rules for the use of radios.

Security Officers - General Guidance and Information

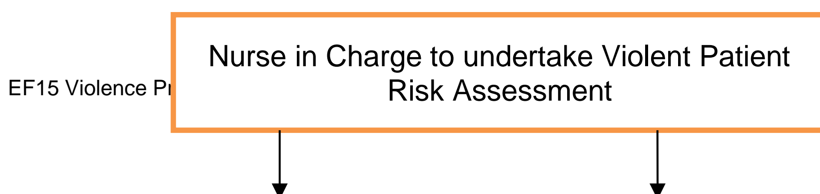
Detailed guidance for Security Officers undertaking this role is available in Appendix H. This guidance will be provided by the Security Manager at the beginning of their period of supervision.

The Security Manager will ensure this document is reviewed with the Security Officer at the beginning of any period of observation.

At the beginning of each nurse shift a verbal handover will be given to the Security Officer by the Ward Sister / Charge Nurse. The handover will provide detail on the patient's current status and will identify if the patient is at risk of physical/non-physical violence to others, along with details relating to confirmation of supervision levels and where the Security Officer is to be located.

At the outset of their period of supervision the Security Officer must be orientated to the clinical environment and informed of fire and emergency procedures and any relevant infection control precaution issues.

Process Flowchart



FOI ref 122-2425

Violent Patient Risk assessment to ascertain level of observation

Level of concern	Level of observation	Who should decide	Who should carry out observation	Level of risk	Review period
To maintain general safety for all in patients unless a higher level indicated	Awareness of whereabouts and wellbeing at all times Minimum standard for all inpatients	Dr and qualified Nurse or MDT; qualified Nurse if no Dr available	Allocated member of nursing staff	1	weekly
When there is a risk of self-harm, unpredictability or risks are unclear and frequent contact needs to be maintained. As a step down from a higher level of observation	Intermittent checks on mental state and risk Maximum time interval should be specified and checks varied within this. Should be used on admission and post transfer until assessment has been carried out	Dr and qualified Nurse or MDT; qualified Nurse in an emergency	Experienced member of nursing staff	2	24hrs
Where there is a serious short-term or other significant risk e.g. violence & aggression	Continuous observation within eyesight – this means in the same room or space (i.e. within easy reach)	Dr and qualified Nurse or MDT; qualified Nurse in an emergency	Experienced member of nursing staff, preferably qualified or in exceptional circumstances security officer	3	4hrs
Where there is a serious and imminent risk of suicide or self-harm with impulsivity or a significant risk to others e.g. violence & aggression	Continuous observation within arm's length When more than one person is allocated there must be a lead person doing the observations	Dr and qualified Nurse or MDT; qualified Nurse in an emergency	Experienced member of nursing staff preferably qualified or in exceptional circumstances security officer	4	4hrs

FOI ref 122

Security Presence Request Form

To be completed by Nurse in Charge

Division	**Ward / Department & telephone ext.**		
Name of Ward Sister / Charge Nurse	**Name of qualified staff who the Security Officer will take instruction from on location**		
Patient's Name	**Patient's Gender**		
Date requested & time requested	**What level of risk does patient pose – see Appendix G. NB patient must be risk level 3/4 to request security.**		
Brief reasons for security presence	**Datix Incident Number**		
Name of Matron informed **NB - must agree to this request**	**Name of Consultant / Sp Registrar informed** **NB - must agree to this request**		
Have Mental Health Liaison / CPN been involved with patient	**Do you feel you may be depriving your patient of their liberty**		
Yes / No Comments	Yes – complete DoLS authorisation forms 1 & 4 No – rationale		
Authorised by			
Job Title	**Person in Role**	**Date**	**Time**

Rational for not authorising security presence	
If security presence authorised Where is the Security Officer to be located – e.g. at the bedside or outside the side room or ward door?	**Has it been explained to the patient / relatives the reason why a Security Officer is in attendance?**
Estimated time of arrival of Security Officer	

4 hourly Review Undertaken				
Name of Nurse in Charge	**Authorised by**	**Continue or Stand Down Security Presence**	**Date**	**Time**
1				
2				
3				
4				

Handover – to be completed by Nurse in Charge			
From	**To**		
Nurse in Charge	**Nurse in Charge**	**Date**	**Time**
Nurse caring for patient	**Nurse caring for patient**		
Security Officer	**Security Officer**		
Information:-			

- **Note 1**: Every other option and means of preventing / controlling and defusing a situation should be attempted before there is any interaction with a violent person. Physical intervention should concentrate on de-escalation and breakaway techniques. Staff must only attempt restraint if they have been trained in specific intervention techniques, which minimise the risk of injury to themselves and the aggressor.
- **Note 2**: It is legally acceptable to use "reasonable" force (proportionate & minimum necessary) to defend yourself when under physical attack.
- **Note 3**: Security Officers can escort people from the premises but cannot physically expel them. If the situation requires this the Police must be called.

NB Original form to be retained in the patient's case notes and a photocopy provided to Security

Appendix H: Guidance for Security Officers Providing Assistance in the Management of High Risk Violent And Aggressive In-Patients

Your Role

To ensure patient safety and maintain the appropriate level of supervision and observation, where patients may require constant supervision.

These circumstances are when a patient presents an extreme risk of physical violence or aggression or threat to life.

You **must not** under any circumstances provide supervision in isolation from clinical staff. Your role is to be present to provide support to clinical staff.

Supervision

Your physical location is to be agreed with the Nurse in Charge. This may be within eyesight or at arm's length.

Your role is to observe a patient for the duration as agreed.

A short comfort break can be taken in liaison with the Nurse in Charge who must ensure that additional cover is provided. For breaks of longer duration the Security Manager or the Trust LSMS or Sodexo CCTV Control (out of hours) must be contacted to arrange replacement cover.

You will receive a verbal handover from the nurse caring for the patient, which will include details relevant to the patient's risk of harm or potential harm to others

If you are unsure or feel unable to take on this role, express your concerns at the start of the shift to the Ward Manager/Nurse in Charge and the Security Manager or Trust LSMS.

Your role does not include provision of personal care for the patient.

If a patient becomes uncooperative they may be encouraged in a supportive manner i.e. return of a confused patient back to their bed area, this is particularly important for patients with a diagnosis of dementia.

Every other option and means of preventing / controlling and defusing a situation should be attempted before there is any interaction with a violent person. Physical intervention should concentrate on de-escalation and breakaway techniques.

Only if staff have been trained in specific techniques, which minimise the risk of injury to themselves and the aggressor, should they attempt physical restraint. **MECHANICAL RESTRAINTS MUST NOT BE USED**.

It is legally acceptable to use "reasonable" force (proportionate & minimum necessary) to defend yourself when under physical attack. Security Officers can escort people from the premises but cannot physically expel them. If the situation requires this the Police must be called.

The patient must be supervised at all times even if you think they are resting or asleep.

You must only accompany the patient to other clinical areas i.e. to x-ray, outpatients or if they wish leave the Ward for other reasons e.g. to go outside to smoke as requested by the Nurse in Charge and in the presence of designated clinical staff. You must not be left alone with the patient at any time.

NB You must never leave the ward with the patient without first gaining permission from the Nurse in Charge, and only then to chaperone designated clinical staff. The Ward Sister / Charge Nurse must always be informed when you, the patient and the designated clinical staff are leaving the ward and when you will return.

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If the patient's condition or behaviour is such that you feel concerned about their safety, or the safety of others in the area you should inform the Nurse in Charge if immediately available.

If you feel the matter is urgent, you should contact the Police on (9)999 for immediate assistance.

If there is a significant change (deterioration) in the patient's condition or behaviour at any time, inform the Nurse in Charge as soon as possible.

Use of Radio Handsets

Radio handsets pose a high risk to medical equipment due to their relatively high-transmitted power. They must not normally be used in clinical areas, especially areas such as intensive care or theatres, where there is likely to be a high concentration of equipment with a critical function.

You should maintain contact with the control room at regular intervals throughout the shift. Use the normal telephone network to communicate with colleagues.

However, in an emergency, any overt risk due to fire, physical violence or serious criminal activity must take priority over the risk of interference with medical equipment and you may use your radio handsets. You should move as far as practicable from any active medical equipment before initiating a call and ensure that clinical staff in the vicinity are aware of the use of the radio.

Handover

At the end of each shift, you should await another Security Officer to take over the supervision of the patient. Do not leave the patient unattended. The Nurse in Charge will handover to the Security Officer taking over.

Professional issues

The use of personal mobile phones other electronic equipment and reading newspapers/books is not permitted, as this will distract you from providing effective continuous supervision.

Security Officers are not to leave their position for meal breaks/comfort breaks until a replacement Security Officer is in attendance. Breaks will be designated by the Security Manager or Security CCTV Control (out of hours) at the start of the shift.

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This guidance does not apply to:
- Searching of premises
- Searching of work areas
- Searching of UHNM employees
- Searching of vehicles

Powers of Search
Searches of both people and property, if properly carried out, can help in the detection, deterrence, prevention and investigation of security related incidents.

The authority to conduct a search of a person, their property or their vehicle is controlled by law. **Staff are considered private citizens and as such have NO legal authority to conduct compulsory searches.**

To lay hands on another person with the intent to search without their consent may constitute a criminal offence of assault, battery or false imprisonment.

Compulsory searching not authorized by law or voluntary searches where permission has been obtained by coercion may result in legal action for damages or compensation for assault, infringement of the right to respect for private life under the Human Rights Act and, if the search is of an employee, action in an employment tribunal.

In exceptional circumstances it may be acceptable to search a person without their consent, for example individuals who are incapable of giving consent due to unconsciousness, serious illness, injury etc and where it is required to confirm identity or to locate emergency medical information (eg information on blood type, diabetes card etc).

It may be appropriate to search an individual for 'items of concern' that the person in charge of the ward or who is in charge of the shift in consultation with other staff available, judge may represent a significant risk. This risk would be to an individual patient, other patients, to the staff, to the unit environment or may be illegal.

Voluntary Searches

Clear and informed consent must be obtained before any voluntary search takes place.
Consent which is obtained by way of threat, intimidation or inducement is likely to render the search illegal. Any person who is to be searched must be informed that they do not have to consent.

If there is a reasonable suspicion that a search may provide evidence of serious unlawful activity or if there is any threat of violence, this should immediately be brought to the attention of the Police, who will decide if a search of the person is appropriate and lawful and act accordingly.

Refusal to submit to a search is not in itself justification for detaining a person pending the arrival of the police.

General Searching Policy
The following principles must be adhered to at all times:

- There must be no search without consent. The person conducting the search must ensure the person to be searched is informed it is voluntary.
- Consent must not be obtained by threats or threatening conduct
- Searches should not, unless absolutely necessary, be conducted in public areas
- The person conducting the search must identify themselves and any others present, and must explain the grounds for the search, the object of the search and that no force can be used to conduct a search
- The refusal to submit to a search is not in itself a justifiable reason for arrest
- Except in exceptional circumstances, only same-sex searches should take place
- Consideration must be given to any medical conditions, cultural or religious issues and the health and safety of all persons involved.
  Special consideration must be given to provisions for the following individuals:
    - People who do not understand English
    - People with impaired hearing
    - Juveniles and children
    - People with mental illness or learning difficulties

An interpreter should be sought for individuals in either of the first 2 categories above

If any person under 18 is to be searched, and the parent/guardian is not present but has consented to the search, it should be conducted in the presence of an 'appropriate adult'. If consent cannot be obtained from

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both the parent/guardian and the person under 18, the search must not take place and consideration should be given to calling the police for assistance.

If the person has a mental illness or learning difficulty, a suitably qualified healthcare worker should be sought to act as an appropriate adult.

An appropriate adult is defined in the PACE Codes of Practice as follows:

In the case of:

A juvenile:

i. The parent, guardian or, if the juvenile is in local authority or voluntary organization care, or is otherwise being looked after under the Children Act 1989, a person representing that authority or organization
ii. A social worker of a local authority social services department
iii. Failing these, some other responsible adult aged 18 or over who is not a police officer or employed by the police

Person who is mentally disordered or mentally vulnerable:

iv. A relative, guardian or other person responsible for their care or custody
v. Someone experienced in dealing with mentally disordered or mentally vulnerable people but who is not a police officer or employed by the police
vi. Failing these, some other responsible adult aged 18 or over who is not police officer or employed by the police

In an NHS setting, the ‘other responsible adult aged 18 or over who is not a police officer…’ should be understood to mean an adult member of staff who is not a member of the health body security staff or connected to the incident under investigation.

If security staff undertake searches there are clear written instructions as to their role and responsibilities.

If there is a requirement to search a person, every effort should be made to have another person present to witness the process. This is particularly important if it is not possible to conduct a same-sex search, when efforts should be made to have a member of staff of the same sex as the person being searched present.

The presence of a witness will help in refuting any claims that items have been ‘planted’ on the person being searched or allegations that coercion or force was used.

When a search is to be conducted, the individual should be informed of their right to have an employee of their choice present whilst this takes place.

Unless absolutely unavoidable, the search should not be visible to onlookers.

All searches should be conducted in a manner that is proportional to the type and size of the item(s) that reasonable suspicion indicates may be concealed. It is important to bear in mind what is being searched for.

Other than in exceptional circumstances, searches should be undertaken by someone of the same sex as the person being searched. The genitalia of males and females and the breasts of women MUST NOT BE TOUCHED, regardless of whether the person searching is of the same sex as the person being searched. Care should be taken not to make contact with these areas, to avoid allegations of indecent assault. In some cases, the person being searched may request that this is only carried out by and/or in the presence of persons of the same sex. Such requests should be complied with unless exceptional circumstances dictate otherwise.

The health and safety of the person conducting the search and the person being searched should always be paramount, and care should be taken if hazardous objects, such as hypodermic needles or other sharp instruments, may be secreted on the person or in their belongings. The person to be searched should be asked if they have any articles on them which may injure the person conducting the search.

Gloves should be worn where possible to avoid contact with bodily fluids or concealed drugs. Never put hands in pockets which cannot be easily viewed – pull the lining up and out instead.

Before any search is begun, the person should be asked if they have the object of the search on their person or in their possession.

The person being searched should not be asked to remove any clothing other than an outdoor coat, hat or gloves. The removal and searching of certain head coverings may be particularly sensitive. If this is the case, such searches

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must be carried out in private and particular consideration given to ensuring that there is fully informed consent and that the search is carried out by a person of the same sex.

Of the object(s) of the search is discovered, the person conducting the search must give the person concerned every opportunity to provide a reasonable explanation. If there is reason to believe that the property is stolen the police should be called immediately.

A receipt must be provided for any item retained

If nothing suspicious is found on the person being searched, the person should be thanked for their cooperation and efforts should be made, where practical and appropriate to remedy any inconvenience caused.

A careful record should be made of the search including:
- The person's name, address, DOB where known, or a description of the person if they refuse to provide identity details.
- Time, date and location of the search
- Reason for the search
- Object of the search ie what the search is looking for
- The outcome of the search ie what if anything is found
- Whether any items are retained.

Such a record should be made in the patient's notes, on Datix or in the Security Officers Pocket notebook

Refusal to be searched and whether to involve the Police
Refusal to submit to a search is not in itself justification for detaining a person and calling the police. However, there may be other grounds to arrest the person; the police should be called immediately if that is the case

Person Search Procedure

This is intended as a general guide only. Any search should be proportionate and take into account the size of the object(s) being searched for.

It is recommended that the individuals conducting the search use the backs rather than the palms of their hands.

1. Stand facing the subject
2. Ask them if he has anything on their person that they are not authorized to have
3. Ask them if they have any dangerous items on their person
4. Ask them to empty their pockets and to remove any jewellery, including wristwatch
5. Search the contents of the pockets, jewellery and any other items
6. Ask them to open any bags or containers, and examine the contents and underneath containers and bottles/cans
7. Once these items have been searched, place them to one side
8. Ask them to remove any headgear and pass it to you for searching
9. Ask them to raise their arms level with his shoulders and stand with their feet apart. Their fingers must be apart with palms facing downwards.
10. Ask them to turn their head away from you during search ie they look left while you search the right side, and vice versa
11. Lift their collar, feel behind and around it and across the top of their shoulders
12. Search each arm by running your hand along the upper and lower sides
13. Check between their fingers and look at the palms and backs of their hands
14. Check the front of their body from neck to waist, the sides from armpits to waist, and the front of the waistband. DO NOT TOUCH THE BREASTS.
15. Check their back from collar to waist, back of the waistband and seat of trousers
16. Check inside of belts
17. Check the back and sides of each leg. DO NOT TOUCH THE GENITALS
18. Check the front of their abdomen and front and side of each leg
19. Look at the area surrounding them for anything they may have dropped before or during the search.
20. Ask them to step to one side to ensure they are not standing on anything they have dropped before or during the search.
21. If necessary the subject may be asked to remove their shoes for examination.

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