# VIOLENT PATIENT MARKER PROTOCOL

**POLICY REFERENCE NUMBER:** Appended to TASID Policy (Appendix 8a) (RM05)

**VERSION NUMBER:** 3

**KEY CHANGES FROM PREVIOUS VERSION**
Updated regarding dissolution of NHS Protect and merger with NEP; 3 year review

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## PROTOCOL SUMMARY

This protocol sets out the process for placing a violent patient marker against an individual.

The Trust monitors the implementation of and compliance with this policy in the following ways:

The SMD retains oversight of the violent patient marker agenda.

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The Director responsible for monitoring and reviewing this Protocol is the Executive Nurse
VIOLENT PATIENT MARKER PROTOCOL

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

VIOLENT PATIENT MARKER PROTOCOL

1.0 INTRODUCTION

1.1 This protocol adopts the principles of NHS National Guidance and outlines the process in place when it is identified that a violent patient marker may be required.

1.2 The role of the Local Security Management Specialist (LSMS) and Security Management Director (SMD), or delegated representative in relation to recommending or placing a violent marker on a patient record is to assist clinical staff in managing future risks of violence.

1.3 The aim of the risk of violence marker is to alert staff to individuals who pose/could pose a risk of violence, and enable staff to reduce the risk of violence.

1.4 The marker should achieve this by:

- Serving as an early warning for staff of a particular individual or situation that may present a risk to them, their colleagues or other patients
- Providing security warnings and handling advice to avoid or minimise any risk
- Where appropriate, enabling staff to seek further advice on what action should be taken
- Assisting in reducing the number of violent incidents reported

1.5 This protocol supports the Trust with meeting its obligations under the Department of Health guidelines, the Management of Health and Safety at Work Regulations 1999, Health & Safety Executive.

1.6 The Trust is committed to providing a safe working environment and safe systems of work to protect all staff, but also recognises the serious nature of placing a violent patient marker on an individual’s record. This protocol aims to balance the risks and needs of both staff and patients.

1.7 The Trust will take all reasonable steps to ensure the safety of staff whilst working on Trust premises or off site whilst on official Trust business, and also of any premises deemed to be Trust property.

2.0 SCOPE

2.1 The protocol applies to all staff employed within the Trust either permanent or on a temporary basis.

2.2 This protocol outlines the process for all staff to follow when considering placing of a risk of violence marker on a patient record.
2.3 A risk of violence marker may be applied regardless of whether the act was intentional or not. The use of a marker will help reduce potential risks to all staff by enabling them to use the information as part of their risk assessment process.

2.4 A risk of violence marker does not just apply to circumstance where the perpetrator is a patient, but may equally apply to their carer, relative, friend or other associate that presents a risk of violence.

2.5 A risk of violence marker may also be applied to a patient/or their carer, relative, friend or other associate who is responsible for a dangerous animal.

2.6 It is important to note that any risk of violence marker placed is not a mechanism for attributing blame. It is a process for alerting staff to the possibility of violence regardless of the cause.

2.7 The risk of violence marker and associated information (warnings, handling advice etc.) must be available to all internal staff that may have face to face contact with the individual.

2.8 Information sharing with external NHS staff, including contractors delivering NHS care, is permissible where the risk justifies it.

3.0 RESPONSIBILITIES

3.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this procedure.

3.2 Security Management Director (SMD)

The SMD has Executive responsibility for this policy and associated procedure as part of his portfolio covering security management and protection of staff. The SMD, or delegated representative, is responsible for final approval of all violent patient markers.

3.3 Non-Executive Security Champion

The designated NED is the Trust Security Champion and is responsible for promoting security management work from the non-executive function at Board level: to challenge, scrutinise and ensure accountability in respect of all security management work, including this protocol.

3.4 Executive Directors/Clinical Directors/Service Directors

Other Directors are responsible for ensuring that there are suitable and sufficient control measures in place to protect their staff from violence, this includes the implementation of this protocol in their directorate.
3.5 **Deputy Director of Risk and Compliance**

The Deputy Director of Risk and Compliance has responsibility for ensuring that the LSMS locally delivers NHS national guidance, this includes the implementation and monitoring of a robust risk of violence marker process.

3.6 **Local Security Management Specialist (LSMS)**

The LSMS is responsible for implementation of NHS security management agenda across the Trust in order to achieve compliance with the NHS Security Management Standards.

The LSMS is responsible for supporting operational staff with the violent patient marker agenda and for recommending and advising the SMD, or delegated representative in the decision making process.

The LSMS is responsible for placing a violent patient marker on a record where there is serious or imminent risk to staff – alongside police involvement – where there is not time to present a case to the SMD, or delegated representative.

3.7 **Departmental Managers/Team Leaders and other Persons in Charge**

Managers and Leads are responsible for ensuring that all staff are aware of the risk of violence marker protocol.

Managers and Leads will ensure that where an individual presents a significant risk of violence to Trust staff or premises, a marker will be sought using this process to protect staff.

3.8 **Workforce, Development & Training**

Workforce, Development & Training are responsible for ensuring that where appropriate during PMVA training, staff are made aware of this protocol.

3.9 **The Clinical (Referring) Team**

The clinical team are responsible for making applications for a violent patient marker and managing all markers placed using this protocol.

3.10 **All staff**

All Trust staff have a responsibility for being aware of this protocol and using the request for a violent marker process appropriately as well as checking electronic systems and patient records as part of their clinical risk processes when planning to see/provide intervention with patients.
4.0 DEFINITIONS

4.1 The Health & Safety Executive defines workplace violence as:

‘Any incident in which a person is abused, threatened or assaulted in circumstances related to their work’.

4.2 Physical assault is defined as:

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

Type of categorised physical assault: Physical assault (no physical injury suffered)* or Physical assault (physical injury sustained)

*Spitting is included in the definition of a physical assault, in circumstances where the spittle hits the individual.

4.3 Non-physical assault is defined as: ‘The use of inappropriate words or behaviour causing distress and/or constituting harassment’.

- Type of categorised non-physical assault: Offensive or obscene language, verbal abuse and swearing*
- Brandishing weapons or objects which could be used as weapons; attempted assaults; offensive gestures, threats; intimidation; harassment or stalking; damage to buildings, equipment or vehicles which causes fear for personal safety.
- Offensive language or behaviour related to a person’s race, gender, nationality, religion, disability, age or sexual orientation; inappropriate sexual language or behaviour.

*The use of swear words may warrant a marker depending on the circumstances in which they are used. For some individuals, swear words may be used in everyday speech, however a marker should be considered where swear words are used aggressively.

N.B. Some of the above examples of non-physical assault can be carried out by phone, letter or electronic means (e.g. e-mail, fax and text).

5.0 DPA 2018 / GDPR 2016 & INFORMATION SHARING

5.1 The LSMS and Clinical Team must be aware of the provisions in the Information Commissioners Office (ICO) guidance on the DPA 2018 / GDPR 2016 and the use of violent marker warnings and ensure that they comply with the guidance.

5.2 The Trust is the data controller and will retain ultimate responsibility in relation to processing, notification and disclosure of risk information and the security and confidentiality of such information.
5.3 The ICO guidance on violent patient markers makes it clear that employers (The Trust) have a duty of care to its staff under Health & Safety legislation. The processing of violent patient markers complies with these legal obligations provided it is fair and justified.

5.4 The Clinical Team will decide who the marker is shared with, but will consider all partnership agencies that may come into contact with the identified risk.

5.5 The LSMS will decide if a DPA request to the police is required requesting criminal history or address risk information (PNC check).

### 6.0 PROCESS FOR A MARKER

6.1 If there is an immediate risk of violence staff should follow related policies (TASID, Zero Tolerance). This includes calling the police on 999 where there is an immediate threat to life or property.

6.2 Reporting

Trust staff must complete a Datix incident form following any violent incident. The Datix Handler will review the incident and immediately inform the LSMS if advice is required.

6.3 The Clinical Team will review the risks of violence and make a decision as to whether or not a violent marker may be required to protect other staff following:

- An incident of violence perpetrated by a patient
- Information shared by another agency regarding a significant risk of violence perpetrated by a patient
- Alert received either locally or nationally regarding a significant risk of violence perpetrated by a patient
- Clinical review where there is a history of violence and a current escalating risk of violence perpetrated by a patient
- Risk of violence related to the address being visited
- Risk of injury from animals at the address

Note that there may be other issues creating a risk of violence to Trust staff that may need a violent patient marker or other control measures to be considered.

6.4 If a violent patient marker is required, the clinical team will electronically complete the Violent Patient Marker Alert form (Appendix 8B) and send it to the Risk Management Team for the LSMS to process.

### Investigation

6.5 The LSMS will review all violent incidents reported on Datix and determine whether or not further investigation is required. The investigation will provide information to support whether or not a violent patent marker is required.
6.6 The LSMS will receive all Violent Patient Marker request Forms and supporting evidence (this may include relevant information from PALS, Complaints, Legal, Safeguarding and other Trust teams and information from other partners e.g. the police to ensure as much information as possible is available to support the request) to present to the SMD, or delegated representative to assess the presenting risks and whether or not a marker can be placed.

6.7 Whilst it is desirable to have as much information as possible to inform a decision, it may be necessary for the LSMS and Associate Director of Risk and Compliance to make an immediate decision to place a marker, based on serious or imminent risks to staff.

**Decision Making**

6.8 The following risk factors should be considered when determining whether or not a record should be marked:

- Nature of incident (physical or non-physical)
- Degree of violence used or threatened by the individual
- Injuries sustained by the victim
- The level of risk of violence posed by the individual
- Whether an urgent response is required to alert staff
- Impact on staff and other victims that witnessed the incident
- Impact on service provision
- Likelihood of a reoccurrence
- Time delay since incident
- Next appointment date for individual and location
- Whether individual is a frequent or daily attender to services
- Whether individual is an inpatient
- Whether the incident is part of a pattern of escalating behaviour
- Mental health state and capacity of individual
- Physical health state of individual
- The opinion of the staff victims of violent incidents
- What other action can be taken to prevent incidents from occurring.

6.9 The LSMS decision to recommend a marker should be based on a specific incident or risk history and evidence gathered during the investigation.

6.10 If the police are called to an incident, the LSMS will liaise with the Investigating Officer to ascertain what action is being taken in relation to criminal investigations where an individual has committed a criminal offence and was responsible for his/her actions (had capacity at the time). The LSMS will support any such investigation to facilitate an expedient outcome. This should not delay placing a violent marker if there is a risk and does not replace any legal action.

6.11 The LSMS is responsible for making the final recommendation on the need for a marker, based on consultation with the victim, clinical manager and the investigation findings.
6.12 All recommendations for a violent patient marker will then be referred to the SMD, or delegated representative for consideration and approval.

Marker Agreed

6.13 Once a decision has been made to place a violent patient marker, the LSMS will:

**IN MENTAL HEALTH, LEARNING DISABILITY & SPECIALIST SERVICES:**

- Liaise with the Electronic Record team who will scan the VPM Form into the Electronic Record. *Note that the VPM request Form will be an Electronic Record Form as soon as possible*
- Liaise with the Information Team, who will place an alert on the patient summary on the Trust intranet.

**IN COMMUNITY HEALTH SERVICES**

- Liaise with the patient’s GP who can add the VPM marker to the relevant record system e.g. SystemOne.

6.14 Placing a marker must not preclude existing lines of communication to alerting staff to the potential risk of violence from an individual if there is an imminent risk. Team / line Managers will manage immediate risks / risk assessments / control measures to mitigate risks to their staff.

Marker Declined

6.15 There may be circumstances where following a review of all evidence; the SMD, or delegated representative decision is that it is not appropriate to place a marker on the record. It may be due to the fact that the individual poses no further risk. If a marker is denied, the reasons must be recorded on the VPM Request form to be further considered by the clinical team.

6.16 The clinical team will need to review the risk management plan to ensure that staff are safe when delivering care to the individual.

**7.0 INFORMING THE PERPETRATOR**

7.1 The SMD or delegated representative will make the final decision as to whether or not the individual should be informed that a marker has been placed.

7.2 There may be exceptional circumstances where the clinical team have recommended not to inform an individual that a marker has been placed on the record:

- Informing the individual may provoke a violent response and put staff further at risk.
- Informing the individual may adversely affect their health.
7.3 If agreed by the SMD, or delegated representative, the LSMS or other nominated person will send a formal notification letter (Appendix 8C) to the individual outlining the reasons for the marker. The letter will clearly explain:

- The nature of the violent incident
- That their record will now show a violent marker
- The reason why the marker is being placed
- Who the information will be shared with and for what purpose
- When the marker will be reviewed
- The complaints procedure
- Relevant contact details
- A detailed record of this decision will be made on the violent patient marker request form, which includes evidence of the risk of violence.

7.4 If the incident was perpetrated by an associate of the individual, the letter should be sent to both the individual and the associate – if the associate’s identity and address are known. **Care should be taken not to disclose any confidential medical information when informing associates.**

7.5 Note that associates will not be informed if by doing so would:

- Create a risk for the patient
- Disclose the patient’s mental health information
- Require the patient’s consent

### 8.0 INFORMING THE VICTIM

8.1 If the marker was requested as a result of an incident the LSMS will inform the staff victim of the incident of the decision reached by the Trust and the reasons why. This feedback will support the Trust pro- security culture.

### 9.0 COMPLAINTS

9.1 When the individual is informed of the decision to place a marker on his/her record, a Trust Complaints Procedure leaflet will be included.

9.2 All complaints will be dealt with in line with Trust Policy and Procedure.

### 10.0 REVIEW OF MARKERS

10.1 The Risk Team will hold a VPM Register and monitor all placed markers. When a marker is added to a record the LSMS will document on the VPM Register:

- The date of the incident
- Date marker effective from
- Review date

10.2 The LSMS will have in place a system that alerts them when a marker is due for review and then submit those markers to the clinical team.
10.3 Review dates will be agreed by the clinical team when the marker is added to a record and will not exceed 12 months from the incident date. A review will be undertaken earlier if there are other risks identified.

10.4 The review of a marker by the clinical team must consider the following:

- The severity of the original document and the impact on the staff member
- Any continuing risk that an individual may pose
- Any further incidents involving the individual
- Any indication that the incident is likely to be repeated
- Any action taken by other agencies e.g. police or the courts

10.5 Where a marker is placed against a patient because of a risk associated with an address, this must be reviewed when the Trust is made aware of a change in circumstances that changes the risk.

10.6 If the recommendation is made by the clinical team to retain the marker on the record, the LSMS will present the recommendation and relevant evidence to the SMD, or delegated representative for consideration and approval.

10.7 If approved, the individual will be informed/not informed as in 7.3 and a new review date will be set.

10.8 When a decision is made to remove and archive the marker based on risk assessment and agreement that the individual's behaviour gives no further cause for concern; the LSMS will facilitate the removal of the marker from the record and inform the individual.

10.9 The patient’s electronic record will need to be opened for the relevant patient and the relevant Alerts form found. A report problem can be started and a descriptor given to remove that alert form. The alert form will then be removed from visibility but a copy will be retained in an electronic legal repository for audit purposes.

10.10 The LSMS will write to the relevant GP to remove a marker from the CHS system.

11.0 OVERSIGHT

11.1 The SMD retains oversight of the violent patient marker agenda.

12.0 NATIONAL, REGIONAL AND LOCAL ALERTS

12.1 The LSMS periodically receives national and regional alerts regarding individuals that present a risk of violence or other criminal behaviour to NHS staff.

12.2 On receipt of an alert, the LSMS will review the risk with the Risk Team in relation to any potential risk to Trust staff.
12.3 If the alert relates to a potential patient, the alert will be added to the Electronic Client Information Database (for Mental Health, Learning Disability and Specialist Services).

12.4 The alert will be cascaded, if appropriate, to Community Health Services staff via the Datix CAS system.

12.5 The LSMS will generate CAS Alerts locally where appropriate.

13.0 ASSOCIATED DOCUMENTATION & POLICIES

This procedure links with the following Trust Policies:

- TASID (RM05)
- Criminal Behaviour Within A Health Environment (Zero Tolerance) Policy & Procedure (CP22)
- Clinical Risk Assessment Policy & Procedure (CLP28)
- Lone Working Policy & Procedure (RM17)
- Security Policy (RM09)

END