Essex Partnership University
NHS Foundation Trust

Therapeutic and Safe Interventions and De-Escalation Policy

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POLICY SUMMARY

This policy aims to ensure that all staff are provided with the information required to enable them to adhere to the principles that underpin the use of restrictive practices and the aim to reduce the use of restrictive physical interventions within the Trust. These principles follow safe and therapeutic responses to disturbed behaviour (MHA Code of Practice, 1983, updated 2015) current best practice guidance.

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

Through the monitoring of Datix forms, compliance figures for training.

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this policy is Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

THERAPEUTIC AND SAFE INTERVENTIONS AND DE-ESCALATION POLICY

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

TASID POLICY

Assurance Statement

The Trust provides a service to people who may require support to when presenting with behavioural disturbances and this policy and associated procedural guidelines aims to promote a consistent positive and therapeutic approach to averting behavioural disturbances, through early recognition and de-escalation.

The governance arrangements within this policy ensures that the Trust takes all reasonable steps to promote appropriate use of and prevention strategies and avoid the misapplication of restrictive practices, particularly physical interventions in line with procedural guidelines.

- The policy aims to outline and define restrictive practices;
- Enable the practitioner to ensure that their practice is lawful, necessary, reasonable and proportionate;
- Guide the practitioner in applying the least restrictive option available
- Promote open communication
- Ensure that dignity, respect, accountability, autonomy and fairness are the fundamental elements of the management of behavioural disturbances

Responses to behavioural disturbance include;

- **Primary interventions** e.g. Positive Behavioural support plans, No Force First model, Trauma Informed Care approach, medication intervention/review enhanced levels of observation.

- **Secondary interventions** e.g. De-escalation

- **Tertiary intervention** e.g. Physical restrictions, debriefing of patients and staff, rapid tranquilisation, seclusion procedure, long term segregation procedure.

1.0 INTRODUCTION

1.1 The Trust recognises and acknowledges that staff need to support people whose needs and risk histories may present with behaviours that challenge. This can be in an emotional or physical way and can be challenging.

1.2 Recovery Based Approaches are used to delivery care in accordance with the principles of a positive, safe and supportive environment.

1.3 Restrictive practices may have to be used to safely manage challenging behaviours. This may involve the physical containment of an individual. For example door locks to ensure patient / residents cannot leave a designated building or area. There may be other examples of more subtle restrictive practices which may be harder to acknowledge such as prescribed medication in the form of a chemical restraint by means of sedative medication on a short or

long term basis, inappropriate use of blanket rules. For guidance in relation to such practices a number of additional policies and clinical guidelines have been developed.

1.4 The Trust advocates, that any violence and aggression will not be tolerated. The Trust recognises that staff have a right to work, and patients / residents have a right to be cared for, in safe environments. See Trust policy Criminal Behaviour within a Mental health Environment CP22 (Zero Tolerance).

1.5 The most common reason for needing to consider the use of restrictive physical interventions are:

- Physical assault by the patient / resident
- Dangerous, threatening or destructive behaviour
- Self-harm or risk of physical injury by accident
- Ensuring and maintaining privacy and dignity where an individual's mental state prevents independent self-management
- Extreme and prolonged over activity that is likely to lead to physical exhaustion
- Attempts to escape or abscond (where the patient / resident is detained under the MHA or deprived of their liberty under MCA).

2.0 DUTIES

2.1 The Chief Executive has overall responsibility for ensuring the principles of this policy and associated guidelines set out by statutory and regulatory authorities such as the Department of Health, Commissioners and the Care Quality Commission and other associated policies are implemented across the organisation. The duty to ensure that all measures needed for the therapeutic prevention, monitoring and management of restrictive practices is delegated to Directors within their areas of responsibility. The Chief Executive has overall responsibility to ensure that patient / residents are protected from abuse and appropriate resources exist to meet the needs of this policy.

2.2 The Board of Directors are fully committed to a safety culture within the organisation and will ensure the effectiveness of restrictive intervention reduction plans. The Board of Directors has to ensure the development of action plans in response to the audit of annual positive behavioural support plans.

2.3 The Executive Chief Operating Officer is the Executive Lead for the therapeutic prevention and management of challenging behaviour including restrictive practices and restrictive practice reduction plans. This will ensure:

- Policy and procedures are embedded into clinical practice as well as ensuring they are monitored and updated regularly using latest recommendations.
- Implementation and regular review of this policy.
- That the board receives information and develops action plans in response to the annual audit of behavioural support plans and restrictive interventions statistical data looking at the quality design and application

- That executive board members who authorise the use of physical interventions undertake awareness training so they are fully aware of the techniques their staff are being taught.
- All operational managers are aware of this policy, understand its requirements and support its implementation with relevant staff.

2.4 Executive Medical Director / Consultants

- The Executive Medical Director and consultants are responsible for ensuring procedures are understood and carried out by medical staff involved in the implementation of this policy.

2.5 The Trust's Risk Management Team is responsible for:

- Ensuring there is a restrictive practice group which monitors and considers Datix reporting regarding restrictive practices. Managing statistical incident information and identifying trends across the organisation.
- Acting as an advisor on non-clinical risk management in the workplace and reporting actions required to reduce or eliminate the risk to staff.
- Providing reports to service commissioners on the use of restrictive practices
- Recording episodes of restrictive interventions (planned or unplanned) and capturing information on the level of intervention to ensure that the least restrictive option has been used.
- Ensuring accurate internal data is gathered and reported through the mandatory reporting mechanisms
- Provide information and reports when requested on statistics in relation to restrictive practices, or to show staff how to download reports from the system.

2.6. Directors and Senior Management will:

- Monitor the implementation and use of this policy by their teams.
- Take action to ensure that all staff are appropriately TASID trained relevant to their role and responsibility (subject to health related exceptions).
- Ensure that there are a minimum of 3 restraint trained staff are on duty on mental health wards if it is not possible to staff the ward in line with agreed establishments.
- Lead and monitor the use of risk reduction plans by their teams.
- Investigate Datix incidents relating to restrictive interventions where there is a significant risk or where injuries were sustained.
- Ensure that appropriate incident prevention and management processes are in place, implemented and monitored in their teams.
- Ensure the least restrictive interventions are used at all times
- Ensure that patient / residents are protected from abuse.

2.7. Local Security Management Specialist is responsible for:

- Leading on day to day work in the Trust to tackle violence against staff and professionals in accordance with the NHS national framework and guidance.
- Having professional awareness of the complex reasons for violence within services and participation in strategic planning to promote the Trusts pro-security culture.
- Providing reports and trend analysis to the Health, Safety & Security Committee regarding violence and aggression incidents.
- Providing advice and support to Trust staff on undertaking risk assessments and risk reduction plans related to challenging behaviour including violence and aggression.
- Providing post incident support to all staff that have been assaulted as well as any member of staff affected by an incident of violence.
- Liaison with the police as appropriate in relation to potential criminal prosecution.

2.8 Workforce, Development & Training Department is responsible for:

- The TASID trainers will monitor the Datix as well as the details from both the weekly restrictive practice report and monthly Prone Restraint incident Analysis report for their clinical areas.

- The TASID Instructor allocated to the clinical areas will provide support, advice and guidance regularly, by phone, email and visiting the clinical areas when necessary.

- The TASID trainers will ensure the course delivery is continually updated to ensure that the training and educational needs meet national standards as well as clinical requirements.

- The TASID trainers will ensure that any changes in professional knowledge and practice are regularly discussed within Restrictive Practice group and fed back to the training team and clinical areas.

- The TASID trainers are part of the PMVA partnership (which consist of Avon & Wiltshire University Trust, Oxford Health University Trust, Surrey & Borders University Trust and Somerset University Trust) ALL are required to attend annual revalidation, where both physical and theory elements of training are revalidated by the organisation within the partnership.

- All TASID Instructors (not the clinical based instructors) are required to attend the partnership revalidation to be assessed by all the PMVA leads. The TASID lead is required to be part of the assessment process of the revalidation of each instructor.

- The physical techniques which are facilitated in TASID course are required to be reviewed every 2 years by independent physiotherapies, who will REBA risk assess each technique, Following National standards.

- Clinical based instructors are required to be revalidated yearly, by the full time Tasid instructors. To ensure both Physical skills and theory elements of the training are up to the required standards to teach Tasid and to be signed off by the Tasid lead.

- New fulltime or clinical based base TASID instructors are required to undertake a 3 week (15 day) TASID training course. Which will be facilitated by the full time TASID instructors and assessed and sign off by the TASID lead.

2.9. Managers and other Persons in Charge will:

- Monitor the implementation and use of this policy.
- Take action to ensure that all staff are appropriately TASID trained iTASID relevant to their role and responsibility (subject to health related exceptions)
- Ensure that there are a minimum of 3 TASID trained staff on duty on mental health/ learning disability wards if it is not possible to staff the ward in line with agreed establishments (unless local staffing is less than this number)
- Ensure that the Trust Risk Management Team is appropriately notified of all incidents via Datix as per incident reporting policy.
- Actively review information recorded via Datix incident forms and investigates incidents appropriately. Ensure that appropriate incident prevention and management processes are in place, implemented and monitored in their teams.
- Ensure staff and patient receive immediate debrief and offered post incident debrief.
- Where required undertake a critical incident analysis for lessons learned to be shared via appropriate reporting structures.
- Complete and review appropriately a Workplace Risk Assessment for Violence & Aggression for their service and area of responsibility (See Trust Risk Assessment Policy) ensuring that systems and procedures are in place for the effective management of any identified risk.
- Ensure all patients have a Behavioural support plan where appropriate completed on admission.
- Ensure No Force First approach is applied to all patents care.
- Ensure a Trauma Informed Care approach (which is an integral element principal of the no force first approach) is applied to all patients care.
- Ensure staff are aware of Restrictive Practice Framework.
- Where required ensure staff have access to security devices / alarms. (Lone working devices and pinpoint).
- Active engagement at ward manager/ Matron level in Restrictive Practice Steering Group.

2.10 Individual staff:

- All staff have a responsibility to attend TASID training yearly and adhere to all new standards, procedures and techniques delivered in these sessions
- All individual staff have a duty of care to ensure that least restrictive intervention possible is practiced.
- Ensure staff adopt a No Force First approach to patient care which is an integral principal of the no force first approach.
- Ensure staff are aware and support the implementation of the Restrictive Practice Framework.
- Ensure every patient in their care has a Positive behavioural support plan where appropriate completed on admission to service/unit.
- All individuals have a duty of care to ensure that patient / residents are protected from abuse.
- Must assess risks and take precautions where they believe that a situation could result in a violent or aggressive incident and where required record information about a patient / resident and brief other relevant staff as necessary to maintain their safety.
- Must take all necessary actions to prevent personal attacks to themselves and others and to defend themselves if appropriate using the minimal amount of force to ensure their safety and escape.
- Undertake appropriate and approved training appropriate to their role.
- Must ensure that they report all incidents surrounding prevention and management of violence and aggression using Datix as well as discussing with the line manager if there is a change in clinical risk.
- Where an individual has been issued with a lone worker device, or other safety devices, they must use it in compliance with the training and instruction provided and to report any problems using the device.
- Are accountable for attending appropriate training in line with Induction & Mandatory Training Policy. Is this necessary
- Have a dual responsibility with The Trust for their health and safety in relation to patient / residents' challenging behaviour including violence and aggression.
- Will always respond in a safe and timely manner to emergency incidents to ensure the safety of staff and others.
- Will immediately report non availability of required alarms or other safety equipment.
- Must ensure Positive Behavioural support plans are written, implemented and reviewed as appropriate.
- If patients / residents wish to formally raise a concern they will be reminded of how to access the local complaints process and independent advocacy services. They will be made aware of how to request the Trust policy' on restrictive interventions.
- The safeguarding team will be informed whenever a patient / resident raise concerns about restrictive interventions. Patient / residents who need alternative support will be offered this support to access and use the complaints procedure.

3.0 DEFINITIONS

The Trust follows the Department of Health guidance and definition of Restrictive Practice set out in the Positive and Proactive Care: Reducing the Need for Restrictive Interventions, 2014 document:

'Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- End or reduce significantly the danger to the person or others; and
- Contain or limit the person's freedom for no longer than is necessary'

RM05 – TASID Policy

Page 9 of 113.2 The Skills for Care and Skills for Health, a Positive and Practice Workforce (2014) provide a simple definition:

"Making someone do something they don't want to do or stopping someone doing something they want to do."

The Mental Health Act Code of Practice advices it is "any direct physical contact where the intention is to **prevent, restrict, or subdue** movement of the body (or part of the body) of another person. More specific examples are available in the associated guideline.

4.0 PRINCIPLES

This policy is broken down into 4 main components

1. Standards supporting pre-delivery of Restrictive Practices
2. Standards supporting delivery of Restrictive Practices
3. Standards supporting post-delivery of Restrictive Practices
4. Standards supporting Risk Reductions of Restrictive Practices

4.1 TASID training to reflect the RRN standards:

- Ensure Behavioural Support Plans are available on all units to be completed with patient on admission to service or unit where appropriate.
- Ensuring the Trust has communicated NO First Force model to all relevant staff.
- Ensure the trust has communication Trauma Informed Care approach to all relevant staff.
- Ensure a 2 tier debriefing process is in place for staff and patients.
- Ensure Restrictive Practice strategy is communicated with all relevant staff.
- Ensure Restrictive Practice Framework is communicated with all relevant staff.

4.2 TASID training has achieved certification against the RRN standards via BILD:

- Ensure a Behavioural support Plan is completed/reviewed for patients where appropriate on admission to service or unit.
- Ensure staff are adopting a No Force First Approach to patient care.
- Ensure staff are adopting Trauma Informed Care approach to patient care.
- Ensure staff and patients are offered the 2 Tier debriefing process.
- Ensure Restrictive Practice Strategy is implemented.
- Ensure Restrictive Practice Framework is implemented.

4.3 Ensure TASID training is reported monthly, evaluated and peer reviewed annually:

- Ensure staff and patients review Behavioural Support plans after each restrictive practice physical intervention, including No Force First approach and Trauma Informed care approach
- Ensure staff and patients received a minimum of immediate debrief post physical intervention and offered a post debrief via psychology team
- Ensure Restrictive Practice Strategy is completed including DATIX reporting

4.4 Ensure TASID training/trainers:

- Adheres to the RRN standards re; revalidation updated skills etc.
- Ensure all techniques are independently risk assessed.
- Engage with Restrictive Practice Steering Group.
- Proactive in responding to clinical needs.

5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

5.1 This policy will be made available across the organisation via the Trust Intranet site and all staff must adhere to this policy and associated policies and clinical guidelines.

5.2 The Executive Chief Operating Officer & Executive Nurse will be responsible for overall monitoring and review together with the Restrictive practice leads, training manager and Local Security Management Specialist.

5.3 This policy will be reviewed at least every 3 years taking into account emerging research, local audit recommendations and lessons learnt from reports, enquiries and positive practice initiatives.

5.4 Any amendments to this policy will be submitted to the following for consideration and endorsement prior to being ratified:

- Clinical Governance & Quality Sub-Committee
- Health Safety & Security Sub-Committee
- Workforce Development & Training Department

5.5 This policy will be monitored for its effectiveness by Restrictive Steering Group and the training team.

6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION

1. DOH Positive and Proactive Care; reducing the need for restrictive interventions 2014
2. Mental Health Act (MHA) 1983: Code of Practice revised 2015
3. National Institute of Clinical Excellence (NICE) Violence and aggression: short-term management in mental health, health and community settings (NG10)
4. National Institute of Clinical Excellence (NICE) Violent and aggressive behaviours in people with mental health problems (QS154) June 2017
5. Restrictive Reduction Network 2019
6. Equality and Human Rights ACT 2015
7. BILD accreditation 2019
8. Care Act 2014
9. Children and Families Act 2014
10. Deprivation of Liberty Act 2010
11. Health and Safety at Work Act 1974
12. Mental Capacity Act 2007
13. Mental Health Units (Use of Force) Act 2018

7.0 REFERENCE TO OTHER TRUST FRAMEWORKS / POLICIES / PROCEDURES

1. Restrictive Practice Framework EPUT 2019
2. CG6 - Advance Decisions and Statements Clinical Guideline
3. CP3 - Adverse Incident Policy
4. CLPG28 - Clinical Risk Assessment and Safety Management Procedure
5. CLP8 - Engagement and Supportive Observation Policy
6. RM08 - First Aid Policy
7. SSOP31 - Protocol for the use of Handcuffs in escorting patients
8. HR21 - Induction, Mandatory Training and Essential Training Policy
9. RM17 - Lone Working Policy
10. CLP75 - Search Policy
11. CLP41 - Seclusion and Long Term Segregation Policy
12. CG71 - Self Harm Clinical Guideline
13. CG52 - Pharmacological Management of Acutely Disturbed behaviour
14. CG92 - Global Restrictive Practices Clinical guideline
15. HR26 - Employee Wellbeing and Management of Sickness and Ill Health Policy

END

Equality Impact Assessment Template

Section 1: Your details

(1.1) Department/ team: Risk Management

(1.2) Locality/Directorate: Compliance and Assurance

(1.3) Assessment Lead/person: Amanda Webb

(1.4) Contact details: The Lodge, SS11 7XX

(1.5) Email: a.webb5@nhs.net

(1.6) Who else will be involved in the process?

(1.7) Please sign & date this form AWEBB (signed) 14/02/2019 (date)

Guidance Note 1:

For Initial EIA's it is best practice to involve the service /clinical manager, and relevant frontline staff.

For Full EIA's it is best practice to involve the service / clinical manager, relevant frontline staff, service users/ carers, appropriate external agencies, and the voluntary and community sector.

Section 2: What is to be assessed?

(2.1) The Restrictive Practice Policy and related procedures and documents.

(2.2) Reviewed and updated policy, procedures and relevant documents.

(2.3) Policy, procedures and documents existed previously but no evidence of an EIA being completed.

Guidance Note 2:

Service = your department / service area and its employees

Functions = your department / service area's activities

Projects = your department / service area's work programmes

Strategy = a plan of action intended to accomplish a specific goal

Policy = a plan of action to influence and determine decisions, actions and other matters

Procedure = a series of steps taken to implement a policy

Section 3: Let's do the Initial Equality Impact Assessment (Screening)

3.1 Could a particular group of people be affected differently in either a negative or positive way by the service / function / project / strategy / policy?

Equality Group	**Positive Impact (benefits)** **Please number each one**	**Negative Impact (disadvantage) or potential negative impact** **Please number each one and provide evidence**	**Please rate each negative impact 'low', 'medium' or 'high'** **See guidance note 3**
Disabled People	Applies equally to all staff	N/A	
Lesbian, Gay & Bisexual People	Applies equally to all staff	N/A	
Women	Applies equally to all staff	N/A	
Men	Applies equally to all staff	N/A	

Equality Group	Positive Impact (benefits) Please number each one	Negative Impact (disadvantage) or potential negative impact Please number each one and provide evidence	Please rate each negative impact 'low', 'medium' or 'high' See guidance note 3
Transgendered People	Applies equally to all staff	N/A	
Black & Racial Minority People (please state which group)	Applies equally to all staff	N/A	
Older People (60+)	Applies equally to all staff	N/A	
Younger People (17-25) and Children Please state male or female	Applies equally to all staff	N/A	
Religious / Faith Groups	Applies equally to all staff	N/A	
Pregnancy and maternity	Applies equally to all staff	N/A	
Marriage and civil partnership	Applies equally to all staff	N/A	
Deprived Groups	Applies equally to all staff	N/A	

If you have rated any negative impact(s) as 'High' please go straight to Section 4 to complete a full assessment.

If you have rated any negative impact as 'Low' or 'Medium please complete the rest of this section on pages 5 and 6.

Guidance Note 3: How to assess negative impacts

Low = It is not discriminatory according to current legislation. However, it might not be seen as being in line with best practice.

Medium = It is not discriminatory according to current legislation. However, it is not in line with the Trust or Department Equality Policy and/or Strategy and requires attention

High = It is discriminatory according to current anti-discrimination legislation (i.e. it is unlawful), and therefore requires immediate action.

3.2 Please list below any actions that you plan to take as a result of any negative impact

EIA Action plan

Low or medium negative impact	Action required to remove or minimise the impact	Lead person	Timescale	Resource implications	Any other comments

3.3 Could you improve the positive impact(s)? Please explain how

3.4 If you have identified no negative impact, then please explain how you reached that decision and provide reference to evidence (for example reviews undertaken, surveys, feedback, patient data verified etc)

Thank you for completing the initial assessment (please email a copy of this report to the compliance function.

Please note that the lead assessment person is responsible for ensuring the actions on pages 9 and 10 are incorporated into your departmental plan.

Section 4: Full Equality Impact Assessment

4.1 Looking back at pages 2 & 3, in which equality areas are there concerns?

- ☐ Disability
- ☐ Sexual Orientation
- ☐ Gender
- ☐ Race
- ☐ Age
- ☐ Religion & Faith
- ☐ Deprivation
- ☐ Marital status
- ☐ Pregnancy and maternity

4.2 Please summarise the negative impact (s) or potential negative impacts

4.3 What consultation has taken place with local people / patient groups in order to complete this full EIA?

4.4 What consultation has taken place with EPUT staff / stakeholders / those we work in partnership with / those we contract with in order to complete this full EIA?

4.5 What equality research / studies / reports have you referred to in order to complete this full EIA?

4.6 What monitoring / evaluation process do you use to collect equality group data (quantitative and qualitative)?

4.7 Please list below any actions that you plan to take as a result of this full equality impact assessment

EIA Action plan

Negative Impact	Action to be taken	Lead person	Timescale	Resource implications	Any other comments

Thank you for completing the full assessment.
Now email a copy of this report to compliance function

Please note that the lead assessment person is responsible for ensuring the above actions are incorporated into your departmental plan or organisation-wide plan

Essex Partnership University
NHS Foundation Trust

Therapeutic and Safe Interventions and De-escalation Procedure

PROCEDURE REFERENCE NUMBER:	RMPG05
VERSION NUMBER:	2.2
KEY CHANGES FROM PREVIOUS VERSION:	Appendix 8d added 2.2 – Extended to August 2024 [April 24 PORG]
REPLACES EPUT DOCUMENT	Restrictive Practice Procedure (renamed)
AUTHOR:	Restrictive Practice Steering Group
CONSULTATION GROUPS:	HSSC
IMPLEMENTATION DATE:	16 November 2017
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NEXT REVIEW DATE:	Extended to August 2024
APPROVAL BY CLINICAL GOVERNANCE AND QUALITY SUB-COMMITTEE:	February 2021
RATIFICATION BY QUALITY COMMITTEE:	April 2021
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PROCEDURE SUMMARY
These procedural guidelines aim to ensure that staff are provided with the current evidence based information and guidance to prevent and manage restrictive practices.
The trust monitors the implementation of and compliance with this procedure in the following ways:
The monitoring of the use of physical interventions through Datix forms, regular Audit undertaken in conjunction with Workforce Development & Training Department and Risk Management Team and supported by the Clinical Audit Team. Also by the dissemination of information from lessons learnt from physical intervention incident analysis.

Services	**Applicable**	**Comments**
Trustwide	✓	

The Director responsible for monitoring and reviewing this procedure is Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

TASID PROCEDURAL GUIDELINES

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

TASID PROCEDURAL GUIDELINES

1.0 INTRODUCTION

1.1 The procedural guidance aim is to promote a consistent positive and therapeutic approach to averting behavioural disturbances, by encouraging a culture across the organisation that is committed to enhance the therapeutic environment.

The Trust has adopted the No Force First approach to facilitate the reduction of any restrictive practice. The key components of this are:

- Commitment to the concept of 'No Force First'.
- Re-defining the relationship between staff and services users as one of 'risk-sharing partnership' rather than 'risk management control' through a review of institutional rules that unnecessarily hinder and frustrate service users.
- Promotion and development of the use of 'recovery focused' positive and continually optimistic language about service users that seeks to avoid negative stereotyping.
- Defining the use of restraint and seclusion as a 'treatment failure' and critically reviewing incidents on that basis.
- Promotion of the concept of trauma informed care – seeing challenging behaviour in the context of previous traumatic events experienced by the service user

1.2 This procedural guidance will provide an overview of restrictive practices to all staff. It will also look at the process for managing behavioural disturbances using primary, secondary and tertiary approaches including reporting and evaluating the use of restrictive interventions/practices.

1.3 When episodes of challenging behaviour do occur these guidelines provide clear and effective strategies as recommendations for actions staff may take to deescalate, manage or intervene to bring the episode to a safe and rapid conclusion.

1.4 The Trust recognises the need to support staff at all times, and especially following an episode of challenging behaviour. The guidance, therefore, must be read in conjunction with Trust guidelines for Employee Wellbeing and Sickness Absence HR26 and associated documents which set out systems and processes to ensure that staff feels supported and that lessons are learnt and shared following incidents.

2.0 DEFINITIONS

2.1 The Trust follows the Department of Health guidance and definition of Restrictive Practice set out in the Positive and Proactive Care: Reducing the Need for Restrictive Interventions, 2014 document:

'Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- End or reduce significantly the danger to the person or others; and
- Contain or limit the person's freedom for no longer than is necessary'

2.2 The Skills for Care and Skills for Health, a Positive and Practice Workforce (2014) provide a simple definition:

"Making someone do something they don't want to do or stopping someone doing something they want to do."

3.0 PRACTICE STANDARDS

3.1 Restrictive practices are not only confined to physical interventions. Any actions or inactions that contravene a person's Human rights may be seen as restrictive practice. These rights must be at the centre of decision-making. Human Rights based approach, focused on the minimisation of the use of restrictive interventions, and ensuring any use of restrictive interventions and other restrictive practices is rights-respecting.

Below are some categories of restrictive practices and how these are applied. Any restrictive practice must be lawful and have a legitimate right and reason to do so. This is not an exhaustive list.

3.2 Physical Restraint

"Any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of another person" *(Positive and Proactive Care: reducing the need for restrictive interventions. DoH April 2014).*

3.3 Environmental Restrictions

This is to limit people's ability to move as they might wish, such as locking doors or parts of the building. This includes the use of electronic keypads with numbers to open doors, complicated door locking mechanisms and door handles.

3.4 Chemical Restraint

This refers to the use of drugs to modify a person's behaviour. Medication that is prescribed to be taken as and when required (PRN) can be used as a form of restraint unless applied responsibly.

3.5 Forced Care

Actions to encourage / coerce an individual into acting against their will, for example having to be restrained in order to comply with instruction or request, or non-application of Section 5/4 following advising an individual you will use it if they attempt to leave.

3.6 Cultural Restrictions

Preventing an individual from following the behaviours and beliefs characteristic of a particular social, religious or ethnic group chosen by them.

3.7 Decision making

Making a decision on the person's behalf or not accepting or acting on a decision the person has made.

3.8 Community contact

Preventing an individual from participating in community activities, including working, education, sports and community events or from spending time in the Community such as parks, leisure centres and shopping centres.

3.9 Contact with family and friends

Preventing or limiting contact with the individual's peer groups, friends or family. For example not allowing the person to receive visitors, make phone calls or allowing them contact with specific friends or family member.

3.10 Blanket Rules / Global Restrictions

Blanket / Global restrictions refers to policy rules or customs that will restrict a patient / residents' rights and liberty that are routinely implemented to all patient / residents within a service without an individual risk assessment to justify its application. There needs to be justification for the implementation of blanket restrictions. They should be avoided unless there is specific justifications which are deemed appropriate and necessary to address the risk or risks identified for particular individuals, the impact of a blanket restriction on each patient / resident should be considered and documented in their records.

3.11 Deprivation of access to normal daytime clothing

Individuals must never be deprived of appropriate clothing with the intention of restricting their freedom of movement; neither should they be deprived of other aids necessary for their daily living (COP 26.161). However there are circumstances where it will be appropriate and necessary to use restrictive clothing in order to prevent risks to self-i.e. tear-resistant clothing. Where this is implemented, a rationale for this must be recorded, the patient must be informed of reasons, reviews must be evidence (including least restrictive alternative strategies) and the use must be for the shortest amount of time.

To ensure privacy and dignity special tear-resistant clothing must only be used when a patient is either in Seclusion or being nursed in Long Term Segregation

For guidance on the use of tear–resistant clothing please refer to Appendix 3c of CLP41, the Policy for the use of Seclusion & Long–Term Segregation.

4.0 UNACCEPTABLE METHODS OF RESTRAINT/RESTRICTVE PRACTICES

4.1 The following methods of restriction are unacceptable, especially if the individual requests or is consenting to any of the following. It may be considered and applied as appropriate, this must be clearly documented. Inappropriate use of restrictions may be viewed as abuse and a safeguarding concern. The following is not an exhaustive list.

4.2 Inappropriate bed height

This is unacceptable form of restraint as it could also lead to an increased risk of falls to the patient and risks to staff.

4.3 Inappropriate use of wheelchair safety straps

Straps supplied with wheelchairs should always be used when provided for the safety of the user. Although patient / residents should only be seated in a wheelchair when this type of seating is required and not as a means of restraint or to restrict the individual's movement when there are lesser options available.

4.4 Using low chairs for seating

Low chairs should only be used when their height is appropriate - they should not be used with the intention of restraining a person; low chairs also pose a risk to staff in relation to manual handling.

Chairs by way of construction immobilise an individual e.g. Reclining chairs, bucket seats. This type of chair should be used for the comfort of the individual and not for the purpose to restrict movement.

4.5 Locked doors

Where units have locked doors for identified risks, there should be clear signage displayed informing individuals and visitors that the doors are locked and who they need to speak to gain exit from the area. If an individual wished to leave and is being prevented by the locked door that patient / resident is being restricted.

4.6 Arranging furniture to impede movement

Furniture should only be used for its intended purpose

4.7 Removal of outdoor shoes and other walking aids or the withdrawal of sensory aids e.g. glasses

As with the above they should be enabled to prevent confusion and disorientation.

4.8 Prone physical restraint

Prone restraint should not be used other than in exceptional circumstances;

- medical reasons
- potentially to exit from seclusion room
- administration of prescribed medication only if other IMI sites are felt not appropriate

Utilisation of supine, seated de-escalation or the release of the patient / resident in a controlled manner if it is deemed appropriate and safe to do so enabling them to move of their own volition to an area mutually agreed with them and staff as alternatives.

4.9 Safety pods

This equipment enables staff to restrict patients/clients movement without the need to go to the floor and may also enable staff de-escalate in them. however if a patient/clients has been placed in a safety pod and left alone but the client is unable to get them out of the safety pod this may be seen as a mechanical restraint.

5.0 ASSESSMENT AND DECISION MAKING

5.1 Risk Assessment and decision making is an integral part of providing care and treatment.

5.2 Risk Factors (**Appendix 1)** and Antecedents and Warning signs (**Appendix 2**) must be taken into consideration in the assessment and decision making process.

5.3 Risk Factors to consider when placing patients on observation are set out in **Appendix 4.** Also see Engagement & Supportive Observation Policy and Procedure, CLP8.

5.4 Risk Factors to be considered when a patient has specific needs are set out in **Appendix 5.**

5.5 Individual assessment should be carried out in partnership with the individual and considers the following.

- The individual's behaviour and underlying condition and treatment, understanding a patient / resident's behaviour, responding to their individuals identified needs and mutually agreeing a way forward. This should always be at the centre of individualised care. All individuals require a rigorous assessment to establish a positive and proactive support plan to identify appropriate management process.
- The patient / resident's mental capacity and mental health. The individual's mental capacity requires consideration as consent must be gained to use any type of restriction unless they lack capacity to make this decision and the restrictive practice is sanctioned under the Mental Health or Mental Capacity Act.
- The environment should be made to reduce the negative effects a care environment. Negative effects of a care environment include high levels of noise and disruption, inappropriate temperature control, inappropriate levels of stimulation, negative attitudes of care staff and poor communication skills.
- The risk to patient / residents and others, when using restrictive practices a balance needs to be achieved that minuses the risk of harm or injury to the individual and others within the area whilst maintaining the dignity, choice and personal freedom of the individual.
- Assessment should always place the individual at the centre of the process, involving them and those important to them as practical to do so. Evidence of personal centred care should always be documented and signed by the individual and identified staff member undertaking the assessment.

5.6 If a restriction is deemed appropriate the following must always be considered.

- The practice needs to have a legitimate goal, it must be necessary to protect the health and wellbeing of the individual or to protect the safety or human rights of others in the area. This should always be the least restricted option.
- Individuals effected by the restriction must be involved in the decision making process to the fullest extent of their capacity.
- The restrictions that are being instigated must be proportionate to the level of risk identified and the least restrictive option to achieve a safe outcome.
- The principles of dignity and respect must be observed at all times and especially at times when restrictive interventions are being implemented.

- There must be continuous review and evaluation of the practice being implemented to ensure that is used for the shortest possible time period and that it is necessary and the most effective practice at this time.

5.7 If the individual has capacity and can give valid consent and their agreement can be gained without pressure, then the restriction can be put in place as long as it does not contravene the law. The individual has the right to withdraw consent / agreement at any time and it is required that they are informed of this right at the outset.

5.8 If the individual withdraws their consent but it is felt that the restriction should continue but it is deemed that the practice should continue, this can only be achieved if the restriction is supported by the Mental Capacity Act or the Mental Health Act, Criminal Law or the Public Health Act.

5.9 **Appendix 8a** outlines the process for when considering placing of a risk of violence marker on a patient record, **Appendix 8b** provides staff with the referral form in doing so.

6.0 PRIMARY PREVENTATIVE STRATEGIES

Behavioural disturbance and the use of restrictive practice can be minimised by promoting a supportive and therapeutic culture within the care environment. Unless an individual is subject to specific justifiable restrictions (e.g. for security reasons), primary preventative strategies should typically include the following,

6.1 Positive and proactive support plans/positive behaviour support Plans

These are created to help understand and **support** children, young people and adults who display **behaviour** that others find challenging. They are designed to guide us in our responses and actions at times of distress. Patients should be involved when making decisions about their care, this is a human right.

This plan should be implemented alongside a risk management plan. The two plans will proactively and reactively manage risk and support the **reduction of restrictions**. Restrictions include any intervention (environmental, physical, relational, psychological or pharmacological) that prevent a person in your care from pursing free action.

This plan should be developed with support from a clinician with behavioural expertise following an assessment and functional analysis of the problem behaviour.

6.2 Advance Decisions

People who are identified as being at risk of presenting with behavioural disturbance which could include challenging behaviour must be given the opportunity to have their wishes and feelings recorded in an advance

statement, if they have the capacity to do so (Trust Policy Advance Decisions and Statements CG6).

6.3 Care and Treatment plan

Staff should ensure that patient / clients who are assessed as being liable to present with behavioural disturbances have a care and treatment plan which includes primary, secondary and tertiary preventative strategies. These individualised care plans, should be available and kept up to date and include the primary, secondary and tertiary interventions.

- Engaging with individuals and their families
- Care and support
- Considering the regulatory framework
- Patient / resident Community
- Patient / resident Characteristics

6.4 Risk assessments

The assessment of clinical risk in mental healthcare is challenging but provides an opportunity to engage with patients, and their careers and families in order to promote the patients' safety, recovery and wellbeing[4]. A good risk assessment will combine consideration of psychological (e.g. current mental health) and social factors (e.g. relationship problems, employment status) as part of a comprehensive review of the patient[5] to capture their care needs and assess their risk of harm to themselves or other people.

6.5 Staff primary prevention strategy

All staff must be aware that their own personal safety is paramount in any situation where they are faced with episodes of aggression or violence. This includes the right to defend themselves using the justifiable, appropriate and reasonable force to ensure they can escape to an area of safety.

6.6 All clinical staff working in inpatient environments will have access to a personal alarm. Staff who work alone or may visit clients in the community will have access to Lone Worker devices, It is the responsibility of each member of staff to familiarise themselves with the use and circumstances in which alarms should be used.

7.0 SECONDARY PREVENTATIVE STRATEGIES

7.1 De-escalation is a secondary preventative strategy. The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. P.r.n. medication can be used as part of a de-escalation strategy but p.r.n. medication used alone is not de-escalation. (NICE 10 2015)

7.2 De-escalation techniques are set out in **Appendix 3.**

7.3 It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance which could include challenging behaviour.

7.4 De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

8.0 TERTIARY INTERVENTIONS

8.1 Physical interventions / restraints are a tertiary preventative measure.

8.2 A physical intervention / restraint is defined as:

"Any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person".

Manual restraint *A skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user. (NICE 10 2015).*

Therapeutic and Safe Intervention (TASI previously referred to as PMVA) is set out in **Appendix 7.**

Mechanical restraint *A method of physical intervention involving the use of authorised equipment, for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare (NICE 10 2015).*

9.0 LEGAL CONSIDERATIONS

9.1 All staff that utilise these interventions must be aware of the legal framework that authorises their use. The main guidance is given in Chapter 1 of the Mental Health Act Code of practice 2015 and should be followed for every incident. Where departures from the guidance occur they should be rigorously recorded and justified as being in the patients best interest.

9.2 The use of Physical intervention must be as a last resort, defensible in law and within Trust Policy and Procedures.

9.3 The use of "Reasonable Force" is legally permitted. All staff must be aware that their own personal safety is paramount in any situation where they are faced with episodes of challenging behaviour. In a one on one situation removal of yourself to a safe **area is the first course of action.**

9.4 Staff need to ensure that the risk is assessed prior to carrying out any physical intervention to maintain the safety of themselves and service users.

10.0 PHARMACOLOGICAL MANAGEMENT OF ACUTELY DISTURBED BEHAVIOUR CLINICAL GUIDELINE (RAPID TRANQUILISATION COP 26.91 – 26.102)

10.1 For information regarding the use of medication in the management of acutely disturbed behaviours, staff must refer to the following Trust policies:

- Formulary and Prescribing Guidelines, Chapter 8 - Pharmacological Management of Acutely Disturbed Behaviour Clinical Guideline (PMAD-B)
- Safe and Secure Handling of Medicines Guidelines

11.0 SECLUSION AND LONG TERM SEGREGATION

11.1 For information regarding the use of seclusion and long-term segregation in the management of acutely disturbed behaviours, staff must refer to the Trust's Seclusion & Long Term Segregation Policy and Procedure CLP41.

11.2 Staff must also be familiar with and follow the guidance given in the Mental Health Act Code of Practice 2015.

12.0 WEAPONS AND HOSTAGE TAKING

12.1 Where a patient / resident presents with a weapon (of any description) or has taken a hostage as part of an episode of challenging behaviour the police must be called immediately. Staff must remove all persons from the area and isolate the patient / resident concerned. Safety of the staff and others takes priority in this matter.

12.2 The procedure described in **Appendix 6** should then be followed.

12.3 In all Community Services where a patient / resident presents with a weapon, the staff member will safely withdraw and dial 999 requesting emergency assistance or call a red alert on their lone worker device. (Please refer to the Trust Lone Working Policy and Procedure).

13.0 INCIDENT REPORTING AND RECORD KEEPING

13.1 All incidents and the interventions used are to be fully recorded in the patient / residents healthcare records and on Datix, see Adverse Incident Procedure and Online Incident Reporting Datix Guidance, Appendix 5.

14.0 SUPPORTING STAFF, PATIENT / RESIDENTS

14.1 Support for staff, patient is detailed in the Employee Wellbeing and Management of Sickness and Ill Health Policy HR26. Support for patients/ residents are referred to in section 15 of this procedure.

15.0 IMMEDIATE POST INCIDENT DEBRIEF AND FORMAL POST INCIDENT REVIEW

15.1 **Immediate post-incident debrief**

After using a restrictive intervention, and when the risks of harm have been contained, conduct an immediate post-incident debrief, including a nurse and a doctor, to identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses.

This is to determine the factors that contributed to an incident that led to a restrictive intervention, identify any factors that can be addressed quickly to reduce the likelihood of a further incident and amend risk and care plans accordingly.

To ensure that the service user involved has the opportunity to discuss the incident in a supportive environment with a member of staff or an advocate or carer.

To ensure that any other service users who may have seen or heard the incident are given the opportunity to discuss it so that they can understand what has happened.

(NICE 10 2015).

15.2 Post Incident for staff is detailed in HR26, Employee Wellbeing, Sickness & Ill-Health Policy

15.3 Managerial decisions will determine the level of post incident review dependant on the seriousness of the incident event. Good practice determines that where tertiary interventions are used and or where significant injury to persons or damage to property result then post incident reviews should occur.

15.4 These discussion should only take place when those involved have recovered their composure.

15.5 The aim of post incident reviews should be to seek to learn lessons, support staff and patient / resident, and encourage the therapeutic relationship between staff patient / residents and their careers.

15.6 Post incident reviews should take place as soon as possible, but in any event within 72 hours after the incident. The review should look objectively at the lead up to the incident, the dealing of the incident and the aftermath of the incident.

15.7 The post incident reviews should wherever possible be led by a person not directly involved in the incident event and address:-

- Any precursors, causative factors and trigger points;
- What happened during the incident;
- Sequence of events;
- Address individual's roles and their decision making processes;
- How a successful outcome was achieved and how the event ended;
- What went well and demonstrated good practice;
- What lessons can be learnt;
- An evaluation of the effectiveness of response times surrounding the incident;
- What strategies / interventions could be used if the incident were to reoccur;
- Issues that senior managers or the MDT need to be aware off;
- Where possible, recommendations should be made as to future management plans for the service user or the organisation.

16.0 TRAINING

Restraint Reduction Network (RRN) Training Standards 2019 provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings. These standards will ensure that training is directly related and proportional to the needs of populations and individual people. They will also ensure that training is delivered by competent and experienced training professionals who can evidence knowledge and skills that go far beyond the application of physical restraint or other restrictive interventions. The Therapeutic and Safe Interventions and De-escalation training model the Trust have adopted under pins all the principals of the Restraint Reduction Network (RRN) Training Standards.

16.1 The Trust will provide education and training surrounding physical interventions through, the Workforce Development & Training Department as guided by risk assessment of staff roles and individual service areas. (See Induction & Mandatory Training Policy / procedure appendix 1 for the training matrix).

16.2 All new nursing staff to inpatient mental health areas will undertake initial training in physical interventions.

16.3 Senior clinical staff are responsible for team based training and ensuring ongoing competency of staff in managing risks associated with lone working. Each team must ensure staff are informed about current policy requirements, through team based induction, preceptorship and supervision.

16.4 The Workforce Development and Training Department will report monthly on compliance levels for mandatory training for the Executive Team, Clinical Governance and Quality, Service Management Teams and Health Safety and Security Sub-Committee.

16.5 Managers are responsible for checking that training has been undertaken by a member of staff and is valid, so as to aid in maintaining the minimum of 3 physical intervention trained staff per shift, unless specified in local operational procedures.

16.6 Staff who are booked onto mandatory training and are, for whatever reason, unable to attend, MUST inform their line manager and ensure that their training is rebooked at the earliest opportunity.

16.7 Staff who do not attend a mandatory training course will be recorded and reported as a DNA unless prior notification was given in line with Induction and Mandatory Training policy.

16.8 A withdrawals and DNA report will be produced monthly as part of the mandatory reporting system.

16.9 Managers must determine if additional training is required in any element of restrictive practice.

17.0 MONITORING AND REVIEW

17.1 The monitoring of the use of physical interventions is an essential part of managing a ward, area, unit or department, therefore all incidents involving physical interventions will be recorded as per Adverse Incidents including Serious Untoward Incidents Policy and monitored by the Ward Manager/Nursing Home Manager Team Leader and Clinical Manager.

17.2 Audit is undertaken in conjunction with Workforce Development & Training Department and Risk Management Team and supported by the Clinical Audit Team with results presented to the Clinical Governance and Quality Sub-Committee and Health, Safety & Security Sub-Committee. This will include as a minimum:

- Duties
- Requirement to undertake appropriate risk assessments
- Arrangements for ensuring the safety of lone workers (see Lone Working Policy)

17.3 Analysis of physical intervention incidents will be undertaken by the Restrictive Practice Group to identify trends and patterns of activity in the use of physical interventions.

17.4 Any lessons learnt from physical intervention incidents that are recognised through the reporting process and the Restrictive Practice Group will be fed into the Clinical Governance Committee for sharing across the organisation.

17.5 Monitoring of training compliance will be undertaken by Workforce Development and Training.

17.6 Datix forms involving physical interventions will be reviewed by trainers, using the Datix communication processes. All clinical inpatient areas have 2 nominated full time instructors who can be contacted they will also monitor the Datixes for their clinical areas. The nominated instructor will provide support and guidance to clinical areas. Any issues/concerns identified will be discussed with the clinical teams and management. The nominated instructor will also provide feedback to the TASI team which then will be feedback to the workforce team and the restrictive practice group.

18.0 POLICY REFERENCES/ASSOCIATED DOCUMENTS

1. Restrictive Practice Framework EPUT 2019

1. CG6 - Advance Decisions and Statements Policy
2. CP3 - Adverse Incident Policy
3. CLPG28 - Clinical Risk Assessment and Safety Management Procedure
4. CLP8 - Engagement and Supportive Observation Policy
5. RM08 - First Aid Policy
6. SSOP31 - Protocol for the use of Handcuffs in escorting patients
7. HR21 - Induction, Mandatory Training and Essential Training Policy
8. RM17 - Lone Working Policy
9. CLP75 - Search Policy
10. CLP41- Seclusion and Long Term Segregation Policy
11. CG71 - Self Harm Clinical Guideline
12. CG52 - Pharmacological Management of Acutely Disturbed behaviour
13. CG92 - Global Restrictive Practices Clinical guideline
14. HR26 - Employee Wellbeing and Management of Sickness and Ill Health Policy

END

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

RISK FACTORS

Certain risk factors can indicate an increased risk of physically violent behaviour. The following lists are not intended to be exhaustive and these risk factors should be considered on an individual basis.

Demographic and Personal Information	
History of disturbed or violent behaviour. History of misuse of substances or alcohol. Carers reporting service user's previous anger or violent feelings. Previous expressions of intent to harm others. Evidence of rootlessness or social restlessness. Previous use of weapons. Previous dangerous impulsive acts. Denial of previous established dangerous acts. Severity of previous dangerous acts.	Known personal trigger factors. Verbal threat of violence. Evidence of recent severe stress, particularly a loss event or the threat of loss. One or more of the above in combination with any of the following: - cruelty to animals - reckless driving - bed wetting - loss of a parent before age 8

Clinical Variables	
Misuse of substances and or alcohol. Drug effects (disinhibition, akathisia). Active symptoms of Schizophrenia or mania in particular: - Delusions or hallucinations focused on a particular person. - Command hallucinations. - Preoccupation with violent fantasy. - Delusions of control (especially with a violent theme) - Agitation, excitement, overt hostility or suspiciousness.	Poor collaboration with suggested treatments. Antisocial, explosive or impulsive personality traits or disorder. Organic dysfunction.

Situational Variables	
Extent of social support. Immediate availability of a potential weapon. Relationship to potential victim (for example known difficulties in relationship are known).	Access to potential victim. Limit setting (for example, staff members setting parameters for activities, choices, etc). Staff attitudes.

Source NICE Clinical Guideline QS154 Violent and aggressive behaviours June 17.

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ANTECEDENTS AND WARNING SIGNS

Certain features may serve as warning signs to indicate that a service user may be escalating towards physically violent behaviour. The list is not intended to be exhaustive and these warning signs should be considered on an individual behaviour.

Antecedents and Warnings	
• Tense and angry facial expressions. • Increased or prolonged restlessness, body tension pacing. • General over-arousal of the body systems, (increased breathing and heart rate, muscle twitching, dilating pupils). • Increased volume of speech, erratic movements. • Prolonged eye contact. • Discontentment, refusal to communicate, withdrawal, fear, irritation.	• Unclear thought processes, poor concentration. • Delusions or hallucinations with violent content. • Verbal threats or gestures. • Replicating or behaviour similar to that which preceded earlier disturbed / violent episodes. • Reporting anger or violent feelings. • Blocking escape routes.

Source NICE Clinical Guideline QS154 Violent and aggressive behaviours June 17.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DE-ESCALATION TECHNIQUES

DEFINITION

The use of techniques (including verbal and non-verbal communication skills) aimed at preventing potential or actual behaviours of concern from escalating.
Restraint Reduction Network 2019

One member of staff should take the primary role in communicating with them. That staff member should assess the situation for safety, seek clarification with the service user and negotiate to resolve the situation in a non-confrontational manner. Its aim is to aim to build emotional bridges and maintain a therapeutic relationship.

Use of the following primary interventions may help the de-escalation process.

- Care plan
- Risk plan
- Positive behaviour support plans (PBSP)
- Existing therapeutic relationship
- Consider which de-escalation techniques are appropriate for the situation.
- Pay attention to non-verbal cues, such as eye contact and respond accordingly.
- Adopt a non-threatening but safe body posture.
- Appear calm, self-controlled and confident without being dismissive or over confident.
- The use of calm down methods to use the patient's own strengths and usual coping mechanisms to help them calm down.
- Manage others in the environment (for example removing other service users from the area, getting colleagues to help and creating space) and move towards a safe area.
- Explain to the service user and others nearby what they intend to do, giving clear, brief, assertive instructions.
- Give clear, brief, assertive instructions.
- Encourage the service user to discuss the issues at hand.
- Ask for facts about the problem and encourage reasoning.
- Attempt to establish a rapport emphasising co-operation.; offer and negotiate realistic options; avoid threats; ask open questions and ask about the reason for the service user's anger.
- Show concern and attentiveness through non-verbal responses.
- Do not patronise and do not minimise the service user's concerns.
- Listen carefully and demonstrate empathy.
- Ensure that staff non-verbal communication is non-threatening and non-provocative.
- Where there are potential weapons, the service user should be relocated to a safer environment and or attempt to remove the potential weapon without putting self or others at risk.
- If a weapon is involved ask for it to be placed in neutral location rather than handed over.

- Consider asking the service user to make use of a designated de-escalation area to help calm and diffuse their anger.
- At all times encourage the service user to discuss and negotiate their wishes.

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FACTORS TO CONSIDER WHEN PLACING PATIENTS ON OBSERVATIONS

In addition to the antecedents and warning signs given in Appendix 2 the following may give an indication that observation above the general level should be considered.

Use the least intrusive level of observation necessary, balancing the service user's safety, dignity and privacy with the need to maintain the safety of those around them.

Give the service user information about why they are under observation, the aims of observation, how long it is likely to last and what needs to be achieved for it to be stopped.

- History of previous suicide attempts, self-harm or attacks on others.
- Hallucinations, particularly voices suggesting harm to self or others.
- Paranoid ideas where the service user believes that other people pose a threat.
- Thoughts or ideas that the service user has about harming themselves or others.
- Threat controls override symptoms.
- Past or current problems with drugs or alcohol.
- Recent loss.
- Poor adherence to, or non-compliance with, medication programmes.
- Marked changes in behaviour or medication.
- Known risk indicators.

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RISK ASSESSMENT FACTORS TO BE CONSIDERED WHEN A PATIENT HAS SPECIFIC NEEDS

When physical interventions are considered as part of risk management plans then further assessment and risk management needs to be considered when the patient/resident has particular needs. These include:-

(i) Children and adolescents
(ii) People with learning disabilities

Consider factors surrounding confused and impaired consciousness and communication strategies with the service user.

(iii) Pregnant women

Promote liaison with appropriate pregnancy support services identifying general good practice guidance and key concerns in the management of pregnancy and acutely disturbed behaviour. Acutely disturbed behaviour equals behaviour demonstrating a high risk of imminent harm towards the unborn baby and the mother.

(iv) The elderly

Consider factors such as frailty and physical health and confused mental states and ability to respond to instruction.

(v) People with a physical disability, including Risk of HIV or other infectious Diseases

Here consideration would need to be made in relation to how the service user can be safely restrained. This may require that the service user has a modified / tailored made restraint procedure prepared for them.

(vi) People with diverse backgrounds that may need an interpreter.

Consideration of the extra time required for effective communication is essential.

Where a service user with particular needs has been identified it may be necessary to consider the support of other specialist services. For instance

- Infection Control
- Health and Safety
- PMVA Lead
- Manual Handling Co-ordinator / Ergonomist
- Specialist Speech and Language Therapist
- Specialist Professional such as Midwife
- Pharmacy

Where additional considerations to manage the individual needs of a service user has been made then this should be recorded. The record should show the risk assessment and the specific care plan that has taken place in relation to the particular individual need.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

WEAPONS (INCLUDING KNIFES, FIREARMS) AND HOSTAGE TAKING

1.0 Trust Staff Response

1.1. Staff must **not** attempt to disarm a user suspected of having a weapon without the assistance of the police.

1.2. If it is suspected that a user has a weapon then the police must be informed immediately using 999, and giving the location and an explanation for the grounds for suspicion.

1.3. If possible and appropriate evacuate the area as quickly and calmly as possible, ensuring the safety of other patients / residents, staff and visitors is paramount.

1.4. If possible and appropriate close and lock any doors in the immediate vicinity to help isolate and contain the area, the aggressor and situation. In the event of hostage taking it may be more appropriate to leave doors open and/or unlocked.

1.5. Observation of the immediate area should be maintained if it is possible to do so without endangering the staff carrying out the observation.

1.6. The Senior Manager (Manager on call) responsible for the unit, the Consultant (or Consultant on call) responsible for the patient and the Associate Director (or Director on call) for the Service must be contacted.

1.7. In all instances where the Police and other emergency services are called to manage an incident involving weapons or hostage taking then the following must be informed.

- Chief Executive
- Medical Director
- Trust Chair
- Clinical Director for the relevant Directorate
- Communications Manager
- LSMS

1.8. The Senior Manager or Associate Director will take over from the Nurse in Charge in the management of the Trust's response to the incident and also take over liaison with the police.

2.0 Police liaison and management of the situation

2.1. Once the police arrive the nurse in charge should establish with the police the appropriate course of action. In most instances it will be appropriate for the police to lead the effort to disarm the user.

2.2. The nurse in charge must provide the police with a full risk assessment on the individual concerned so that the response of the police is proportionate and appropriate.

2.3. The Police will set up a perimeter which they control in order to ensure the safety of police officers and others who may already be within the perimeter or entering it.

2.4. If the police are called to attend a serious incident involving weapons or a serious incident involving hostage taking the Trust's Major Incident Policy must be activated and a Major Incident Control Centre established. The following factors will be considered:

- Ongoing police liaison
- Movement in, around and out of unit site
- Potential risks for adjoining units
- Evacuation and relocation plans
- Contact with relatives
- Press liaison
- Communication with the Health Authority and PCTs

2.5. The police must be provided with:-

- A list of patients / residents and staff on the unit concerned (including ancillary staff)
- A secure and private area for the use of specific officers
- Access to staff with detailed knowledge of environment or individuals concerned.

2.6 The incident may last for lengthy period of time and management plans for staff arriving on and going off duty will need to be made. In addition the welfare of other patients / residents will need to be considered up to and after the incident has been resolved.

2.7 Once the user has been disarmed, his/her room and all his/her belongings must be searched in order to establish that no other weapons are hidden.

2.8 Urgent consideration should be given to placing the patient / resident in a more secure environment if the patient / resident are currently residing on an open unit. A full risk assessment on the user concerned must be carried out.

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Therapeutic and Safe Intervention and de-escalation (TASID) the management of Violence and Aggression

The Therapeutic and Safe Interventions and De-escalation training model the Trust have adopted under pins all the principals of the Restraint Reduction Network (RRN) Training Standards 2019 where the focus is on prevention strategies. TASID adopts the world health organisation's approach to reducing violence and aggression Primary Secondary and Tertiary.

Use a restrictive intervention only if de-escalation and other preventive strategies, including p.r.n. medication, have failed and there is potential for harm to the service user or other people if no action is taken. Continue to attempt de-escalation throughout a restrictive intervention. Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance.

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

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

1.0 Decision Making for the Use of Physical Intervention/Restraint Tertiary

1.1 Where risk assessments identify that physical intervention/restraint may be needed, their implementation should be planned in advance and recorded as tertiary strategies within the positive behaviour support plans (or equivalent).

1.2 On other occasions, behavioural disturbance may not have been predicted by risk assessments. In such cases emergency management of the situation and the use of physical intervention/restraint should be based on clinical judgement which takes account of relevant best practice guidance (such as those published by the National Institute for Health and Care Excellence (NG10)) and all available knowledge of the patient / resident's circumstances.

1.3 Restrictive interventions should be used in a way that minimises any risk to the patient / resident's health and safety and that causes the minimum interference to their autonomy, privacy and dignity, while being sufficient to protect the patient / resident and other people. The patient / resident's freedom should be contained or limited for no longer than is necessary. Unless there are cogent reasons for doing so, staff must not cause deliberate pain to a patient / resident in an attempt to force compliance with their instructions (for example, to mitigate an immediate risk to life).

1.4 The choice and nature of physical intervention/restraint will depend on various factors, but should be guided by:

- The patient / resident's wishes and feelings, if known (e.g. by an advance statement).
- What it is necessary to meet the needs of the individual based on a current assessment and their history.
- The patient / resident's age and any individual physical or emotional vulnerability that increase the risk of trauma arising from specific forms of restrictive intervention.
- Whether a particular form of restrictive intervention would be likely to cause distress, humiliation or fear.
- Obligations to others affected by the behavioural disturbance.
- Responsibilities to protect other patient / residents, visitors and staff, and the availability of resources in the environment of care.

1.5 Any use of restrictive interventions must be compliant with the Human Rights Act 1998 (HRA), which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR).

1.6 Where an incident occurs, either spontaneously or as the result of a deterioration of a situation that has not responded to preventative strategies or de-escalation techniques and it is necessary to use advanced management interventions of Physical intervention / Rapid tranquilisation this is considered a Psychiatric Emergency and requires the presence of the following to ensure a safe conclusion of the incident:

- Alarm systems to summon other staff to assist in the management of the incident.
- Grab bags must be available on all inpatient / resident wards / units containing Resuscitation Equipment, including Defibrillator, Bag Valve Mask, and Oxygen, suction, all of which must be contained in good working order
- Attendance of a Doctor.
- Site Co-ordinator upon arrival will be informed and updated on the situation.

1.7 For Nursing Homes where an incident occurs either spontaneously or as the result of a deterioration of a situation that has not responded to prevention strategies or de-escalation techniques and it is necessary to use advanced management interventions of Physical intervention / Rapid tranquilisation this is considered a Psychiatric Emergency and requires the presence of the following to ensure a safe conclusion of the incident:

- Alarm systems to summon other staff to assist in the management of the incident.
- Grab bags must be available containing Resuscitation equipment including Defibrillator, Bag Valve Mask, and Oxygen, cannula, fluids, suction, all of which must be contained in good working order.
- Nurse in Charge

Source: NICE Clinical Guideline QS154 Violent and aggressive behaviours June 17.

- Contact Nursing Home Manager

1.8 Where a patient / resident is restrained unintentionally in a prone/face down position, staff should either release their holds or reposition into a safer alternative as soon as possible.

1.9 In all circumstances where restraint is used one staff member must monitor the patient / residents head, airway and physical condition throughout the restraint to minimise the potential of harm or injury. Observations that include vital clinical indicators such as pulse, respiration and complexion (with special attention to pallor or discoloration) must be carried out and recorded. Staff must be trained to be competent to interpret these vital signs. If the person's physical condition and/or their expressions of distress give rise to concern, the restraint must stop immediately.

1.10 Staff must continue to monitor the patient / resident for signs of emotional or physical distress for a significant period of time following the application of restraint.

1.11 Staff must only use methods of restrictive intervention for which they have received and passed professional training. Training records must record precisely the techniques that a member of staff has been trained to use.

1.12 A member of staff should take responsibility for communicating with the person throughout any period of physical intervention in order to continually attempt to de-escalate the situation.

1.13 Staff must not cause deliberate pain to a person in an attempt to force compliance with their instruction. Where there is an immediate risk to life, in accordance with NICE guidelines, recognised techniques that cause pain as a stimulus may be used to mitigate that risk. These techniques must be used proportionately and only in the most exceptional circumstances and never for longer than is necessary to mitigate the risk to life. These techniques can only be used by trained staff having due regard for the safety and dignity of patient / residents.

1.14 People must not be deliberately restrained in a way that impacts on the airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, ribcage and/or abdomen. There must be no planned or intentional physical intervention of a person in a prone/face down position on any surface, not just the floor. This will best be achieved through the adoption and sustained implementation of restrictive practice reduction programmes and the delivery of care pathways that incorporate Positive and Proactive Behaviour Support Plans or equivalent.

1.15 Where unplanned or unintentional incidents of any restrictive practice occur there should always be recording and debrief to ensure learning and continuous safety improvements.

Source: NICE Clinical Guideline QS154 Violent and aggressive behaviours June 17.

1.16 Staff must not deliberately use techniques where a person is allowed to fall, unsupported, other than where there is a need to escape from a life threatening situation.

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

1.18 Prone restraint should not form part of a planned intervention and must be viewed as an unplanned event. There may be exceptional circumstances where a patient / resident may request to be restrained in the prone position and these will need to be discussed as an MDT with the patient / resident to explore the reason for this request and appropriate plan recorded and circulated to all staff.

2.0 Using Physical Intervention/Restraints

2.1 When a decision to use physical intervention has been made the Nurse in charge should where ever practical carry out the following actions:-

- Assemble a physical intervention team.
- Inform the team of what the patient / resident is likely to do.
- State any possibility of infection and take appropriate precaution.
- Direct other staff not involved in the physical intervention with tasks such as removal of obstacles, management of other service users etc.
- Feeding in substitute members of staff where fatigue or injuries dictate.
- Prepare Rapid tranquilisation medication when this decision is made.
- Prepare the seclusion room (if appropriate) if this decision is made.
- Ensure the attendance of a doctor / duty doctor.
- Ensure Emergency resuscitation equipment is present at the incident.

2.2 The designated team if possible and time allows should determine team roles, especially the allocation of the lead for the physical intervention who will take on the responsibilities listed below. Be briefed on the situation and possible causes and determine a plan of management of the incident including expected outcome of the physical intervention.

2.3 One member of staff should assume control throughout the process. He or she is responsible for:-

- Liaison with the nurse in charge.
- Maintaining de-escalation techniques with the patient / resident and creating a dialogue of communicating the actions the team will take with the patient / resident to achieve a quick and favourable outcome.
- Setting out for the patient / resident the clear, positive instructions and expectations of behaviour that will end the use of physical intervention.
- Respond to and reinforce all compliance by the patient / resident.

- Protecting and supporting the patient / residents head and neck, where required. (The protection of the head constitutes a duty of care owed to the patient / resident).
- Ensuring their airway and breathing are not compromised.
- Ensuring vital signs are monitored.
- Leading the team through the process by giving clear instructions and relevant information.

2.4 If a physical intervention ends up on the floor a head person must physically be in place or an identified member of the team accepts that responsibility. In exceptional circumstances if this is not practicable (possibly due to environmental factors) then another member of staff must take over the roles and responsibilities of the head person as outlined above.

Other considerations for the use of physical intervention must include.

- Strict avoidance of excess weight being placed on any area, but particularly the areas of fingers, head, neck, thorax, abdomen, back or pelvic area.
- Where possible the use of at least one same staff to patient / resident gender especially where female patient / resident physical intervention is concerned, if necessary substitute physical intervention staff as required and safe to do so.
- Determining the end of Physical intervention must be the decision of the physical intervention team leader. They should take into account where appropriate advice from other physical intervention team members the Doctor and Nurse in Charge and considered factors such as:-
- Has the patient / resident calmed sufficiently for physical intervention to be terminated. If so what follow up interventions are to follow? I.e. observation levels, movement to low stimulus environment etc.
- Has physical intervention been used for an excessive amount of time with no response from the patient / resident? Consider Rapid Tranquillisation and or Seclusion as alternatives to lengthy physical intervention with attendant risks.
- Maintain continual assessment of the patient / resident to enable early reintegration into the main ward environments.

2.5 When physical intervention has been used, staff must report the incident on Datix and include all the restraint details. Following any violent incident event in mental health and learning disability services, the priority is reconciliation. The continued development of the therapeutic relationship between staff patient / resident can be enhanced by the acknowledgement of any incident event. Ideally on the day following any incident where appropriate staff and the patient / resident should meet to discuss the event, the rationale for any procedures used, triggers and causes of the incident and plans regarding how future incidents may be avoided.

2.6 In Community Health Services a post incident review would be undertaken prior to any future service provision to the patient / resident.

Source: NICE Clinical Guideline QS154 Violent and aggressive behaviours June 17.

3.0 Post Incident Management

3.1 Account for all patient / residents and staff ensuring their safety and wellbeing, (incidents have been used to distract staff to allow other patient / residents to self-harm or abscond etc.). Determine the safety of the environment for continued care of patient / residents.

3.2 A Doctor must examine the patient / residents for physical injuries especially where an injury has occurred or is suspected and or adverse symptoms are observed this might include breathlessness, fainting or potential head trauma. This examination must be recorded in the healthcare records. Any injuries or adverse symptoms of the patient / resident, staff or others must be reported.

3.3 Nursing staff must carry out basic vital signs observations as soon as possible after the event especially if physical intervention and rapid tranquilisation procedures have been used. This should be repeated up to every 4 hours (more frequent if necessary) and for up to a period of 24 hours minimum and recorded on a MEWS chart. After this period the Doctor and Nurse should decide if monitoring should continue on a regular basis if necessary.

3.4 In conjunction with the Doctor, make an assessment of the patient / resident potential to relapse consider all possibilities regarding safety, including observation status and staffing levels. Consideration must be given that includes transfer to more secure services such as a Psychiatric Intensive Care Unit (PICU).

3.5 If required inform senior management of the incident and the seriousness of the incident. Update frequently on actions taken.

3.6 Anyone present at the time of the incident will be offered immediate debrief support this includes staff, patients / residents and visitors who were involved or in the area.

3.7 If there are 5 incidents with 1 patient / resident in 1 week a review needs to be undertaken with someone not involved in the incident.

3.8 All incidents of prone restraint must be reviewed and lessons learnt.

3.9 Patients / residents should be given the opportunity to record and have filed within their healthcare records their view and account of their experience, including that of any intervention used.

Essex Partnership University
NHS Foundation Trust

VIOLENT PATIENT MARKER PROTOCOL

POLICY REFERENCE NUMBER:	Appended to TASID Policy (Appendix 8a) (RM05)
VERSION NUMBER:	3
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RATIFICATION BY QUALITY COMMITTEE:	April 2024
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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.

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this Protocol is the Executive Nurse

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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 maker 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

Last Name			First Name		
NHS No.		Date of Birth		Unit / Ward	

Alert Form

VIOLENT PATIENT MARKER REQUEST/ALERT

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

- Is there an immediate risk to life or property? If yes – please call the police on 999 and state 'there is an immediate risk to life or property'
- Is an immediate response required to alerts staff (if yes please contact the Risk Team on 01268 739731)
- Nature of any relevant incident (physical or non-physical violence)
- Degree of violence perpetrated
- Injuries sustained by the victim
- The level of risk posed by the individual
- Impact on staff of relevant incident
- Impact on service provision
- Likelihood of a reoccurrence
- Time delay since relevant incident
- Outcome of last clinical review
- If request is driven by other factors – what are they
- All evidence of risk of violence to be recorded on this form
- Next appointment date for individual
- Is this escalating behaviour
- Mental health state and capacity of individual
- Physical health state of individual

Date of request		Dates reviewed	
Perpetrator			
First Name		Last Name	
Date of Birth		NHS Number	

Patient		Relative / Carer		Ex – Patient		Member of the public	

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

	First Name	**Last Name**
Responsible Clinician		
Care Coordinator		

		Yes	**No**
Is this an urgent request – is there an imminent threat			
If there is an imminent threat, please tick what action has been taken	**Reported to police**		
	Staff all safe		
	Trust property secure		
	Line Manager informed		
	Datix completed		
	Risk reviewed		
	Control measures in place		

Incident History					
Nature of previous incidents ***(please mark all that apply)***					
Physical violence / assault harassment		**Threats to kill**		**Threats to harm**	
Stalking		**Attempted assault**		**Firearms**	
Knife / blade		**Other weapons**		**Verbal abuse**	
Criminal damage		**Other – please state**			
Please give a summary of the most recent Trust incident including date of incident and Datix reference number if known					
What was the degree of violence used or threated					
Negligible ***(no harm)***		**Minor** ***(low harm)***		**Moderate** ***(moderate harm)***	
Major ***(severe harm)***		**Catastrophic** ***(death / catastrophic)***			

Last Name		First Name	
NHS No.	Date of Birth	Unit / Ward	

What injuries were sustained by the victim – physical and non – physical				
What was the impact of the incident on staff and others who witnessed it				
Was mental health state a contributing / causative factor	Yes		No	
Was there any impact of the last incident on service provision *(if yes please explain e.g. building locked down)*				
Was this an isolated incident or part of an escalating pattern of behaviour				

Risk Rating Information

What is the likelihood that this incident will be repeated

How likely a risk is to occur or to recur is an important part of assessing a risk and its ability to cause harm. Some risk only cause harm with repeated exposure, others by their very nature are harmful with only one occurrence. Assess how likely a risk is to occur or recur according to the table below.

Likelihood of Risk

Level	Detail description examples	Tick
1	Rare This will probably never happen / recur or may occur only in exceptional circumstances (<20%). The expected frequency is no more than once.	
2	Unlikely Do not expect it to happen / recur but it could occur at some time (21 – 40%)	
3	Possible Might happen or recur at some time (41 – 60%)	
4	Likely Will probably happen or occur in most circumstances (61 – 80%)	
5	Almost certain Is expected to occur in most circumstances or recur, possibly frequently (>81%)	

What is the potential impact of a reoccurrence

1		2		3		4		5	
Negligible *(no harm)*		Minor *(low harm)*		Moderate *(moderate harm)*		Major *(severe harm)*		Catastrophic *(death / catastrophic)*	

Last Name		First Name	
NHS No.	Date of Birth	Unit / Ward	

The overall score or Risk Rating is determined by multiplying the impact and the likelihood scores together. The grid below should be used to circle the overall risk rating

Risk Rating

		Impact									
		1		2		3		4		5	
Likelihood	1	Low 1		Low 2		Low 3		Medium 4		Medium 5	
	2	Low 2		Medium 4		Medium 6		Medium 8		High 10	
	3	Low 3		Medium 6		Medium 9		High 12		High 15	
	4	Medium 4		Medium 8		High 12		High 16		Extreme 20	
	5	Medium 5		High 10		High 15		Extreme 20		Extreme 25	

Forensic History ***(please include any criminal violence where the individual was not charged by the police)***

Date	Offence / charge	Outcome / sanction *(include no further action from police)*

Is the person on Probation	**Yes**		**No**	
Has the person been referred to the CJMHT	**Yes**		**No**	

Current mental health diagnosis / issues

Current MHA status ***(include CTO)***

Last Name		First Name	
NHS No.	Date of Birth		Unit / Ward

Current clinical risk		
Risk	**Reason**	**Plan in place**

Please list services accessed by patient		
Service	**Frequency**	**Point of contact**
E.g. Depot Clinic at Warrior House	***E.g. Weekly***	***E.g. CPN Smith***

Action to be taken by staff that will have contact with this individual		
Please give specific instruction as to what action is required that has been agreed by the clinical team. *(E.g. do not visit at home, must be seen by 2 clinicians, banned from unit please call the police etc.)*		
	First Name	**Last Name**
Form completed by		
Team Manager		
Date		

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

Please return form to your LSMS in the Risk Team for a violent marker / risk alert to be presented to the Security Management Director for approval and placing on the record						
For LSMS/SMD use only						
	First Name		**Last Name**			
Approved by						
Date marker placed on record		**Patient informed**	**Yes**		**No**	
Date patient informed		**How was patient informed**				
Reasons for informing/not informing patient						
Date marker reviewed		**Marker retained or removed**				
Date removed from record		**Date patient informed of removal**				
MARKER DENIED						
	First Name	**Last Name**				
Denied by						
Reasons for denial						

Signature		**Date Completed**	
First Name		**Last Name**	
Designation			

Essex Partnership University
NHS Foundation Trust

Date:

Recipient's address

Department / Unit / Person
Made-up-place
1 Fiction Road
Countrytown
Anyshire
L12 3AB

Tel: 01234 000000
Fax: 01234 000000
Email.address@nhs.net

Notification of risk of violence marker being placed on an NHS record

Dear ……

I am writing to you on behalf of EPUT as the Security Management Director. Working with the Local Security Management Specialist, part of my role is to protect NHS staff from abusive and violent behaviour and it is in connection with this that I am writing to you.

(Insert summary of behaviour complained of, include dates, effect on staff/services and any police/court action if known)

Behaviour such as this is unacceptable and will not be tolerated. EPUT is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence, threats or abuse.

The NHS Constitution makes it clear that just as the NHS has a responsibility to NHS patients, so patients have a responsibility to treat staff with respect and in an appropriate way.

All employers have a legal obligation to inform staff of any potential risks to their health and safety. One of the ways this is done is by marking the records of individuals who have in the past behaved in a violent, threatening or abusive manner and therefore may pose a risk of similar behaviour in the future. Such a marker may also be placed to warn of risks from those associated with service users (e.g. relatives, friends, animals, etc.).

A copy of the trust policy on risk of violence markers is enclosed/can be obtained from the Trust LSMS.

I/the Violent Patient Marker Panel have carefully considered the reports of the behaviour referred to above and have decided that a risk of violence marker will be placed on your records. This information may be shared with other NHS bodies and other providers we jointly provide services with (e.g. ambulance trusts, social services and NHS pharmacies) for the purpose of their health and safety. This decision will be reviewed by the Violent Patient Marker Panel within four weeks.

This decision will be reviewed again in twelve months' time and if your behaviour gives no further cause for concern this risk marker will be removed from your records.

Any other provider we have shared this information with will be advised of our decision.

If you do not agree with the decision to place a marker on your record, and wish to submit a complaint in relation to this matter, this should be submitted in writing to:

Complaints Department
The Lodge
The Chase
Wickford
Essex SS11 7XX

Tel: 01268 407817
Tel: 01268 739717
epunft.complaints@nhs.net

Yours faithfully,

Trevor Smith
Executive Chief Finance & Resources Officer and Security Management Director

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Pinpoint Operational Procedural Guidelines

1.0 INTRODUCTION

1.1 There are occasions when staff may need to summon immediate assistance from colleagues.

1.2 The Pinpoint Alarm system is an aide for alerting staff to these situations.

1.3 It is essential that the Clinical and Support Services maintain a safe environment for patients, staff, and visitors.

2.0 SCOPE

2.1 This procedural guideline is applicable to all staff, inclusive of nursing, medical, therapy and facilities staff that use the Pinpoint alarm system.

2.2 To assign responsibility and provide instructions for the monitoring and use of the Pinpoint alarm system.

2.3 To ensure every member of staff is aware of all the operational issues, correct and safe use of the Pinpoint alarm system.

3.0 RESPONSIBILITIES

3.1 It is the responsibility of the managers of each department to ensure that these procedural guidelines are adhered to and upheld at all times.

3.2 It is the direct responsibility of the person in charge of a particular shift to ensure the correct and safe use of Pinpoint alarm system.

3.2 It is the responsibility of each staff member to be aware of the correct and safe use and to follow these guidelines.

4.0 IMPLEMENTATION

4.1 The Pinpoint alarm system will alert staff and initiate a response to a situation on the wards or in a department, where assistance is required.

4.2 As part of the local induction it is the responsibility of Senior Sister/Senior Charge Nurse or designated person in charge to ensure that every member of staff has been fully inducted and understands how to operate and respond to calls when issued a Pinpoint Personal Infrared Transmitter (PIT) PIT alarm.

4.3 In the absence of senior staff, it is the responsibility of the person in charge of the shift to ensure the member of staff issued a Pinpoint PIT alarm has signed the unit induction sheet and fully understands the operational issues for using the Pinpoint alarm system.

4.4 The nurse in charge of the shift on the wards and the person in charge of other departments will ensure that all bank/agency staff signs to agree that they fully understand the operational procedures. The Senior Sister / Senior Charge Nurse / Department Manager will hold this form on record.

4.5 On the wards a PIT alarm will be issued by the security nurse on each ward at the commencement of the shift. This will be signed in and out by both the hospitality nurse and the staff member, using appendix 1

4.6 It is the responsibility of the individual staff member to ensure that the PIT alarm is signed for and returned back to the designated ward / area. The staff member will be aware that if the PIT is missing, the last person to whom the PIT alarm was allocated may be held accountable for the loss.

4.7 The records will be kept safe and audited by the nurse in charge, and countersigned by the Senior Sister/Senior Charge Nurse/ Manager on a set day each week that is conducive to the Ward.

4.8 The PIT alarm is to be attached to the loop on the front of the uniform as worn by nursing staff or belt of other staff whilst on duty.

4.9 It is the responsibility of each individual staff member to check the PIT alarm issued to them using the transmitter tester box or testing station within the staff office. Additionally each time they collect their PIT alarm, staff must re-charge it using the testing station provided within the office for this purpose. If the PIT alarm has not been used to activate an alarm it should take less than five seconds to bring it to full charge.

4.10 The PIT alarm system is intended to alert staff and initiate a response to an incident. The PIT alarm has two modes of activation:

The first is by pressing the button on the base of the PIT. This causes the alarm system to generate a pulsing tone. This signals that the user is in a potentially threatening situation.

The second is by pulling the PIT alarm away from the securing pin and dropping it or placing it in a pocket. This causes the system to generate a high pitched continuous alarm which signals that the user is involved in an incident. It is not recommended that the PIT alarm is thrown as this may mislead the system to read the wrong location sensor. **The activated PIT alarm is a source of powerful light and direct contact of the beam with eyes must be avoided.**

4.11 After activating a PIT alarm, it is essential that the PIT is re-charged on the ward or non-ward location using the TTS provided for this purpose. Recharging takes only a matter of seconds.

4.12 The location of an activated alarm will be displayed on the local ward or departmental main display unit as well as repeater panels within the ward or department of activation.

4.13 In addition the system will activate pagers held by allocated members of nursing staff across the wards comprising the facility. These staff will together comprise the Rapid Response Team. No member of this team shall

leave the facility without formally handing over responsibility to another member of the nursing staff.

4.14 In ward areas, staff on duty within the ward will respond immediately to any activated alarm. They will be supported by the Rapid Response Team.

4.15 For activations in non-ward areas the response will be made only by the Rapid Response Team. To assist Rapid Response Team members reaching the source of the activation quickly an over the door "Follow my Leader" light system is provided in all non-ward areas. Rapid Response Team members will also carry a master key allowing entry to all doors throughout the facility.

4.16 The audible alarm will sound until either muted at any of the repeater panels , or until the system is reset at the main panel by using the re-set key system and the pin replaced into the individual PIT alarm. Staff attending the activation will have the option to mute the system at the nearest repeater panel before re-setting at the main display unit. This may be appropriate if the activation was a false alarm or the incident was quickly resolved.

4.17 **It must be noted that the system also has a permanent mute feature. Under no circumstances shall staff permanently mute the system, for example due to repeated nuisance type incidents. However, in the event that the system is inadvertently or accidentally muted a message will flash on the panels after 30 minutes. If this occurs the mute feature must be de-activated immediately.**

4.18 The system also includes an emergency call feature linked to accessible bathrooms and WCs. When activated this will sound a different tone from PITs activated alarms and will register on panels as a patient call.

4.19 All display units and receivers must be tested on a monthly basis by the Estates Department to ensure they are functioning correctly. A silent test function is provided for this purpose. Details of the tests should be recorded by the Hospitality Nurse on the Ward Log.

4.20 Staff working in Reception Area, Corridors etc will be issued their PIT alarm via Reception. The same procedure for testing and signing alarms in and out will apply in these areas.

4.21 For Audit purposes where required the date, time and service of all alarm activations is recorded on a database (Incipog) held centrally within the Basildon Mental Health Unit.

5.0 RECORDING, MONITORING AND REPAIR

5.1 The Security Nurse will check each PIT daily and any problems encountered will be recorded and reported to the Estates Helpdesk, and the Trust Security & Compliance Officer

5.2 If a problem is encountered with the Pinpoint alarm system it is the Site Officer's responsibility to report this to the Estates Department and the Trust Security and Compliance Officer immediately.

END