Salisbury NHS
NHS Foundation Trust

Violence Prevention & Reduction Policy (Incorporating Intervention and Restriction, Lone Workers Guidance)

Type of document

Please tick the relevant box:

Policy (must do)	✓
Guidance (should do)	□
Protocol/procedure (must do)	□

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Post Holder Responsible for Policy:	H&S Manager
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Version	Updated By	Updated On	Description of Changes
1.0	Keith Loader Colette Martindale	01/07/12	New Document
1.1	Keith Loader Colette Martindale	01/07/15	Policy fully updated with regards to reporting of incidents and the process of using Datix Web 3.5.7 The sending of warning letters having been authorised by DSN or Directorate Manager can be delegated to Lead Nurse. 4.5.2 Training updated 4.6 Control & Restraint Team updated 6.0 Inclusion of Violence & Aggression Sub Group. Change to quarterly meetings for Security Management Committee. All Appendices updated with regards to reporting on Datix Web.
1.2	Keith Loader Martin Plastow	12/06/18	All references to NHS Protect removed from 1.3, 2.1, 3.1, 3.5.1, 3.5.2, 3.5.5, 3.5.6, 3.5.11, 4.3, 6.0, 7.1 3.4 Person Alarms replaced with VERA Procedure. All references to Control & Restraint replaced by Intervention & Restriction 4.0, 4.1, 4.2, 4.3, 4.4, 4.5, 4.5.1, 4.5.2, 4.5.3, 4.6, 4.9 4.4 Include Clinically Lead 4.5.3 Include 20mins review, Include Violence & Aggression Sub Committee, Delete LSMS. 4.7 Deleted ED & MAU 5.5 Include VERA 6.0 Delete NHS Protect annual V & A figures. 6.0 Delete monthly, include quarterly
1.3	Keith Loader Martin Plastow	07/03/22	Policy name change to Violence Prevention & Reduction Policy. Minor changes to make reference to Violence Prevention & Reduction Standards. Inclusion of Training Matrix Appendix R. Patient Markers have been replaced with Alerts. 4.4 Refers to the following policies: • Restrictive Physical Intervention and Therapeutic Holding Policy in Children and Young People • Restrictive Practices Policy For Adults (18 years and above)
2.0	Troy Ready H&S Manager	5/3/2024	Major rewrite and transfer of policy ownership to H&S Manager

TABLE OF CONTENTS

1. Preamble
- 1.1 Introduction
- 1.2 Scope
- 1.3 Aim & Purpose
- 1.4 Staff Groups Affected

2. Responsibilities
- 2.1 Roles & Responsibilities
- 2.2 Definitions

3. Managing Violence and Aggression
- 3.1 Managing Violence and Aggression – Quick Action Flowchart
- 3.2 Preventing and Deterring Violent and Aggressive Behaviour
  - 3.2.1 Children and Young People
  - 3.2.2 Confusion, Dementia and Delirium
  - 3.2.3 Anti-Social Behaviour and Patients with Capacity
- 3.3 Body Worn Cameras
- 3.4 Violence Prevention Key Workers
- 3.5 Restraint and Restrictive Practice
- 3.6 VERA
- 3.7 Offensive Weapons

4. Reporting Violent & Aggressive Behaviour

5. Debriefing and Staff Management

6. Consequences of Violent Behaviour
- 6.1 Warning Letter
- 6.2 Exclusion from premises/entry with conditions
- 6.3 Exceptions and conditions of exclusion
- 6.4 Acceptable Behaviour Agreements (ABA)
- 6.5 Provision of services at an alternative location or by an alternative provider
- 6.6 Patient Alert on Medical Records
- 6.7 Recording and Sharing information

7. Reviews, challenges and complaints

8. Delivery and proof of receipt of letter
- 8.1 Hand Delivery (NHS Premises)
- 8.2 Hand Delivery (Home)
- 8.3 Post
- 8.4 Requesting a Response

9. Data Protection

10. External Reporting and Investigation

11. Training

12. Lone Workers Guidance
- 12.1 Lone Workers
- 12.2 Employee Responsibilities
- 12.3 Hazards of Lone Working
- 12.4 Community Based Lone Working
- 12.5 Office Based Lone Workers
- 12.6 Risk Assessments
- 12.7 Duress Alarms

13. Process for Monitoring Compliance & Effectiveness

14. References & Associated Documents

15. Equality Impact Assessment

16. Appendices

1. Preamble

1.1 Introduction

Salisbury NHS Foundation Trust (the Trust) is committed to providing a safe and secure environment for staff, patients and visitors. All staff should expect to come to work without fear of being verbally, mentally or physically abused. Unfortunately, healthcare workers are likely to come across patients, visitors and next of kin who may intentionally, or unintentionally, be abusive or lash out. In accordance with the Health and Safety at Work etc. Act (1974), subordinate Regulations and Approved Codes of Practice, the Trust will develop a strategy to assess the potential risk of violence or aggression, implement strategies to prevent behaviour escalating, and ensure staff are trained on conflict resolution to de-escalate behaviour to reduce the risk of harm, so far as is reasonably practicable.

The NHS England Violence Prevention and Reduction Standard (the Standard) provides a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence. The Trust has undertaken a review of the Standard to ensure each element is met and has developed the Violence Prevention & Reduction Policy (the Policy) in order to outline how the Standard will be met.

1.2 Scope

This policy covers the prevention and management of the risk of violence and aggression towards staff, patients and visitors within the Trust and focuses on improving and reducing that risk. Management of violence and aggression, in any given situation, will always be underpinned by using a therapeutic, hierarchical response based on the principles of de-escalation and least restrictive intervention. (See Appendix A Force Continuum).

The Policy does not cover violence and aggression from one staff member to another.

1.3 Aim/Purpose

The unpredictable nature of patients confronted with the uncertainty and anxiety associated with being in hospital or who are confused, agitated and lack capacity mean staff will be exposed to violent and aggressive behaviour. Notwithstanding the above, the Trust has a duty of care to ensure a safe place for care for patients, and a safe place of work for staff, so far as is reasonably practicable. The Trust is committed to reducing the consequence and likelihood of harm as a result of violence and aggression.

The Policy aims to provide steps on how the Trust will take reasonably practicable steps to manage and respond to violence and aggression. Actions include, but are not limited to:

- Guidance, education and resources for staff to adapt and undertake dynamic assessments to ensure their safety, and the safety of others.
- Guidance, education and resources on managing violence and aggression in:
    - Children and Young People,
    - Patients with confusion and lack capacity,
    - Patients and next of kin displaying antisocial behaviour.

Demonstrating what is reasonably practicable in managing violence and aggression across the Trust will be through the availability of documented risk assessments completed by the:

- Trust H&S Manager for divisions and wards where there is a risk of violence and aggression, and
- Ward Managers for specific patients with a risk of violent or aggressive behaviour.

Individual risk assessments are an ongoing and dynamic process that must reflect

changes to the environment and patient behaviour. Advice and support on risk assessment can be sought from the H&S Manager, CAMHS, MHLS, Security or Clinical Lead but must be completed on admission, at each patient review and as circumstances change.

1.4 Staff Groups Affected

All staff who work within the Trust, including all voluntary workers and those persons who are not directly employed by the Trust (e.g. other NHS employees, GPs visiting the site and contractors). The Policy also covers staff who are working for the Trust in the community, in patients' homes or other premises.

2. Roles, Responsibilities and Definitions

2.1 Employer Roles and Responsibilities

The Trust Board	The Trust is responsible for ensuring a systematic approach to the management of violence and aggression exists, is subject to review and remains effective.
Chief Executive Officer (CEO)	The CEO is responsible for ensuring the Trust has developed an approach to manage the risk of violence and aggression and has a process to ensure this process is effective.
Chief People Officer (CPO)	The CPO is the executive lead, nominated by the CEO, to oversee the management of and prevention of V&A across the Trust. The CPO will work with the Violence Prevention and Reduction Working Group (VP&RWG) Chair to ensure a strategy to manage violence and aggression is developed.
Divisional Managers	Are responsible for implementing Trust wide strategies developed by the VP&RWG within the Division and ensuring Divisional representation at the VP&RWG.
Local Security Management Specialist (LSMS)	The LSMS is externally accredited and delegated responsibility for the overall security of the Trust's premises and protection of staff, patients and visitors. The LSMS will: Develop relationships with clinical services to promote early recognition, prevention and de-escalation of potential aggression with the focus on reducing the risk of its recurrence. • Promote evidence based best practice, from a security management perspective. • Analyse security incidents in a consistent manner to identify trends, draw conclusions and make recommendations. • Applying sanctions by one or more of a combination of civil, criminal, disciplinary and procedural measures. • Creating proactive security awareness and minimising the risk by promoting the deterrence and prevention of breaches of security. • Report on security performance to the Health and Safety Committee and Security Management Committee. • Develop Trust policies and procedures relating to security issues. • Ensure that victims of crime are supported. • Investigating breaches of security in a fair, objective and professional manner. • Liaising with external agencies as appropriate, e.g. Police, Crown Prosecution Service. • Promoting a range of proactive and reactive security generic actions. • Providing expert security advice to protect people, property and assets. • Seeking redress through the criminal and civil justice systems against those whose actions lead to the loss of NHS assets and resources.

	• Support and advise Managers undertaking security risk assessments either as part of a rolling programme or at the request from managers by reviewing the current situation and make conclusions and recommendations. • Advising on all aspects of the physical security of buildings. • Carry out security inspections on all Trust sites when required. • Investigate on any security related incidents as directed.
Matrons, Clinical Leads & Ward/ Department	Matrons, Clinical Leads & ward/department leaders must make arrangements for the effective implementation of this Policy. This includes: 1. Promoting a culture of early recognition, prevention and de-escalation of potential aggression, using techniques that minimise the risk of its recurrence. 2. Assess the risk to patients and staff and complete individual risk assessments for patients presenting with a risk of violence and aggression 3. Instruct staff on the policy and ensure on-going communication mechanisms, such as staff meetings, supervision, post-incident reviews etc. 4. Attend internal violence reduction training.
Staff	Staff should not place themselves in harm's way. Staff have a responsibility to follow safe working practices and: 1. Take reasonable care of their own health and safety 2. Co-operate with managers to implement measures to reduce incidents of violence and aggression 3. Be aware of their own behaviour when confronted with abuse or the potential for conflict or violence to occur 4. Not retaliate or interact in a manner likely to inflame or aggravate the situation 6. Follow the requirements of the Policy 7. Report all incidents and near misses of abuse and violence using the DATIX incident reporting system 8. Attend internal training.
Child and Adolescent Mental Health Services (CAMHS) and Mental Health Liaison Service (MHLS)	To assess the mental capacity of patients, develop clinical action plans and advise on the provision of a safe environment for patients, where mental health contributes to episodes of violence and aggression.
H&S Manager	Develop H&S performance measures and actions to demonstrate reduction in injuries, time lost and exposure to risks in the workplace. Performance measures will include V&A results. The H&S Manager will chair the VP&RWG
Patients, next of kin & visitors	To behave in a way that does not result in harm to staff through violent, aggressive or intimidatory conduct.
Violence Prevention and Reduction Working Group	Monitor the management of violence and aggression, develop actions for the Trust to consider in improving the management of violence and aggression, reporting to the Health and Safety Committee and to the Security Management Committee.

2.2 Definitions

Definitions relating to violence and aggression are included below:

Violence and aggression – refers to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether violence or aggression is physically or verbally expressed, physical harm is sustained.

Work-related violence - The Health and Safety Executive (HSE) defines it as any incident in which a person is abused, threatened or assaulted in circumstances relating to their work. This can include verbal abuse or threats as well as physical attacks.

Assault – refers to the intentional application of force to another person without lawful justification resulting in physical injury or personal discomfort.

Verbal Abuse - The use of inappropriate words or behaviour causing distress and/or constituting harassment.

Rapid Tranquillisation - The use of medication to calm the patient, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression, thereby allowing a thorough assessment to take place and allowing comprehension and response to spoken messages throughout the intervention.

3. Managing Violence & Aggression Guidance

3.1 Quick Action Flowchart

Verbal Warning and Risk Assessment
Do not put self, or remain, in harms way (considering the need to manage a risk of falls, self-harm or harm to vulnerable patients such as the elderly, disabled and children) Ward Manager, Nurse in Charge, Site Manager, Matron, or Consultant to assess the cause of the aggressive behaviour, taking into consideration confusion, dementia, delirium or capacity and complete a dynamic risk assessment of the risk to the patient, others and staff. The behaviour is reviewed with the patient and consideration as to whether an understanding or behaviour agreement can be made with the patient or whether further mitigations (RMN, 1-1 care, etc.) should be made. Consideration can also be given to change of bed or ward location, changes to their medication, care plan etc. If, on assessment, there is a significant risk in the aggressive behaviour, immediate action may need to be taken to minimize the risk of harm to the patient or any other person. This might involve immediate physical or pharmacological restraint; in the patient's best interests A Care Plan should be simultaneously completed to manage and minimize the risks going forward, which may involve multidisciplinary and multiagency review, and a process put in place to review this Care Plan. Verbal feedback can still be given to the patient that their behaviour is unacceptable If the behaviour is not the result of confusion, dementia or delirium and continues, then a formal verbal warning can be issued to the patient; the patient will be told politely but assertively that the Trust does not tolerate staff receiving abuse. Report on Datix.

Formal Written Warning
Continue to remain outside of harms way and in addition to the above: Call Security Matron, Divisional Head of Nursing, Site Manager, or Consultant informs the patient violence and aggression is not acceptable and that a continuation will result in a formal written warning Review and update risk assessment to manage patient. If patient or next of kin or visitor does not modify behaviour issue written warning. Report on Datix Flag behaviour on Lorenzo and patient notes

Letter of Exclusion
If, despite issuing a verbal and written warning, the patient continues to display abusive behaviour, or there has been an assault on staff, consider a move to exclude the patient, next of kin or visitor from site. Matron, Divisional Head of Nursing, Site Manager, or Consultant informs the patient violence and aggression is not acceptable and that if behaviour continues, a panel will be convened to consider exclusion from the Trust. In the event of behaviour in ED, the Consultant in Charge in consultation with Duty Manager and Exec on call can consider and action exclusion. Formal written warning Review and update risk assessment to manage patient. Report on Datix Flag behaviour on Lorenzo and patient notes

3.2 Preventing and Deterring Violent and Aggressive Behaviour

Whilst the Trust does not condone violence and aggression, there are many environmental and operational factors that can contribute to frustrations that lead to acts of violence and aggression that are beyond the control of the Trust. These include but are not limited to:

- Cancelled clinics and appointments or delays in treatment
- Delays in being seen, especially in ED
- Delays in transfers
- Lack of staff availability to see or respond to patients in a timely manner.
- Shortages of managers and reception staff resulting in a lack of information, poor or absent communications and services
- Overcrowding, noisy waiting rooms, inadequate seating
- Smoking or vaping within the hospital and its grounds

In all circumstances swift action to prevent an incident escalating is essential. Trust staff may be able to quickly defuse the situation by using the skills they have learnt on Conflict Resolution Training courses and/or a combination of the following behaviours:

1. Identify self, presenting ID to avoid
2. Adopting a sympathetic, empathic, understanding approach, and attempt to show an understanding of the person's position
3. Speaking calmly and standing with an open posture remaining balanced and ready to move away
4. Allowing individuals to discuss the source of concern and offering to help if possible
5. Not disagreeing or countering an argument where it is not necessary
6. Not giving orders or using status or authority as a threat

7. Not making threats or promises that cannot be carried out or offering rewards for what probably started out as improper and possibly unlawful conduct
8. Controlling behaviour in body language, feelings, expressions or gesticulations
9. Being alert and sending for assistance and being prepared to leave immediately to avoid an escalation of the situation or possible injury
10. Remain calm and state politely but assertively that the behaviour is unacceptable, pointing out why the particular behaviour is inappropriate or offensive.

Despite attempts to prevent violent and aggressive behaviour still occurs. The Trust has recognised abuse, violence and aggression stems a number of key areas, and has developed measures to reduce the frequency, and consequence, of harm and to ensure an appropriate response to protect staff. The key areas associated with violence and aggression are:

- Children and young people
- Patients with confusion, dementia and delirium that lack capacity, and
- Anti-social behaviour from patients, visitors and next of kin who have capacity.

3.2.1 Children and Young People

Patients admitted with mental health and behavioural concerns is challenging to both patient and staff. Patients have displayed ongoing aggressive behaviour, acts of violence and damage and extended admissions often increase the risk of self harm or assault of staff. The Trust therefore relies upon effective observation from external resources such as an RMN, and community carers who may be aware of warning signs, understand how to intervene effectively, can communicate positively to calm a patient down.

Identifying triggers that cause a patient to become violent and aggressive is a key to preventing harm to staff and patients. Clear strategies to prevent violence and aggression relies upon input from CAMHS, or the MHLS, and ongoing consultation with clinical staff to ensure staff do not come to harm. In managing the risk of violence to staff, ward managers will complete an enhanced nursing care plan to identify actions that prevent self harm and harm to others. Any care plan should consider:

- Use of Restrictive Practice Policy.
- 1:1 supervision from an RMN or carer.
- Consultation with CAMHS or MHLS.
- Daily Multiple Disciplinary Team (MDT) discussions
- Nursing the patient in a side room.
- The reasonably practicable removal of equipment and furniture that could be used as a weapon, for self-harm or to cause damage. Mindful the room will not be akin to a safe room, will require access to emergency equipment and will retain numerous ligature points that cannot be removed.
- Use of seclusion mattress and soft furniture that cannot be used as a weapon or to cause damage and removal of standard hospital beds and movable furniture.
- Security presence on the ward if violent or aggressive behaviour escalates.
- Intervention by Matron and Divisional Head of Nursing where violence and aggression manifests.

If violent or aggressive behaviour continues consideration should be given to notifying the police.

It is also necessary, once the situation has been deescalated to explain to the patient how behaviour was unacceptable, the impact behaviour has on the department and discussions on introducing a behavioural agreement to reach an agreement on acceptable standards of behaviour.

3.2.2 Patients with confusion, dementia and delirium that lack capacity

The Trust has seen an increase in the reports of violence and aggression from patients admitted with confusion, dementia, and delirium. The management of violence and aggression within this cohort of patients is nuanced, must be clinically led and cannot rely exclusively on the use of security, 1:1 observation or isolation. There are often underlying medical conditions that require diagnosis and treatment, and the management of confused patients requires time and patience to understand patients' thoughts and clarify realities.

In managing the risk of violence to staff clinical staff will complete a local care plan that includes, but is not limited to:

- Completing the dementia care bundle
- Refer to the Acute Delirium Care Pathway
- Use of the Mental Capacity Act Framework
- Consultation with MHLS
- Enhanced Nursing Assessments
- Fluid and bowel charts
- Medical intervention to manage cause of confusion and delirium
- Referral to Trust Dementia Lead
- Training and education
- Completing the 'This is Me' booklet
- Patient falls assessments to determine if patients are safe to wander.
- Distraction techniques – fidget mitts, lived realities, wandering, and memory stop café, clocks and calendars.
- 1:1 supervision.
- Documenting and communicating individual triggers that cause violent and aggressive reactions to staff.

3.2.3 Anti-social behaviour / individuals with capacity

It is important to recognise and understand banter, innuendo, raised voices, rude gestures or environmental stressors can cause, escalate or provoke people to become frustrated and angry and this can subtly or very quickly turn into overt aggression or violence. This may be within the ward environment, outpatients and in ED.

Staff should be mindful that violence and aggression born of agitation and frustration can escalate quickly. Staff must be aware of personal safety and always ensure an escape route exists when consulting with a patient, next of kin or visitor and to ensure patients, visitors and next of kin are not between you and a door. This is especially so within consult rooms where patients and staff are having confidential discussions.

If there is an immediate risk of harm, it will be necessary to disengage from the individual, call security for assistance or use the personal alarm if issued to alert local staff members. Where this is not possible staff can, according to the Trust Restrictive Practice Policy (Appendix B), use such force as is reasonably necessary and proportionate to defend themselves for the specific purpose of creating an opportunity to escape.

The Trust has adopted a reduction of violence and aggression campaign based on advice from Wiltshire Police Operation Cavell's No Excuse For Abuse. Posters and campaigns seek to visualise issues of violence and aggression, generate awareness of the problem and are expected to indirectly reduce the harm to staff. In trying to manage the risk of violence and aggression the Trust will consider resources such as the Design Council's Reducing Violence and Aggression Through a Better Experience project.

In the rare event of a firearms or weapons attack, adopt "RUN, HIDE, TELL". In extremis, the Trust's premises may need to be put into 'lockdown' and the Major Incident Emergency plans may need to be activated (please refer to these relevant policies).

3.3 Body Worn Cameras (Emergency Department and Security Staff)

The primary purpose for using Body Worn Cameras (BWC) within the Trust is to improve the safety of patients, visitors, and staff. More specifically BWC useage is expected to deter individuals from violent behaviour and to provide evidence to the police should staff be subject to violent conduct. BWC are most frequently worn by ED and Security staff but are available to other clinical areas as a need arises.

3.3.1 ED staff

BWC's are kept within ED in docking stations for staff to sign out and return at the end of the shift. Staff are responsible for operating the BWC for the shift duration. Any incidents recorded must be reported by staff to the nurse in charge and reported on Datix.

3.3.2 Security Staff

BWC will be signed out by the security officer at the commencement of each shift and will be responsible for operating the BWC for the shift duration. Any incidents recorded must be reported by to the Security Manager and reported on Datix.

The Security Manager will administer the BWC system and liaise with other departments and agencies for release of footage if appropriate and relevant.

3.4 Violence Prevention Key Workers

The Trust will train workers to provide a local ward response to the immediate risk of violence and aggression through techniques that seek to diffuse a situation, and prevent acts of violence and aggression escalating. The Trust will refer to such staff members as Violence Prevention Key Workers (VPKW).

To become a VPKW individuals will complete the following internal and external training:

- Conflict Resolution eLearning
- Trauma Informed Care eLearning
- Introduction to Violence Reduction eLearning
- Mental Capacity Act and Deprivation of Liberty Safeguards Workshop
- Prevention and Management of Violence & Aggression Workshop.

VPKW's will be asked to attend key worker meetings to be scheduled on an annual basis and share information with departments to improve the local management of violence and aggression. Information from the meetings will be reported to the Violence Prevention and Reduction Working Group.

3.5 Restrictive Practice

Despite best efforts to manage behaviour the use of restraint: physical, mechanical, environmental or pharmacological may be required. For example, an immediate risk of physical assault, dangerous, threatening or destructive behaviour, or attempts to abscond when detained under the MHA or a Deprivation of Liberty Safeguard.

The use of all restraint must be in accordance with the Trust Restrictive Practice Policy (Appendix B):

- Use the least restrictive approach at that moment in time, and reduced as the patient de-escalates.
- Be applied only as long as is absolutely necessary.
- Not rely upon the deliberate application of pain.
- Be carried out by staff who are appropriately trained.
- Cease if there is a risk to the safety of the patient and consider alternative restraint methods.

The use of restraint must balance the need to ensure the safety of staff, and others, against what is reasonable, necessary and the least restrictive option available. In most circumstances, physical restraint will be undertaken by security staff trained and competent

to undertake restraint and hold patients. But the use of restraint must be led, and overseen, by clinical staff present during the use of restraint.

In addition to physical restraint, other reasonable, necessary and least restrictive options include rapid tranquillisation, seclusion and observation. Reasonable, necessary and least restrictive practices must never include aids to secure patients to beds, chairs or fixed objects, unless used by Prison Officers or Police.

Violence that occurs suddenly, and without time to de-escalate or summon help, may require immediate physical action in self defence. The use of self defence is acceptable in law, providing the amount of force is reasonable to prevent harm and the use of force is proportionate to the level of immediate threat. In almost all instances, this will be limited to taking steps to remove a patient holding staff, taking defensive steps to stop being struck and creating a safe distance to ensure harm is not caused.

The LSMS, Clinical Lead and Safeguarding Team can advise on the best and next line of action which may prevent an incident occurring. It is important to remember that we can, as a Trust, in the right circumstances, take the following actions to prevent or redress a situation.

Involve other specialist staff: police, clinical psychologists, security team

- Impose sanctions,
- Have patient / relative behaviour agreements
- Operate warning system to manage inappropriate behaviour
- Place violent patient markers on individuals' medical records
- Withdraw treatment (except in emergencies)
- Clinical management as appropriate
- Prosecution by magistrate or Crown Court via the Crown Prosecution Service.

3.6 Vulnerable, Emergency, Response, Action (VERA)

As part of the resilience planning, the Trust has introduced a procedure for staff to use if they are in a compromised and difficult situation and become isolated in a clinic or office and feel they are at risk from another person. By the use of a "safe word" system, where if staff feel they are at risk they can use this word when raising an alarm and a response will be instigated. The person who has confronted that member of staff will not be aware they have raised an alarm. The safe word is 'VERA' - VERA means 'Vulnerable, Emergency, Response, Action'. If a member of staff finds themselves in a compromised situation raise the alarm by:

1. Dialling 2222
2. Switchboard will answer with 'Emergency' and wait for a response
3. Give this exact message to main switchboard: 'Give your name, exact location and request 'VERA'. Switchboard will link with the security team who will go to that location.

Please note this does not replace calls for assistance for security this is a response for a compromised situation only.

3.7 Offensive Weapons

Where a person is brandishing a weapon that is likely to cause harm in a threatening manner that creates an imminent risk of harm it is important to remain calm, obtain assistance from the security team, secure the safety of patients and if appropriate contact the police via 999. In the event of an immediate risk, it is essential to ensure your own safety at all times. Key actions include:

- Not trying to disarm the person,
- Clearing the immediate area calmly, and
- Contacting security,

A dementia patient brandishing a cutlery knife whilst using a zimmer frame does not pose an imminent risk to staff, or patients, if brandishing a knife in a threatening manner. In this instance if there is no immediate risk of harm and it is reasonable to ensure the safety of self and others by diffusing the situation from a reasonable distance.

4 . Reporting Violent & Aggressive Behaviour

Where the incident is of a serious nature, or is happening there and then, contact should be made immediately with the security team via 2222 informing them of your location. Further assistance may then be requested such as the police depending on the nature and seriousness of the incident.

Where any person is the subject of an assault, aggressive behaviour or unacceptable behaviour, this must be reported as soon as possible on Datix. Where a member of staff is the victim, and cannot report on Datix, their line manager should do so. The Trust and unions encourage staff to report an assault to the police, but this decision remains an individual decision by the person assaulted.

Where a patient is the victim, it is the responsibility of the person in charge of that patient at the time of the incident report as above. If the victim is a visitor then, if applicable, it would be the witnessing member of staff or the member of staff the incident is reported to report it.

All Datix incident reports will be regularly monitored by the LSMS, Health and Safety Manager and Risk Management Team to determine whether there needs to be further investigation by the LSMS and any additional support given to those members of staff affected. This will also provide a system to support staff in completing and updating risk assessments.

5. Debriefing and Staff Management

Instances of violence and aggression should be subject to a post incident huddle to ensure lessons are learned from incidents and that action is taken to prevent the risk of re-occurrence. Post incident reviews would be expected to identify what led to the incident and what could have been done differently to prevent behaviour escalating and communicating this to the team.

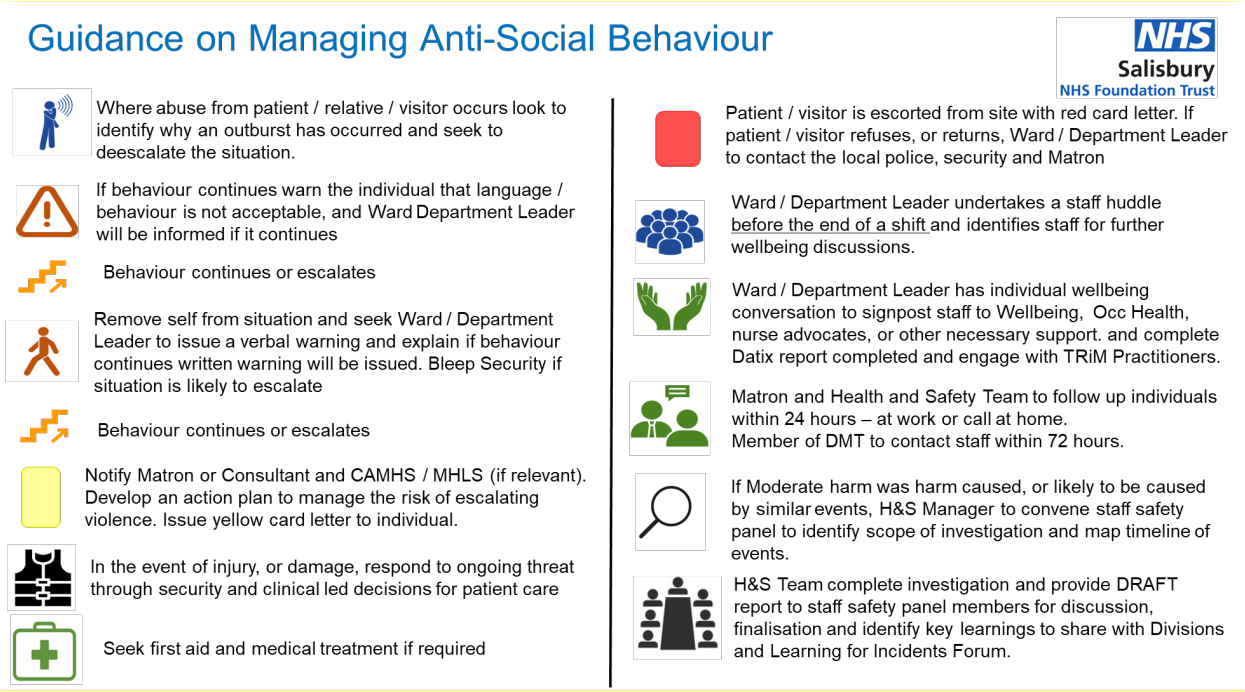
More importantly, there is a need to support staff exposed to these situations. Debriefing staff can evaluate the physical, mental and emotional impact on staff and provide an opportunity for referrals to TRiM or counselling. The ward/ department lead, or Matron, would be expected to undertake debriefing sessions with staff and make referrals to TRiM, Health and Wellbeing, Chaplaincy, relevant union body or Occupational Health.

The Wellbeing and Occupational Health Departments can provide support and advice to managers and staff involved in or affected by violence & aggression. This includes:

- Help recognise and prevent stress-related problems as they arise
- To assist in ensuring available support is utilised
- Arrange confidential appointments with the Counsellor
- Work with Occupational Health and Human Resources to devise "Return to Work" programmes for employees absent due to work-related stress as a result of an incident.

Where a staff member(s) has sustained an injury it may be necessary to remove the member of staff to safety to gauge how they are feeling and offer support. If the member of staff requires medical treatment refer to Emergency Department (ED) should occur before the staff member leaves the Trust premises.

The diagram below outlines the steps available to ward staff, managers and ward leaders where teams, and individuals, are exposed to violence and aggression.



6. Consequences of Violent Behaviour

The consequences outlined below do not apply to those patients who, in the judgment of the relevant clinician, do not have capacity or are not capable of understanding the consequence of actions. This includes but is not limited to patients with dementia, confusion, delirium, mental health or minors. These individuals require continued care and a patient specific assessment (outlining the potential triggers for behaviour) should be carried out in consultation with the relevant clinical experts such as the Trust Dementia Lead, CAMHS, MHLS.

It is expected the majority of deliberate physical assaults and many non-physical assaults will be reported to the police only with the consent of the victim for investigation along with consideration of appropriate action in this policy.

There are a number of actions available to the Trust where patients, visitors or next of kin are violent and aggressive. The action taken by the Trust will depend on the seriousness of the behaviour alleged, the harm caused or the risk of harm created by behaviour. These actions need to be within a reasonable period of time to link consequence with actions. The Trust reserves the right to take the following action:

- Issue a warning letter
- Impose restrictions on entry to premises
- Direct the patient to access services at another location
- Reporting to police where the behaviour may be a criminal offence
- Individuals also have the right to commence civil legal action against individuals after seeking independent legal advice.

It is important to consider carefully whether it will be possible to take the further actions threatened, as failure to follow up may result in an escalation of the behaviour. Where in doubt further advice can be sought from the LSMS, Safeguarding or Clinical Lead.

6.1 Warning Letters

If behaviour is not the result of confusion, dementia or delirium and continues despite verbal warnings the Trust does not tolerate staff receiving abuse. The Trust can issue a formal warning to the individual communicating the Trust does not tolerate verbal, intimidatory or physical aggression and will outline the consequences of continued behaviour.

Warning letters will:

- Be issued by the Department Matron or delegated to the lead nurse of the relevant department to expedite the process:
- Include a brief explanation of failure to heed verbal warnings, the nature of the unacceptable behaviour,
- Include a right to reply, and
- Identify the impact behaviour has had on services, and
- Outline the actions available to the Trust should behaviour identified in the letter not change.

A copy of a warning letter can be found at Appendix G.

6.2 Exclusion from premises/entry with conditions

If a warning letter was issued and ignored or significant harm was caused to staff and the patient had capacity to understand the decision and consequence of actions, the Trust can move to exclude the individual from the Trust or impose conditions on entry. Any decision to exclude or restrict access to the Trust should be made in consultation with, and based on the clinical reasoning of, the Clinical Lead, Matron, Divisional Head of Nursing and Divisional Operations Manager.

Exclusion letters should include:

- Name of the Divisional Head of Nursing or Divisional Manager authorising the sending of the letter.
- Brief description of the behaviour or incident.
- Details of any previous steps taken to address the behaviour.
- State why the behaviour is unacceptable and impacts it has had on people and NHS services.
- State precisely what premises the person is not permitted to attend with reference to an enclosed map if this will clarify matters.
- Set out under what conditions (if any) future entry to premises will be permitted
- Set out what will happen if exclusion or entry conditions are breached or if behaviour is repeated.
- State who will be informed or copied in.
- Advise if NHS records marked.
- Give date when exclusion will be reviewed and/or marking removed from records.
- Provide information on how decision may be challenged and provide details of complaints process.
- If exclusion is also part of an acceptable behaviour agreement include the agreement as a separate document. (If exclusion from premises or entry only under conditions is to be part of a behaviour agreement please read in conjunction with section 7 and associated template letter/agreement).
- In all cases involving patients copies of exclusion letters should be forwarded to the patients GP.

It is important to be clear about the precise location(s) the individual should not attend. This may be a complete exclusion or entry may be permitted under certain specified conditions. Any ambiguity could lead to the individual attending premises and lead to further incidents.

The Trust associated external grounds (e.g. a car park) can also be included in any exclusion though consideration should be made to ensure than these areas do not include any of the public highways or other rights of way which pass through the site.

Maps may be a useful way of ensuring that the position is made clear to all concerned.

As the Trust site is large, where access under specified conditions is permitted, it may be useful to specify which routes should be used to enter and leave the site.

6.3 Exceptions and conditions of exclusion
In many cases it may be necessary for the person displaying the unacceptable behaviour to return to the site for treatment either on a regular basis or in an emergency. In these cases the individual can be excluded from the site and only permitted access in certain circumstances. The conditions will depend on the nature of the unacceptable behaviour, the type of services offered and any medical conditions or mobility factors the person may have. Example of exclusion exceptions which will permit access to a hospital site in certain circumstances:

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

Exclusion from premises/entry with conditions letter can be found at Appendix H.

6.4 Acceptable Behaviour Agreements (ABA)
ABA's, as used by the police and local authorities to manage anti social behaviour, are useful and appropriate for patients admitted with behavioural conditions that may have capacity and require medical treatment and are minors who are admitted to the Trust as a place of safety. An ABA is included as Appendix I and should provide:

- Name of the Divisional Head of Nursing or Divisional Manager authorising the sending of the letter.
- Brief description of the behaviour or incident
- Details of any previous steps taken to address the behaviour.
- State why the behaviour is unacceptable and impacts it has had on people and NHS services.
- An outline of behaviours expected/not acceptable, any appropriate conditions
- The consequences if the ABA is broken.
- State who will be informed or copied in.
- Advise if NHS records marked with an alert.
- Give date when agreement will be reviewed and/or marking removed from records.
- Provide information on how decision may be challenged and details of complaints process.
- In all cases involving patients copies of exclusion letters should be forwarded to the patients GP.

To ensure clarity and to assist in appropriate information sharing, it is recommended that the agreement should be set out separately from the letter.

A behaviour agreement is voluntary and no one can be compelled to sign one, nor can a lack of response be taken as agreement. Conditions then can be tailored to the circumstances and because it is a voluntary agreement, conditions can be included which it

may not be possible to use in any legal contract or court order. An example of this would be where a condition relates to agreeing to take medication as prescribed.

6.5 Provision of services at an alternative location or by an alternative provider
Where there has been a complete breakdown in the relationship between the Trust and the person involved, or where the risk to staff or others cannot be managed to an acceptable level it may be necessary to consider providing care at an alternative location. Any decision to exclude or restrict access to the Trust should be made in consultation with, and based on the clinical reasoning of, the Clinical Lead, Matron, Divisional Head of Nursing and Divisional Operations Officer.

Consideration of changing the location or the provider of services must take into account the views of the relevant clinicians **before** any decision is reached and/or communicated. In cases where there is disagreement within the Trust (e.g. staff involved, clinical expert, and LSMS) it may be necessary to seek legal advice before proceeding. Letters should include:

- Name of the Divisional Head of Nursing or Divisional Manager authorising the sending of the letter.
- Brief description of the behaviour or incident
- Details of any previous steps taken to address the behaviour.
- State why the behaviour is unacceptable and the impact it has had on people and NHS services.
- Give details of new location or provider, or other arrangements made to provide services.
- State who will be informed or copied in.
- Advise if NHS records marked with an alert.
- Give date when new arrangements may be reviewed (if applicable) and/or when any marking removed from records.
- Provide information on how decision may be challenged and details of complaints process.

A Provision of Services at an Alternative Location Letter can be found at Appendix J.

6.6 Patient Alert on Healthcare records (paper & electronic)
Where an incident of unacceptable behaviour has taken place, consideration should always be given to whether the incident should be noted in the person's medical records (or if appropriate their family members', spouse's or partner's records). It is important to state that the alert is not a mechanism for attributing blame; it is a process for alerting staff to the possibility of violence, whether such actions are deliberate or take place as a result of a medical condition or as a response of treatment or medication. A decision should also be made on whether other staff or organisations should be made aware in order to help them assess if they are at risk. Examples of the type of incident that may warrant a Violent Patient Alert are included in Appendix K.

If a decision is made to place an alert on Lorenzo and the patients notes, the alert should include the following information:

- who, or what the alert applies to
- a brief classification of the type of incident
- date the alert is effective from and review date
- whether the individual has been notified
- essential and relevant handling information or advice to staff about who to contact for further advice or guidance. This should include a relevant contact for staff who work off-site or out of hours.

Where possible, the alert should provide staff with additional information to manage the risks that an individual poses. It is suggested that the additional information may include:

- advice that staff should exercise caution when dealing with the individual
- a brief description of the incident, e.g. physical or non-physical assault
- information relating to an individual's medical condition, treatment and care if relevant
- advice that the individual should not be denied treatment and care
- whether or not the individual has been notified that their records have been marked with an alert
- security warnings, specific areas of risk or trigger factors
- essential guidance on how to deal with the individual
- advice for staff about who they should contact if another incident occurs whether that is the LSMS, security personnel or police.

The same principles apply when placing an alert on the records of a patient's associate, irrespective of whether an alert relates to a carer, relative, friend or animal. All decisions on marking records should be based on the risk to staff rather than on any relationship between the individuals concerned.

Finally, the decision to add an alert should not preclude any other existing lines of communication being used to inform staff if there is an imminent risk to them.

These guidelines outline the process, roles and responsibilities that are relevant when an incident has taken place. It is therefore important that the following are aware of how the process will operate:

- all NHS staff who may be subject to incidents of violence
- the line managers of staff who have been subject to physical or non-physical violence and who share the responsibility for ensuring the safety and security of their staff
- the LSMS with responsibility for investigating incidents, and presenting their findings to the Health and Safety Committee.
- members of the Health and Safety Committee are responsible for approving the decision for an alert, reviewing alerts and to make decisions not to notify an individual of an alert and considering any complaints.

The following risk factors should be considered when determining whether an alert should be placed on a record:

- nature of the incident (i.e. physical or non-physical)
- degree of violence used or threatened by the individual
- injuries sustained by the victim
- the level of risk of violence that the individual poses
- whether an urgent response is required to alert staff
- impact on staff and others who were victims of or witnessed the incident
- impact on the provision of services
- likelihood that the incident will be repeated
- any time delay since the incident occurred
- the individual has an appointment scheduled in the near future
- staff are due to visit a location where the individual may be present in the near future
- the individual is a frequent or daily attendee (e.g. to a clinic or out-patients)
- the individual is an in-patient
- the incident, while not serious itself, is part of an escalating pattern of behaviour
- the medical condition and medication of the individual at the time of the incident.

The decision to use an alert should be based on a specific incident and not personal opinion or hearsay. As part of the investigation into an incident, the victim should be asked by the LSMS for their opinion as to whether an alert is justified, but this alone will not warrant an alert. The decision for a marker to remain on a patient record must follow an LSMS investigation which provides evidence that an alert is required, and that the Health and Safety Committee has ratified the decision.

If the police are called to an incident, the LSMS should liaise with the investigating officer to ascertain what action they are taking. Any wait to receive relevant information from the police should not delay the decision-making process for an alert. If a decision is made to place an alert on a record, this should not prevent or replace any legal action being taken against the individual.

It is important to stress that, in relation to decisions on placing alerts on records, the role of the LSMS is not to establish whether the act was intentional or based on an underlying clinical condition, treatment or care, but to assist staff in managing future risks. For incidents where the individual is thought to be responsible for their actions, the LSMS should facilitate any police enquiries or consider further investigation in line with established policies.

The LSMS is responsible for making the final recommendation on the need for an alert, based on consultations with the victim, their line manager and any others, e.g. Consultants / Doctors, the nurse supervising the ward or unit, and after taking into consideration the risk assessment carried out by the clinicians in charge of the patient. A Violent Patient Marker for Medical Records Entry is included as Appendix M.

6.7 Recording and Sharing information

It may be necessary to share information with others regardless of what other action is taken. This may be both in order to assess risk and to prevent other people or organisations from referring the person to premises from which he may have been excluded.

It is essential that decisions are based on reliable and sufficient information and that detailed and accurate records are maintained in case decisions have to be reviewed or are challenged.

What records should be kept will depend on what is available but the minimum should be a report from a reliable source who witnessed the incident. Examples include -

- Datix Incident Report
- Previous incident reports relating to the same person
- Details of external incidents

While the taking of the actions outlined in this policy is ultimately a matter for the Trust it is important to establish whether any other body may also be dealing with the individual concerned.

In all instances letters of warning, exclusion or alternate provides must be shared with the patients GP, the Safeguarding Team, Local Commissioning Authorities and the Police.

In the interests of fairness it is also necessary to provide a right to reply to any decision made to warn, restrict or prohibit access to the Trust. An example of a Violent Patient Letter is included as Appendix L.

7. Reviews, Challenges, and Complaints

The decisions relating to the actions in this policy, taken by the Trust, are subject to a review or complaints process. The seriousness of any incident and any risk posed by further behaviour will determine whether any warning remains in place pending the outcome of a review or complaint.

In the vast majority of cases it will not be appropriate for a warning or other action to remain in place for an unlimited period. The Health and Safety Committee will review the decision after a set period but this must be within 12 months of the incident. Notification of the outcome of the review should be given in writing and any other parties to whom the information has been copied should also be notified.

8. Delivery and Proof of Receipt of Letter

There are a number of factors which will contribute to the decision on the most appropriate method of delivery. A balance must be struck between ensuring that the individual in question receives any letter and the risk that certain delivery methods pose.

8.1 Hand delivery on NHS premises

In some cases it may be appropriate to invite the person concerned to a meeting to discuss their behaviour and issue any letter to them in person. This may be useful where the person is likely to have on-going contact with the members of staff involved. This method of delivery guarantees that the person involved has received the information. **Before any meeting takes place a thorough assessment of the potential risks involved must be carried out.**

8.2 Hand delivery at home address

This method of delivery may be appropriate where previous correspondence has been returned and it is known that this is a deliberate attempt to avoid receipt. Unless the person delivering the letter knows or confirms verbally that the addressee is the person taking delivery (rather than simply posting it through the letter box) this method will only confirm that delivery has been made to the address. Due to the risks of attending a person's address and delivering what may be unwelcome news this method should only be used when absolutely necessary and after a thorough risk assessment.

8.3 Postal delivery

For the majority of letters normal postal services will suffice. Enhanced postal services (e.g. recorded and special delivery) may offer some proof of posting however it should be noted that they can only prove that an item was delivered to the address stated. The Post Office delivers to addresses not to individuals and will accept signatures where required from any adult at the address. Delivery by post offers no guarantee that the individual to whom the letter is addressed has taken receipt.

8.4 Requesting response

Where a response is required, and where face to face delivery has not been used, a prepaid return envelope must be included. This should remove a potential excuse for not responding and may prevent further attendance(s) at the premises.

9. Data Protection

The ICO guidance on violent warning alerts makes it clear that the employer has a duty of care towards its staff under health and safety legislation. The processing of alerts information by the data controller, in this instance the Trust, is necessary to comply with these legal obligations, so long as it is fair and justified.

10. External Reporting and Investigation

Through MARAC information sharing processes, the Trust is required to add electronic alerts to records, if the Police share information that someone is a risk to Professionals. The Trust does this via Safeguarding & they remain live for 12 months. The Trust does not inform the individual, as they will not be aware they have been discussed at MARAC. This process does not require the Health and Safety Committees ratification.

10.1 Investigation

The LSMS in conjunction with the Head of Risk Management should review the Datix report and determine what level of further investigation is required. In most cases they will have to speak to the victim and any witnesses and seek the views of all relevant staff as an important part of the decision-making process.

This will enable a thorough assessment of future risks to be made. Based on the severity of the incident, resulting risk rating and in line with local policy, this should determine the response time necessary for the LSMS to conduct an investigation before making a decision as to whether an alert is required.

10.2 No action required

There may be circumstances where, following an investigation and risk assessment as part of the Trust's risk management process, the Health and Safety Committee decide that it is not appropriate for the alert to remain on the patient record. This may be because, following an incident, the individual poses no further or significant risk. In this instance, the Health and Safety Committee should not recommend an alert and should record the decision taken in accordance with local procedures.

10.3 Reviewing an alert

Best practice requires that alerts are periodically reviewed, to ensure they are up to date and remain relevant. Any updates in relation to risks and handling advice should be included as necessary. Records should not be marked for longer than necessary and alerts should be removed when there is no longer a risk. When an alert is first placed on the records, the LSMS is responsible for adding all relevant dates, including when the incident occurred, when the alert is effective from and a review date

The LSMS will periodically identify those alerts that require reviewing and submit these with recommendations to the Health and Safety Committee for consideration.

The LSMS will have in place a system to identify when an alert is due for review. All alert records should be kept secure and access controlled to prevent unauthorised use.

All violent patient alerts will be reviewed within 12 months of the incident by the Health and Safety Committee. The review date will be determined case by case and initially set following ratification of the alert.

As part of the decision-making process, the review should consider the original decision on which the alert is based, including:

- the severity of the original incident 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.

All patients who are the subject of violent patient alert will be advised in writing following the decision of any review to continue with the alert.

When a decision is taken that the individual's behaviour gives no further cause for concern the alert should be removed immediately, the LSMS is responsible for ensuring that this is completed. The individual should be notified of the removal of the alert as soon as possible.

10.4 Notifying Patient of an Alert

The Health and Safety Committee is responsible for sending a notification letter to the individual outlining the reasons for the Alert. The letter should clearly explain:

- the nature of the incident
- that their records will show an alert
- the reasons why the alert is being placed on their records
- who the information may be shared with and for what purpose
- when the alert will be reviewed for removal
- the process for complaints
- relevant contact details.

If the incident is committed by an associate of the patient, a letter should be sent to *both* the patient and the associate, if the associate's identity and whereabouts is known. The patient's letter should inform them of the decision that has been made; the associate's letter should include all the relevant information included, as above. Care should be taken not to disclose any confidential medical information when notifying associates.

There may be exceptional cases when it is decided that notifying the individual may increase the risk that they pose to staff and that notification is not appropriate. These may include situations where:

- informing the individual may provoke a violent reaction and put staff at further risk. A detailed record must be kept of any decision not to notify an individual and the reasons for this course of action
- notification of an alert may adversely affect an individual's health. In this instance, the senior clinician responsible for the individual's care must review the case and make the decision that notification is not appropriate for clinical reasons.

Any decision, based on exceptional circumstances, not to notify an individual should be reviewed by the Health and Safety Committee. In each instance, the LSMS is responsible for making the initial decision during the investigation and submitting the necessary evidence to the panel outlining the reasons not to notify. If the decision is based on health grounds, the evidence should include a written statement from a senior clinician explaining the reasons why notification may adversely affect an individual's health. If notification may provoke a violent reaction, the evidence should support this.

11. Training

The Trust has carried out risk assessments to identify those areas that are deemed at risk from episodes of violence and aggression. The Trust training matrix identifies the various levels of training available.

Prevention and Management of Violence and Aggression training is based on an integral de-escalation model that emphasises the therapeutic importance of returning control and autonomy to the individual at the earliest opportunity.

	Frequency	Low Risk /All Staff	Medium Risk Staff	High Risk Staff	VPKW	Security
Conflict Resolution MLE	2 yearly	X	X	X	X	
Conflict Management – Face to Face	2 yearly		X	X	X	
Positive Management of Violence and Breakaway Training (with AMcC)	2 yearly			X	X	
Advanced Breakaway Training	Annual					X
Mental Capacity Act and Deprivation of Liberty Safeguards Workshop	2 yearly		X		X	

Low Risk Staff – All clerical, office based and nonclinical facing roles such as estates, facilities, IT and senior clinical management roles.
Medium Risk Staff – Ward leaders, staff in charge of shifts and hands on clinical management roles.
High Risk Staff – Care giving staff in all medical and post-surgical wards, Radnor Ward, Sarum Ward and ED.

12. Lone Workers Guidance

12.1 Lone workers

A lone worker is identified as someone who works on their own, away from other colleagues and not able to communicate or readily access help when in difficulty or in an emergency. Examples would be community midwives on a house visit, laboratory staff working out of hours, therapists on call in the community or an estates worker on a contract to another healthcare organisation.

This is not the same as many workers in the hospital who are isolated and **work alone** by acting independently. They have access to other colleagues within earshot or by a communication device but safe systems of work still need to be identified. Examples would be a staff member working on switchboard at night, housekeeping on early morning shifts in a yet unoccupied building or someone working late in the office a night.

It is paramount that each department that has lone workers or isolated staff undertake risk assessments appropriate to the risk and puts procedures to protect staff within their department enabling them to be safe and secure. This should include contact protocol whilst they are vulnerable, reporting procedures, guidance, logging on and off duty, emergency contact procedures, and training in conflict management if that is required or identified in the risk assessment.

There are many protective procedures that are available. Mobile communication is the obvious mechanism, but there is diary tracking, wipe boards, buddy systems and many more, the LSMS and the Health & Safety Department can offer advice for departments who wish to establish, review or replace procedures.

Identified lone workers should be provided with reliable means of communication, for example mobile phones and where appropriate personal attack alarms and any other aids that are identified as part of a risk assessment.

12.2 Employee Responsibilities
All employees have a responsibility to work within this guidance. The department manager should undertake a risk assessment using the Trust's Risk Assessment Process and also the Risk Assessment Guidance (if visiting a patient) when working alone. Once the risk assessment has been undertaken then staff have a duty to work within its guidelines.

12.3 Hazards of Lone working
It is important for staff to understand that our community does not have a high crime level compared with some other areas in the country. However, there are hazards associated with lone working in the community.

Line Managers and lone workers should consider certain high risk activities:

- Working with patients/people who have known risk factors e.g. violence and/or aggression
- When staff both within the hospital and in the community convey medication, equipment or valuables
- When staff are required to travel between sites/ homes and offices
- When staff are handling cash or banking

12.4 Community based lone working
Managers should consider the need to have two staff members attending a patient's property for the first visit to try and establish if there are likely to be any problems at the property associated with the patient or their family. This would also include the presence of animals that may be a risk to staff. Lone workers should be provided with reliable means of communication. For example, mobile phones for emergencies and, where appropriate, personal attack alarms. See Appendix C (Community based lone workers guidance).

12.5 Office based lone workers
Staff who work alone in offices can also be at risk, for example working at the weekend or out of 'normal' office hours. Sometimes it is possible to avoid this working pattern. If it is not avoidable, then a risk assessment should be undertaken. Some safety action points can be found in Appendix D (Office based lone workers guidance). Also consideration should be given to the use of the VERA procedure.

12.6 Risk Assessments
It is paramount that each department that has lone workers risk assessments undertake regular reviews which must be carried out at least once a year. Procedures must be in place for the staff within the department enabling them to be safe and secure within their working environment.

This should include reporting procedures, guidance, logging on and off duty, emergency contact procedures, and training in conflict management. There are four main considerations that are very important when assessing lone worker risks:

- They have full knowledge of the hazards and risks they are exposed to.
- That they know what to do if something goes wrong.
- That someone knows about their location, and when they are expected to return.
- Never assume that it won't happen to you – know the risks.
- Access to the risk assessment and the identified control measures.
- Emergency alarm systems need to be regularly tested (usually annually).

Line Managers have a duty to ensure their staff's safety when they are at risk. It is good practice for staff and Line Managers to undertake a pre-risk assessment from a check-list when visiting outside of the hospital. It is only necessary to undertake this when new activities or patient visits are being planned. This can be found in (Appendix E Community Based Lone Workers) and (Appendix F Office Based Lone Workers).

12.7 Duress Alarms

Many clinical settings do not require the use of duress alerts because of the availability of emergency call bells that prompt immediate arrival to the area of concern and in considerable numbers.

In non clinical or remote areas there may be a need to consider a duress / alert process. Departments will assess the risk of lone workers and consider duress / remote worker alarms that suit the specific needs of the department.

13. Process For Monitoring Compliance & Effectiveness

The Trust monitors violent and aggressive incidents within the Trust, this is achieved through:

- Reviews of incident reports (via the Security Management Committee Violence Prevention and Reduction Working Group and the Health and Safety Committee). This looks at trends and themes.
- Annual review of the Violence Prevention & Reduction Standards
- Publication of the annual report by the LSMS, which reports back to the Health and Safety Committee and also the Security Management Committee, and end of year review at JBD.
- Status of current security arrangements.
- Compliance with risk assessments and incident reporting (as per the policy).
- Arrangements in place for Lone Workers, highlighting areas at risk
- Organisation wide risk assessments will be included and progress against action plans to address the identified security issues.

Take up training across staff groups, identified in the TNA.
Evidence that staff are being supported following involvement in incidents.

The Risk Management Department monitor and record all reported incidents. The Violence Prevention and Reduction Working Group meets to review incidents of violence and aggression and to review training needs of the Trust from risk assessments carried out in departments.

The Security Management Committee meets to review security related incidents and any current issues, as well as steering the strategic direction within the Trust. This group reports all identified risks to the Health and Safety Committee.

14. References & Associated Documents

Offences Against Persons Act (1861)
Violence Prevention & Reduction Standards.
A Professional Approach To Managing Security In The NHS, 2005
Health & Safety Rules and Regulations
Data Protection Rules and Regulations
Adverse Events Reporting Policy
Risk Management Policy and Procedure
Restrictive Physical Intervention and Therapeutic Holding Policy in Children and Young People
Restrictive Practices Policy For Adults (18 years and above)

15. Equality Impact Assessment

The Trust aims to design and implement services and policies that meet the diverse needs of its services, population and workforce, ensuring that none are placed at a disadvantage

over others. This document has been assessed against the Trust's Equality Impact Assessment tool. This document has been assessed as not relevant to the duty.

A copy of the completed Impact Assessment has been included as Appendix N.

16. Appendices

Appendix A Incident Reporting Flow Chart & Force Continuum Chart
Appendix B Trust Restrictive Practice Policy
Appendix C Community Based Lone Workers Guidance
Appendix D Office Based Lone Workers Guidance
Appendix E Community Based Lone Workers Assessment Form
Appendix F Office Based Lone Workers Assessment Form
Appendix G Warning Letter
Appendix H Exclusion from premises/entry with conditions letter
Appendix I Acceptable behaviour agreements letter
Appendix J Provision of services at an alternative location or by an alternative provider letter
Appendix K Examples of the type of incident that may warrant a Violent Patient Alert
Appendix L Violent Patient Alerts (Letter to Patient)
Appendix M Violent Patient Alerts (Electronic Medical Records Entry)
Appendix N Equality Impact Assessment