

Health and Safety Executive		Sector Information Minute	
		SIM 07/2006/04	
Cancellation Date	01/05/2009	Open Government Status	Fully Open
Version No & Date	1: 01/05/2006	Author Unit/Section	Health Services Unit

Target Audience:
AFQ Inspectors,
FOD Inspectors

PUBLIC SECTOR PROGRAMME 2006/07 - GENERAL GUIDANCE ON THE MANAGEMENT OF VIOLENCE & AGGRESSION IN HEALTHCARE

This SIM provides information and guidance to supplement the PSP 'Management of Violence & Aggression in Healthcare' SIM 07/2006/03

INTRODUCTION

1 The health and social care sectors in England, Scotland and Wales make up one of the biggest employers in Great Britain, and issues of managing violence and aggression continue to be a matter of serious concern. To fully realise improvements in sickness absence targets across the public sector, HSE has forged a collaborative programme of work with other government departments and agencies to target action at the high risk areas. This SIM outlines some of the key areas of work underway that Inspectors should be aware of.

IMPACT OF WORK-RELATED VIOLENCE

2 The negative consequences of violence are well documented. It has been estimated that stress and violence together possibly account for approximately 30% of the overall costs of ill-health and accidents (1). A recent report from the Healthcare Commission has also found that while there has been a slight decrease in violence, bullying and harassment from 2005, nearly 12% of staff still experienced physical violence and 27% experienced bullying, harassment of abuse from patients or their relatives. Additionally, recent 2004/05 data from the NHS Security Management Service show that there were 43,301 physical assaults against NHS staff working in Mental Health and Learning Disability settings, 11,482 in the Acute Sector, 5,092 in Primary Care Trusts and 1,329 in Ambulance Trusts.

3 Violence may be attributed to many factors, including impatience, frustration (e.g due to lack of information or boredom), anxiety (e.g lack of choice, lack of space), resentment (e.g having no right to appeal decisions), drink, drugs or inherent aggression/mental instability. Shift working also heightens the risk, as over half of incidents reported under RIDDOR in 2003/04 and 2004/05p occurred between 15:00 and 22:00. The majority of incidents also involve employee interaction with people

from all sections of society, many of whom are needy and vulnerable. The hazard of violence cannot therefore be removed, however, the risk of violence can be reduced.

STRATEGIES AND INITIATIVES IN PLACE TO REDUCE INCIDENTS

4 The Welsh Assembly Government and NHS Wales launched the Welsh Passport Scheme for Violence and Aggression, and this provides a framework for the delivery of violence and aggression training within the NHS in Wales. It contains guidance to ensure its effective assessment and management. Additionally, the Welsh Audit Office report 'Protecting NHS Staff from violence and aggression (Sept 2005)' identified a number of key recommendations for NHS to take on board in order to reduce the number of incidents and ensuing costs, and reinforcing the need to have clear training priorities for key staff and to ensure that there are suitable delivery mechanisms.

5 The 'Managing Health at Work – NHS (Scotland) Partnership Information Network' (PIN) set out standards to improve the health at work to all staff in NHS Scotland. Comprehensive guidance is provided on the management and strategic approaches required. Inspectors may find this useful as a reference guide when conducting operational activities. NHS Scotland have set a target to reduce the number of injuries, accidents and incidents at the end of 2006 by at least 25%. Additionally, the introduction of the Emergency Workers (Scotland) Act to protect emergency care staff from assault or hindrance while conducting their business, has raised the political and social profile of the difficulties and challenges facing NHS staff.

6 The National Audit Office report 'A Safer Place to work - Protecting the NHS Hospital and Ambulance Staff from Violence and Aggression' 2003 (England) found that nurses and other NHS staff who have direct interaction with the public, for example, ambulance and accident and emergency staff, and staff who work in mental health units, often have a higher risk of exposure to violence and aggression. The average number of incidents for NHS mental health and learning disability Trusts is almost two and half times the average for all Trusts, despite evidence that staff working in mental health units are much less likely to report verbal abuse.

7 The NHS Employers Organisation (England) have issued guidance 'The Management of health, safety and welfare issues for NHS Staff' on a range of key workplace issues ranging from health and safety, to managing sickness absence and stress. It sets out the business case for effective management of violence and aggression - one of the key levers being pursued for improving overall sickness absence across the NHS.

8 The Counter Fraud and Security Management Service (NHS SMS), a Special Health Authority of the Department of Health, took over responsibility for all policy and operational matters relating to workplace violence in the NHS (England) from April 2003. Its' remit is set out in the strategy 'A professional approach to Managing Security in the NHS'. Specific activities include replacing the Zero Tolerance Campaign and implementing recommendations from the National Audit Office Report (para 6 refers).

9 In November 2003, the NHS SMS issued 'Directions' requiring NHS to put in place specific organisational arrangements to facilitate change, including:

- **Nominating a Security Management Director and Non-Executive Director with responsibility for security management work** - Each Health Body (eg any Trust, including Primary Care Trusts and Strategic Health Authorities) are required to nominate a Security Management Director and Non-Executive Director to take responsibility for security management matters, including measures to deal with violence and aggression.
- **Appointing a 'competent person' for the day-to-day delivery of these arrangements** - health bodies are required to appoint a Local Security Management Specialist (LSMS) and ensure completion of an accredited training programme. LSMSs are helped in their functions by Area Security Management Specialists (ASMS) who co-ordinate regional approaches and maintain an overview. ASMSs report directly to the NHS SMS Operational Manager. Within mental health and learning disability settings, nominated LSMSs will undergo a more specialised accreditation training programme, which is currently being piloted.
- **Establishing mechanisms for reporting incidents of violence and aggression both internally and nationally** - The 'Directions' require that the Executive Director be informed of any incident of physical (3) or non-physical (4) (verbal or intimidating behaviour) violence and aggression to staff. Health Bodies are required to establish arrangements for the internal reporting and investigation of such incidents, including reporting to the Police, the NHS SMS and HSE (as appropriate). The NHS SMS definitions of verbal and physical assaults (for their purposes) is broader than HSE's definition - see annex 1 for further details. Health Bodies are also required to ensure that those suffering incidents of violence and aggression are provided with any necessary support arrangements, eg counselling or occupational health support.
- **Creating a Legal Protection Unit** – A Legal Protection Unit (LPU) has been established to work with health bodies, and provide advice on cost-effective methods of pursuing a range of sanctions against offenders. The LPU assist the police and the Crown Prosecution Service in prosecution of individuals who assault NHS staff.

10 Given the overlap of responsibilities between HSE and NHS SMS, a Concordat was published in March 2005 to clarify working arrangements on our overlapping interests, and to set out the principles for how the two organisations will collaborate in particular circumstances. Inspectors should be familiar with the Concordat and the specific arrangements in place when planning either interventions or enforcement action. The Health Services Unit meets with the NHS SMS on a quarterly basis to review Concordat arrangements and work priorities, and would welcome feedback from Divisions, to help inform the meetings. Details should be forwarded to the 'healthservices' general account.

11 The NHS SMS are also seeking to expand their role within Wales. Discussions are still underway as to how best to complement existing strategies and the Welsh Passport Scheme for Violence and Aggression. Further information will be made available on a decision has been reached.

POLICIES THAT SHOULD BE IN PLACE

12 Measures for dealing with violence and aggression require a sound risk assessment. Unless there is senior management support and commitment demonstrated in a policy which contains individual obligations, it is unlikely that the risk of violence will be taken seriously and controlled effectively. The policy should therefore contain an authoritative statement on how the risk will be controlled. It should enable everyone to know their individual responsibilities, demonstrating the importance of involving all levels of the workforce, and consulting safety representatives regarding the proposed content, implementation, monitoring and review of the policy.

13 To ensure that the policy and the procedures are effective, and the risk assessment remains valid, a process of monitoring the risk control measures and reviewing the appropriateness of the policy and procedures should be in place. The following checklist is suggested:

- **Purpose – The written policy is a statement of intent and needs to be backed up with appropriate systems and mechanisms to ensure compliance. These should include:**
 - A pledge to protect staff at work
 - The definition of violence
 - Details of the employer's legal requirements
 - Details of the manager's legal responsibilities, duties of the Security Management Director and Local Security Management Specialist (LSMS)
 - Details of the employee's responsibilities (does it cover contract/temporary staff, and the right for staff to defend themselves?)
 - Information on risk assessment measures
 - Details of local prevention and reduction plans
 - Details of local emergency procedures (what should be done, what can be expected during an incident?)
 - An explanation of staff training procedures
 - An explanation of local reporting procedures
 - Information on post-incident support
 - A commitment to cultivating good relations with the local police and Crown Prosecution Service in order to pursue cases of violence
 - A demonstration that the policy has been communicated and implemented, and
 - Specific precautions for staff working in the community - Inspectors should also be aware of guidance published by the NHS SMS (in March 2005) to manage risks to 'lone workers' across the NHS. The guidance 'Not Alone – A guide for the Better Protection of Lone Workers in the NHS'.

14 With the passing of the Crime and Disorder Act 1998, local authorities and police, in co-operation with other bodies such as the NHS Trusts and Health Authorities, are legally required to develop and implement crime and disorder strategies. Some trusts are actively involved with local crime prevention groups to share information,

advice and intelligence on particular issues which might influence the management of some difficult situations.

NATIONAL TRAINING PROGRAMMES

15 The NHS SMS introduced a national training syllabus for 'conflict resolution training' (a 1 day mandatory event) for all "front line" staff and professionals who work in, or provide services to the NHS, and are at risk from violent behaviour. NHS SMS require that health bodies determine who are "front line" staff. The course roll-out began in 2004 and it is being delivered directly by NHS SMS, or via internal or external trainers, accredited by NHS SMS. The training covers non-physical intervention methods including recognising 'warning signs', communication skills, cultural and diversity awareness and de-escalation techniques. Each year, health bodies are required to submit a plan detailing how and what training will be provided to its staff and this is being monitored centrally. It is expected that by April 2006, approx 250,000 frontline staff will have completed this training.

16 The course is not targeted at staff working in mental health, nor does it address physical intervention skills. Operational staff should not interpret the existence of the 'conflict resolution' training course as implying that other, higher levels of training (such as 'breakaway' or 'physical intervention') are not required. Inspectors are asked to take account of a health body's training plan for the delivery of 'conflict resolution' training when considering enforcement action and compliance timescales.

17 A separate non-physical training syllabus for mental health and learning disability environments 'Promoting Safer and Therapeutic Services' has also been introduced. It describes the learning outcomes to be achieved and aims to provide staff with the skills to recognise and defuse potentially violent situations. Staff are expected to receive this training first, before undertaking any further training in physical intervention skills. As from 1 December 2005, NHS Trusts providing mental health and learning disability services are expected to adopt the national training syllabus with a view to ensuring delivery by 31 March 2008. Where training programmes already exist (either in-house or via an external provider), Trusts must ensure that such training meets the standards of the national syllabus.

18 The new syllabus has been designed to complement other work underway on physical interventions skills and the regulation and accreditation of trainers in these particular settings. The National Institute for Mental Health in England (NIMHE) is leading on this area of work and are aiming to publish draft proposals by Summer 2006.

PHYSICAL SKILLS

19 The extent to which the use of such interventions are used is a controversial issue in health care. The question as to whether the use of such interventions is justified in particular circumstances is often a balance between clinical judgment, common law duties and the duty to protect the safety of staff and others. However, restraint should usually be a last resort for managing violence to staff, and current medical opinion is that mechanical restraint should not be used within mental health services (4). If restraint is deemed necessary, it should be used with consideration

for the self-respect, dignity, privacy, cultural values, and any special needs (e.g. physical illness or disability) of the service user. Methods of restraint to be used for particular services users should be recorded in individual care plans. Annex 2 provides a brief description of some of the more commonly used techniques.

20 Inspectors should concentrate on ensuring that the employer has taken appropriate steps to minimize any risks to employees that might arise from physical interventions. Where such techniques are expected to be used, the employer should assess the employees capabilities and provide appropriate training. The employer should also ensure that appropriate systems of work are in place, including appropriate policies, procedures and suitable staffing to undertake the identified techniques.

21 Successful physical skills training for the protection of healthcare professionals facing violence at work needs to be effective, task-related, lawful, ethical and as safe as possible with minimum-injury potential to both parties. Skills that are taught should be proven to be useful, relevant, simple and instantly available when required. They need to be easy to teach, and easy for staff to maintain competency in their use.

22 Specific guidance for either the training or undertaking of physical skills includes:

- Department of Health (2003) – Guidance on the Use of restrictive physical interventions for staff working with Children and Adults who display extreme behaviour in association with learning disability and/or autistic spectrum disorders
- National institute for Mental Health in England (2004) - Mental Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-Patient Service-User Settings (note this guidance is currently under review and the revised version is expected to be published by June 2006)
- Royal College of Psychiatrists guidance - 'Management of Imminent Violence: Clinical practice guidelines to support mental health services' describes criteria to be addressed when drawing up policies and protocols for work related violence in mental health. These guidelines should be familiar to all members of the clinical team, relevant services managers and senior managers (eg Trust Executives, clinical directors) and heads of local training and education departments.
- Royal College of Psychiatrists – Strategies for the Management of Disturbed and Violent Patients in Psychiatric Units – provides a model for the management of services users in this environment, and gives an overview of various control and restraint techniques.
- National Institute for Clinical Excellence (NICE) guidelines –Guideline 25 provides a framework for the management of disturbed behaviors in psychiatric inpatient settings and emergency departments to assess risk, de-escalate and calm down a potentially violent situation, with specific

advice for those staff required to employ physical interventions (including restraint).

- British Institute of Learning Disabilities (BILD) accreditation scheme for trainers of physical interventions in learning disability and education settings. It is based on the BILD '**Code of Practice for Trainers in the Use of Physical Interventions**'.
- NHS Estates Health Building Note 35 - '**Accommodation for people with mental illness**' advises that good communication systems should be in place, and consideration should be given to alarm call systems, for use by services users and staff. Alarm call points should be situated so that they can be operated if a door or exit is blocked. A separate project is underway to review best practice in the design of seclusion units by NHS Estates and the results are expected to be published in Autumn 2005. Electronic copies of HBN 35 are available from HSE on request.

RESEARCH

23 HSE recently published a research report which demonstrates the value of effective evaluation of training programmes, and the importance of designing and delivering training as part of a hierarchy of measures to managing violence and aggression in healthcare. The research found that training programmes were of more benefit when these provided a broader organisational context as the main thrust of the training event, rather than those that concentrated on teaching individual skills.

24 It also identifies the core content elements that should be considered by employers and employees when conducting a training needs analysis to inform the best design and delivery.

25 It provides 5 organisational case studies to illustrate how these organisations (mental health, acute and ambulance) approached their training programmes and some of the lessons learned. Additionally, further research will report in June 2006 on the core competencies identified for effective and ineffective trainers in this domain, and evidence of best practice procedures for training delivery.

FEEDBACK

26 The Sector would like to receive any examples of good practice or possible case studies to demonstrate effective management of violence and aggression issues. Please forward to the general 'healthservices' e-mail account.

CONTACT DETAILS

27 Jo Gravell, Health Services Unit, VPN 508 4293

ANNEX 1

WORK-RELATED VIOLENCE - COMMONLY USED DEFINITIONS

- “Any incident in which a person working in the healthcare sector is verbally abused, threatened or assaulted by a patient or member of the public in circumstances relating to his or her employment’ – **Health Services Advisory Committee 1997**
- 'Any incident in which a person is abused, threatened or assaulted in circumstances relating to their work' - **HSE Violence at Work a guide for employers INDG69 (rev) 2000**
- ‘The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort’ – **physical assault definition contained within Directions to NHS Bodies November 2003**
- ‘The use of inappropriate words or behavior causing distress and/or constituting harassment’ – **non-physical assault definition contained within Directions to NHS Bodies November 2003**

ANNEX 2

TECHNIQUE DESCRIPTIONS

Isolation techniques –includes: the quiet room, room restriction, limit setting, time-out, the seclusion room, open-area seclusion, intensive care areas.

Physical restraint – in some cases, diffusion attempts fail and physical restraint becomes necessary. Includes gentle holding as a physical intervention to eliminate undesirable problem behaviors without the use of punishment procedures. Geared towards children with learning difficulties.

Holding therapy –comprises the physical control of a person's limbs by carers who maintain contact with the disturbed person for as long as it takes for them to calm down.

Bearhugging – approaching from behind, the carer places their arms around the aggressor in a bearhug and places their head next to that of the aggressor with mutual side-of-face contact which, with gentle pressure prevents headbutting either backwards or sideward to the carers face.

Immobilising –is effected by a three-person team who approach an aggressor swiftly with one staff member leading and the other two tucked in behind in a side-on-position. The objective is to immobilize the aggressor safely (usually taking them to the floor in a controlled manner) and this is achieved by the lead person holding the head, while the other two team members take responsibility for holding an arm each in a secure position.

Breakaway –useful for the most common one-on-one attacks, involves a variety of simple moves that incorporate leverage rather than strength. This means that a relatively weak individual can disengage a variety of the common holds used by a stronger aggressor.

Control and Restraint –provides a framework of practical team work skills, with the aim that nobody is hurt. The idea underpinning C&R is that, in the rare circumstances when the only option left is to restrain an aggressor physically, the restrainers operate according to a prescribed action and can function effectively as a three-person team. It may sometimes be necessary for team members to wear safety equipment (e.g pads and shields).

Pin-down – this was developed mainly for use with disturbed children. It originated as a means of holding down disturbed aggressive children by controlling all four limbs which were held fast until the person became calm. However, it developed incrementally to include a regimen of sanctions, so much in fact, that current guidance prohibits this technique.

Managing Violence and Aggression – A Manual for Nurses and Health Care Workers - 1999

1	Framework guidelines for addressing workplace guidance in the health sector – ILO 2002
2	http://www.cfsms.nhs.uk/files/VAS_Explanatory%20notes.pdf
3	http://www.cfsms.nhs.uk/files/NPAGuidance.pdf

4	The recognition, prevention and therapeutic management of violence in acute in-patient psychiatry: a literature review and evident-based recommendations for good practice – Jan 2002
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