VIOLENCE AND AGGRESSION, POLICY AND PROCEDURE

Profile	
Version:	*5.0*
Author:	*Interim Head of Health and Safety*
Executive sponsor:	*Director of Estates & Facilities*
Applies to:	*All Trust Staff, Patients, Visitors and all other relevant persons & stakeholders on Trust premises.*
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Approval	
Approval person/Committee:	*Health, Safety and Fire Group*
Date:	*16 July 2019*

Policy Gateway

Please complete the checklist and tables below to provide assurance around the policy review process.

☒ Everyone who should be consulted about this policy/guidance has been consulted

☒ The target audience for this policy/guidance has been identified

☒ The correct policy template has been fully and properly complied with

☒ The correct approval route for this policy/guidance has been undertaken

☒ A Word version of this policy/guidance has been saved for future reviews and reference

Please set out what makes the author to be an appropriate person to conduct this review:
The Interim Head of Health and Safety is the competent person to lead on undertaking this review; in consultation with the members of the Violence and Aggression Taskforce Group.

Please set out the legislation, guidance and best practice consulted for this review:
The Health and Safety at Work, etc Act 1974 and all subordinate Rules, Regulations and Approved Codes of Practice (ACOPs).

Please identify the key people involved in reviewing this policy why, and when:
All members of the Health, Safety and Fire Group. December 2018 All members of the Violence and Aggression Taskforce Group. December 2018 & February 2019

Summarise the key changes that have been made and why:
Further to a Health and Safety Executive inspection at the Trust in November 2018, this policy has been fully revised and updated and it now incorporates a new risk assessment template and flow charts to assist in the decision-making process of managing persons who are threatening or intimidating towards Trust staff.

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Executive Summary

Every member of staff working for or on behalf of St George's University Hospitals, NHS Foundation Trust (hereinafter referred to as the **Trust**) has the right to come to work without fear of being abused or assaulted. Unfortunately, the environment in which healthcare workers operate means that many of them are likely to come across patients and people who may (because of their medical condition, for example) unknowingly and unintentionally be abusive or lash out at them. There are also other patients and people who knowingly and intentionally become disruptive and cause harm.

The Trust recognises that under the Health and Safety at Work etc. Act (1974) and its subordinate Regulations and Approved Codes of Practice (**ACOP**), proactive measures must be taken to prevent such harm to its staff, whilst they are at work. Therefore, the purpose of this policy is to help all managers, staff and their representatives to work together to risk assess situations where it is foreseeable that staff are likely to be exposed to abuse.

When abuse, violence or aggression is foreseeable then reasonably practicable and proactive measures and procedures can be put in place to prevent and mitigate such abuse, emanating from whomever or whatever source.

The Trust is committed to having a zero tolerance in allowing its staff to be abused or assaulted and therefore this policy explains an escalation process whereby abuse perpetrators will initially be given a verbal warning to say that inappropriate behaviour will not be tolerated. This can be followed by a formal written warning, with the later possibility of exclusion from Trust premises and/or withdrawal of some services or care to those who are persistent offenders or particularly violent.

The policy cannot provide exhaustive lists or examples or what abusive, threatening, violent or aggressive behaviour that Trust staff are likely to experience, whilst they are at work. It is also not reasonable to have exact proscriptive rules and procedures that staff must follow in sequence in order to diffuse and stop such behaviour.

The policy does however provide a range of reasonable advice and guidance, proactive and preventative measures that can be taken to protect staff. The Trust is also cognisant that patients have an impairment of the mind or brain may be aggressive and violent and this is taken into consideration whilst managing their care needs.

Quick action flowchart relating to aggressive / violent Patients

Initial assessment of a patient who is being aggressive: Verbal warning / Care Planning Approach

1. An incident occurs where a patient is being abusive, swearing or exhibiting threatening behavior
2. Trust staff must not put themselves or remain in harm's way. They should remain professional and try to calm and defuse the situation. CAVEAT: It is acknowledged that some patients may have some form on neurological impairment and staff are still required to provide close personal care in order to manage risks (e.g. of falls or self-harm) to the patient.
3. A senior manager with a clinical role* makes an assessment of the cause of the aggressive behavior, taking into consideration whether the aggressive/violent behavior relates to a disorder of the brain or mind, and completes a dynamic risk assessment of the risks to the patient, other patients and staff.
4. The behavior is reviewed with the patient and consideration as to whether an understanding or behavior 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.
5. If the patient is assessed as having a disorder of the mind or brain which is a significant factor in the aggressive behavior, 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 (see the **Restrictions and Restraints Policy** and **Mental Capacity Act DOLS Policy** for further details).
6. 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 behavior is unacceptable; however no formal verbal warning is necessary in such cases.
7. If the behavior is not related to an impairment of mind or brain, and no agreement can be reached, then a formal verbal warning is issued to the patient; the patient will be told politely but assertively that the Trust has a zero tolerance to its staff receiving abuse.
8. A DATIX form will be completed to state exactly what the unacceptable behavior was and what was said or threatened. The details of the verbal warning will also be documented in the patient's health records (flagged) if applicable.

* A senior manager with a clinical role can include: The Ward Manager or Nurse in Charge; The Site Practitioner; The Matron; The Consultant; The Clinical Team Leader, or the Duty Manager out of hours

A continuation or escalation of the abusive behaviour: Formal written warning

1. Staff must not put themselves or remain in harm's way. They can call the Security department Ext. 3333 at St George's and Ext. 2222 at Queen Mary's Hospital to assist. If alone out in the community, staff must remove themselves from the abusive situation and immediately contact their line manager or clinical supervisor
2. A senior manager with a clinical role* informs the patient that the Trust has a zero tolerance of abuse to its staff and that a continuation or escalation of the abusive behavior is unacceptable, and a **formal written warning** will be served
3. The care team review and update the individual patient's risk assessment. They will consider the specific actions emanating from the risk assessment and create or update the plan for managing this patient. The plan will include specific precautions and preventative measures to be taken by the Trust staff treating this patient
4. Give (or post) the written warning letter (adapt the example in (**Appendix 2**) and a copy of the Trust's Violence and Aggression Policy and Procedure, to the patient
5. A DATIX form will be completed to state exactly what the unacceptable behavior was and what was said or threatened. The problem describing the inappropriate behavior will be added to the patient's clinical record in ICLIP (SONOMED CT term with classification of non-clinical)
6. A copy of the written warning (see example in **Appendix 3**) will also be sent to:
   - The Consultant / Senior clinician in charge of the patient's care
   - The Local Security Management Specialist
   - The patient's GP

Escalation to Part 3 on the next page.

If, despite the issuing of formal verbal and written warnings, the patient repeatedly or persistently exhibits abusive behaviour, consider a move to exclusion

1. A senior manager with a clinical role* must inform the patient that their behavior continues to be unacceptable and will now result in a special panel being convened to consider more stricter means of providing care or treatment
2. An Exclusion Panel** is convened and a second formal written (adapt the examples in **Appendix 2 & 3**) warning letter of exclusion is given or sent to the patient; the letter is signed by the Chief Executive, Divisional Medical Director, DDO or the DDNG,
3. A copy of the letter will be inserted into the patient's health records and copies sent to
   - The Consultant / Senior clinician in charge of the patient's care
   - The Local Security Management Specialist
   - The patient's GP
4. Alternative patient treatment options will be sought and actions will be undertaken to support Trust staff in pursuing a prosecution and/or considering applying for a formal banning order

** The Exclusion Panel will include: Clinical director or Divisional Medical Director, DDO or DDNG. Consultant/Senior person In charge of patient care, Trust Security Manager, External Agencies where required.

Flowchart relating to aggressive / violent Visitors, Relatives, Parents, Guardians, Carers

Initial assessment of a visitor, relative, parent, guardian or carer who is being abusive: Verbal warning

1. An incident occurs where a patient's relative, parent, guardian, carer or a visitor (to the Trust) is being abusive, swearing or exhibiting threatening behavior
2. Trust staff must not put themselves or remain in harm's way. They should remain professional and try to calm and defuse the situation
3. A senior manager*, undertakes a dynamic risk assessment of the situation / abusive behavior and whether the perpetrator poses an immediate risk to themselves, any patient, staff or others
4. The abusive behavior is discussed with the perpetrator and consideration is given as to whether they understand that what they are doing is not acceptable
5. A behavioral agreement can be made but if no agreement can be reached then the perpetrator will be told politely but assertively that the Trust has a zero tolerance to accepting abuse and a formal **verbal warning** is issued
6. The perpetrator can be asked to leave the ward, department or area, or indeed the Trust's premises
7. A DATIX form will be completed to state exactly what the behavior was and what was said

*A senior manager can include: The Ward Manager or Nurse in Charge; The Site Practitioner; The Matron; The Consultant;
The Clinical Team Leader, or the Duty Manager out-of-hours

A continuation or escalation of the abusive behaviour: Formal written warning

1. Despite the verbal warning, if there is a continuation of the abusive behavior, a senior manager* informs the visitor, relative, parent, guardian or carer that further abusive behavior is unacceptable, and a formal written warning will be served
2. The Trust's Security staff Ext. 3333 at St George's and 2222 at Queen Mary's Hospital may be called to assist in dealing with the abusive situation. In more serious situations the police (999) will be called to attend
3. If alone out in the community, staff must not remain in harm's way and they must remove themselves from the abusive situation and immediately contact their line manager or clinical supervisor
4. The senior manager composes a formal **written warning** letter, in which the circumstance of the unacceptable

abusive behavior is explained

5. This letter is then given (or posted, if the address is known) to the visitor, relative, parent, guardian or carer (adapt the example in **Appendix 2**) along with a copy of the Trust's Violence and Aggression Policy and Procedure.
6. A DATIX form will be completed to state exactly what the behavior was and what was said.

Move to consider removal or an exclusion from Trust premises

1. In extreme cases, a habitual offender may persist in abusing or threatening Trust staff. When these perpetrators are known to be on Trust premises, the Security staff (At St George's Extn. 3333 / at Queen Mary's Hospital Extn. 2222) must be informed and the police may also need to be informed, to have them removed.
2. If, the address of the perpetrator is known, a second formal letter of exclusion (adapt the example in **Appendix 2**) from Trust premises will be issued.
3. Depending on the circumstances, the Trust may need to begin legal proceedings to exclude the perpetrator from Trust premises and prevent them intimidating or harassing Trust staff
4. Further actions can be undertaken to support Trust staff in pursuing a prosecution against an assailant if they have been abused or assaulted by a patient's relative, parent, guardian, carer or a visitor (to the Trust).

1 Introduction

The Health and Safety at Work etc Act 1974 places a legal duty upon employers to provide for the health, safety and welfare of their employees whilst they are at work. These duties are further explained in the Management of Health and Safety at Work Regulations 1992 (As amended: 1999) which state that employers (the Trust) are required to assess the risks to the health and safety of their employees and implement and monitor their safety management arrangements. The Trust must also provide adequate information, instructions, training and supervision to its staff to enable them to prevent or mitigate harm, so far as is reasonably practicable.

Violence and aggression towards healthcare workers is a nationally recognised work-related risk. In 2017 Over 17,000 assaults on NHS workers were reported. This fact has been recognised in the Assaults on Emergency Workers Offences Bill (2018) which states that an assault on an emergency worker / healthcare worker will be considered as an aggravating offence which allows a doubling of the sentence for the offender.

It is essential that all Trust staff feel safe and secure, so that they can perform their duties, free from fear and in full knowledge that there are strong management procedures in place to ensure that effective action can be taken should they find themselves in a threatening or abusive situation and in need of immediate help.

2 Purpose

The purpose of this policy is to provide a framework to proactively assess and manage foreseeable risks to staff in order to lessen the likelihood and severity of incidents of abuse, intimidation, violence and aggression occurring, so far as is reasonably practicable.

The policy shows the commitment that the Trust has in supporting those staff that have been abused or involved in violent or potentially violent situations perpetrated by patients, patient’s relatives, parents, carers, visitors to the Trust or any other person, whilst they are at work.

3 Definitions

Abuse: For the purposes of this policy, rather than list all the possible meanings and permutations of the word **abuse**; this generic word is used to cover all forms of violence, aggression, threatening behaviour etc. as listed in section 6.1.

Assault: At Common **Law**, an intentional act by one person that creates an apprehension in another of an imminent harmful or offensive contact. An **assault** is carried out by a threat of bodily harm coupled with an apparent, present ability to cause the harm.

Assault occasioning actual bodily harm (section 47): Actual Bodily Harm (ABH) means any hurt or injury calculated to interfere with bodily health or comfort and would include a hysterical or nervous condition arising from an assault. The degree of injury is more substantial than that required in Common Assault and would include evidence of bruising, strains, sprains, minor wounds, etc.

Crown Prosecution Service guidelines suggest that the following injuries will not amount to ABH but should be proceeded with as Common Assault (Section 39): grazes, scratches, abrasions, minor bruising, reddening of the skin, superficial cuts, black eye, swelling

Attempt: A common example of an attempted assault is where a person throws a stone at another person (victim) but misses. Provided that the victim believed in the possibility of

immediate personal violence, an assault would be complete, despite the stone having missed its intended target.

Battery: This is where actual contact is achieved and no matter how slight, provided the contact is hostile and unlawful, an assault will be constituted.

Common assault and battery (Criminal Justice Act 1988, Section 39): Common Assault and Battery shall be summary offences and a person found guilty of either of them shall be liable to a fine, or imprisonment not exceeding 6 months, or both

Flag: A symbol (or word) that is displayed on a patient's dashboard, patient list or banner-bar (analogous to a warning road sign at the side of a road) in a clinical system (See also the Trust Flags and Alerts Policy)

Harassment: Repeated attempts to impose unwanted communications and contact upon a victim in a manner that could be expected to cause distress or fear in any reasonable person.

Health and Safety Executive (HSE) definition of Violence at work: 'Any incident in which a member of staff is abused, threatened or assaulted by a patient/client or member of the public in circumstances arising out of his or her employment, and includes incidents of verbal abuse'.

Acts of **violence** and **aggression** includes:

1. Physical Assault with or without the use of a weapon, which results in actual physical harm e.g. bruising, lacerations, fractures, unconsciousness, burning, poisoning etc
2. Physical Abuse or manhandling where the assault does not result in actual harm or physical signs pf injury
3. Threats or intimidation whether verbal, written or communicated in a manner that indicates or suggest harm to a person or property
4. Actual or threatened criminal damage to property either belonging to the Trust, its staff or the organisation, per se.

Intentionally or Recklessly: The act must be done intentionally or recklessly i.e. on purpose or without due care to avoid it. The Offences Against the Person Act 1861 classifies assaults according to the amount of force used and the severity of the injury inflicted.

Local Security Management Specialist (LSMS): is a person who has been trained by the NHS Security Management Service (NHS SMS), in security techniques and procedures developed for the NHS.

Lone working: A lone worker is an employee who performs a work activity that is carried out in isolation from other workers without close or direct supervision.

Non-physical Assault: Is defined as 'the use of inappropriate words or behaviour causing distress and/or constituting harassment'

Offensive weapon: Is defined in the Prevention of Crime Act 1953 as "any article made or adapted for use for causing injury to the person or intended by the person having it with him for such use by him or by some other person".

Physical Assault: Is defined as 'the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort'

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, updated 2013 (RIDDOR): Employers must notify their enforcing authority in the event of an

accident at work, to any employee, resulting in death, major injury or incapacity from normal work for seven or more consecutive days. This includes any act of non-consensual physical violence done to a person whilst they are, at work.

Stalking: Behavior which curtails a victim's freedom, leaving them feeling that they constantly have to be careful. In many cases, the conduct might appear innocent (if it were to be taken in isolation), but when carried out repeatedly so as to amount to a course of conduct, it may then cause significant alarm, harassment or distress to the victim.

Threat: A threat is enough to constitute an assault and personal contact is NOT necessary, e.g. where one person points a gun at another. The essence of the offence is the actual apprehension by the victim of imminent force or contact. The victim must believe that the offender can put the threat into effect.

4. Scope

The requirements of this policy are relevant to all Trust staff, temporary or permanent, working for or on behalf the Trust, in all the locations registered with the Care Quality Commission, to provide its regulated healthcare activities. The policy also applies to any member of staff carrying out work on other premises out in the community, such as care homes or patient's homes.

The requirements of, and the protective measures outlined in this policy, equally apply to or are relevant to, Agency, Bank and locum staff, contractors, voluntary workers, part-time workers, patients, patient's relatives, parents and carers, visitors, students and members of the public on Trust controlled premises

The principles and procedures of this policy primarily relate to acts of intimidation, violence or aggression carried out by people on Trust premises where these abusive actions are directly aimed at or affect Trust staff. Issues of harassment, including sexual, racial or other types of discrimination, violence and aggression between Trust staff, or from Trust staff towards a patient or any other person, whilst at work; these situations are more appropriately covered by the Trust's Bullying and Harassment Policy, its Human Resources and Disciplinary Proceedings Policies, and are therefore outside the remit of this policy.

This policy explains that Trust staff do not have to tolerate abuse and whilst they may feel they have the professional obligation to safeguard, treat and care for their patients they also have the right to protect themselves and immediately withdraw from conflict situations to maintain their personal safety; even if in doing so results in an increased risk of harm to the patient, e.g. stepping back when an aggressive patient lashes out and the patient is at risk of falling when not closely supervised.

Where patients have a disorder of the brain or mind which is a moderating factor in violence or aggression, a documented risk assessment / management and care planning approach, lead by the team treating the patient, must be put in place, in order to inform all carers and relatives as to how to best manage the patient.

5. Roles and Responsibilities

5.1 The Chief Executive

The Chief Executive provides leadership to the Trust on all matters relating to maintaining the health, safety and welfare of Trust staff whilst they are at work. They also have overall responsibility for the safety of any patient, visitor or any other relevant person whilst they are on Trust controlled premises or in the care of Trust staff. The Chief Executive has nominated

the Director of Estates and Facilities as the Trust's strategic lead on Health and Safety issues.

5.2 The Director of Estates and Facilities

The Director of Estates and Facilities also provides leadership to ensure that there are suitable and sufficient management policies, procedures and safe systems of work in place to proactively assess the likelihood of Trust staff being abused, threatened or assaulted and that adequate resources and training are then provided to reduce or eliminate the identified risks.

They have the delegated lead role of providing assurance to the Trust Board on all relevant health & safety, fire safety and security issues.

They are responsible to:

1. Inform the Trust Board of any actual or potential breaches of health and safety legislation; including significant acts of intimidation, violence or aggression towards Trust staff
2. Provide support to senior managers and Trust staff throughout any investigation into serious abuse incidents and until legal proceedings have been concluded
3. Monitor the investigation and prosecution of serious incidents, providing assistance to the Police or other authorities (HSE) when necessary and ensuring that appropriate legal advice is available to Trust staff
4. Advise managers on the application of the range of sanctions against those responsible for assaults against Trust staff.

5.3 Medical, Nursing and all other Directors

All Directors have corporate responsibility to help provide a safe working environment and ensure adequate arrangements, resources and support is provided to implement the requirements of this policy: the relevant safety Regulations (ACOPS); safety related training requirements; any associated safe systems of work; and communicate and apply this within their respective Directorate.

5.4 Assistant Director for Health, Safety, Security and Fire / Local Security Management Specialist (LSMS)

The Trust LSMS/Security manager covers the following responsibilities on the St George's hospital site. For sites not owned by the Trust, including multi tenanted sites or care homes the security/LSMS services on those sites may be supplied by a third party. However, the Assistant Director of Health Safety Fire and Security will be responsible for overseeing the compliance of all sites to ensure that risks are sufficiently mitigated. The responsibilities of the LSMS will include ensuring that

1. Security on the St George's main site meets the requirements of national mandatory and statutory framework and any specific local security requirements for the Trust
2. Systems are in place to effectively manage security, per se, and tackle intimidation, violence or aggression on site; this includes monitoring CCTV systems
3. Security staff receive appropriate accredited training and provide relevant advice and guidance to proactively assist Trust staff in the management of violence and aggression.
4. Intimidation, violence and aggression incidents, including no-harm and near-miss incidents that security staff deal with or are reported to them, are fully documented using the DATIX system

5. They provide reports and trends on intimidation, violence and aggression to the Violence and aggression Taskforce Group and thence to the Health, Safety and Fire Group
6. Keep abreast of any operational changes and new NHS security initiatives and inform the Director of Estates & Facilities, and other relevant managers, of any ongoing investigations or actions by the Police, the HSE or other agency, as appropriate

5.5 Violence and Aggression Taskforce Group

For the Trust to maintain an overview of the extent to which abuse, violence or aggression impacts on Trust staff and the overall operations of the Trust. A Violence and Aggression Taskforce Group has been operating with the aims of:

1. Supporting staff who have been or are potentially subject to abuse (V&A) in the workplace
2. Approving the contents and procedures in this Violence and Aggression Policy and Procedure(Identification, Assessment and Management of Intimidation, Violence and Aggression) Policy and Procedures
3. Promoting initiatives to help managers and staff to assess foreseeable risks, prevent and manage potential or actual abuse directed towards themselves, patients and any other relevant person within the Trust
4. Monitoring incident data of abuse within the workplace; including reviewing trends in incidents, near-miss and No-harm incidents
5. Reducing the number and severity of V&A related incidents risk rated moderate and above
6. Escalating high-risk areas/incidents to the Chief Nurse, The Medical Director and all other Directors and proposing remedial actions to mitigate the identified risks

The Taskforce Group meets bimonthly, and the meetings are chaired by the Assistant Director of Facilities. The meetings are considered quorate in the presence of the chair or their nominated deputy and four other members of the Group. Administrative support is provided by the Health and Safety department administrator.

Attendance at Group meetings is open to others, where the Group feels that such attendance is relevant or necessary for the effective consideration or progression of topics on the agenda. The Group work under the authority of the Health, Safety and Fire Group; the Chair reports to this upper Group both by exception and as part of the annual Trust Security Report.

5.6 Health, Safety and Fire Group

The Health, Safety and Fire Group are responsible for ensuring that policies and procedures are discussed, approved and in place to explain the means of protection and supporting staff and managers and all other relevant persons who could be adversely affected by the Trust's operational activities and its undertakings.

The Group is responsible for overseeing that local managers and Heads of Departments provide adequate resources, support and priority to these matters i.e. in undertaking risk assessments and putting in place suitable control measures to ensure the health, safety and welfare of all relevant persons.

The Group will receive updates and assurance from the Violence and Aggression Taskforce Group, on the actions they are taking and any hindrances to progress their actions. The Health, Safety and Fire Group will also receive reports from the Divisions which will include Violence and Aggression coded incidents; any significant risks and their management

thereof; the actions they have taken to support their staff who have been subject to violence and aggression; security measures they have taken to improve the working environments.

In turn the Health, Safety and Fire Group reports up to the Trust Risk Committee and significant risks are reported to the Risk Management department for inclusion on the Trust Risk Register as required.

5.7 Divisional General Managers / Divisional Directors of Nursing & Governance / Clinical Directors / Lead Consultants

All these managers must ensure that

1. They comply with the requirements of this policy and that violence and aggression risk assessments (See **Appendix 6**) are carried out and retained within their areas of responsibility
2. Action plans and resources relating to the findings of the risk assessments are put in place, followed through and periodically reviewed at time appropriate to the level of the risk
3. Members of staff are fully supported when reporting violence and aggression related incidents
4. Having undertaken the risk assessments and put in place suitable control measures, it may still be necessary to add these risks onto the Divisional Risk Register.
5. They investigate all Violence and aggression related DATIX incidents that take place in their departments and provide feedback to the reporter.

5.8 Local Managers / Matrons / Supervisors / Heads of Departments/ Site Practitioners/ Clinical and non-clinical Team Leaders

It is not reasonable to specify the exact roles and responsibility for every level of management or the specific responsibilities commensurate with their job title. However, it is reasonable that managers (per se) and their staff must co-operate to gather intelligence on the foreseeability of any work-related hazards and risks and put control measures in place to eliminate or reduce those risks. Local managers, supervisors or department heads have a responsibility to ensure that:

1. A ward / department or area risk assessment has been carried out and a suitable action plan to address those identified risks is in place and monitored **(as per Appendix 8)**
2. They Identify those staff most at risk, such as lone workers out in the community and reception staff and take reasonable practical steps to eliminate or reduce the risks
3. They identify safe working practices and provide appropriate training for their staff, commensurate with their roles and responsibilities, e.g. de-escalation training / conflict resolution training, Prevent training, and breakaway techniques
4. Have local arrangements in place to treat known abusive patients and evaluate the effectiveness of any control measures that are put in place
5. Provide immediate support to their staff who have been subject to abusive, violent or aggressive incidents by listening to their account of the incident; debriefing and discussing with their staff the options open to them; offering counselling; reporting the matter to the police and the Security Manager (Trust LSMS); completing a Datix or statement; offering victim support advice; and any support that their staff representative or Union can provide
6. Where appropriate, managers should also inform their staff of the Criminal Injuries Compensation Scheme (**See Appendix 1**) and accompany and assist the staff victim of assault through any legal proceedings and court attendances

7. Ensure that DATIX incident reports are completed and that they investigate and address the issues raised in them, in a timely manner and provide feedback to the incident reporter.

Other significant factors for managers, supervisors and heads of department that they need to consider (This is not an exhaustive list)

1. The degree to which an assault or threat undermines the personal dignity, freedom and confidence of the victim
2. Any previous recorded incidents of abuse, this may be anecdotal or occurring some time ago, but their nature and degree of severity may still need to be considered relevant
3. The effectiveness of taking any formal action in preventing a repetition of the abusive behaviour i.e. the health problem / illness of the abusive patient must be considered. (E.g. confusion due to medical or mental illness and all other examples provided in section 6.1).
4. The patient's age, mental capability, disability, their understanding of English and comprehension or what is being asked of the abusive perpetrator
5. It is acknowledged that on occasions, some staff may request or refuse to treat a patient who has been threatening or abusive towards them
6. The Trust, through the relevant departmental management team, will decide whether patients, who refuse to accept services or treatment on racial, sexual, or on any other similar grounds, may also be implicitly refusing to accept these services and treatment from other Trust staff

5.9 Trust Staff of SGH Trust

The Trust does not expect staff to intervene in such a manner as to place themselves in harm's way in order to protect or prevent damage to or theft of property or to deliver care. Every member of staff has a responsibility to follow safe working practices, therefore Trust staff must:

1. Take reasonable care of their own health and safety and that of others who may be affected by what they do or do not do
2. Co-operate with managers to implement measures to reduce incidents of intimidation 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 with patients or others in a manner which is likely to inflame or aggravate the situation
5. Share information with other Trust staff so that the members of their teams are forewarned of likely risks and comply with the findings of local risk assessments (see **Appendix 8**)
6. Be responsible for adhering to and co-operating with the procedures in this policy and help address the issues of violence and aggression within the workplace
7. Report all incidents and near misses of abuse and violence using the DATIX incident reporting system
8. Attend Conflict Resolution Training, or any other personal safety training provided by The Trust's and attend refresher training on the 3rd year.
9. Any member of staff who has been assaulted is entitled to know about the 'Legal options available to a staff victim after an assault (see **Appendix 1**)

5.10 Security Department at St George's Hospital Main site

At the main Trust site in Tooting SW17, the Security department are responsible for:

1. Providing timely and adequate response to **3333** or other Emergency Assistance calls relating to intimidation, violent or aggression
2. Documenting and preparing security reports on intimidation or violent incidents they attend
3. Only (trained) Security staff should apply holding and controlling techniques; they are not expected to apply these techniques alone. Verbal interaction must be used before and during any attempts at physical Breakaway or Holding and Controlling, and continue until the incident ceases
4. Listen to the advice and guidance of clinical staff when dealing with patients (who are, or appear to be, violent or aggressive)
5. Wearing their stab proofed vests and any other Personal Protective Equipment (PPE).

5.11 Security at Premises not owned or operated by the Trust

Managers and landlords at Community Health premises (not under the control of SGH Trust) are responsible for ensuring that they have local security arrangements in place. The Trust expects these providers to operate the same safety and security standards as are set down in this policy.

In the community healthcare settings, should violence and aggression break out, Trust staff must dial 999 and ask for police attendance before informing the relevant Trust departments. At Queen Mary's Hospital in Roehampton, staff who require the immediate assistance of Security Staff (Who will respond 24/7) must dial **2222.**

5.12 Other stakeholders & service providers

There are several other stakeholders with which St George's University Hospitals interact with and rely on; these include for example, retailers on Trust premises, Contractors, PFI partners, St George's University of London, MITIE and other service providers. The Trust co-ordinates and cooperates with these bodies/businesses as necessary to seek their cooperation on security & policy matters in order to ensure the safety and wellbeing of all relevant persons on Trust premises.

5.13 Occupational Health Department (OHD)

The Occupational Health Department (OHD) provide or facilitate post-incident counselling services for all staff who have or may have been adversely affected by any violent / potentially violent incident, whether emotional or physical. Staff can self-refer to the department but it is preferable that the victim's line manager arranges the referral. Where appropriate, staff may be referred on from the OHD to other relevant specialist clinics or agencies.

The OHD collates figures relating to the number of referrals as a result of anxiety/stress, work related ill-health, and work related accident/incident experienced in the workplace. They present this information and incident trends to the Health, Safety and Fire Group.

5.14 The Health and Safety Department

If an incident results in a member of staff being killed, suffering a specified major injury or is incapacitated from work for more than seven consecutive days (including weekends) as a result of an assault / violent incident. The Health and Safety Department must be informed immediately so that this can be investigated and assessed as to whether the incident fits the criteria to be reported as an F2508 report to the Health and Safety Executive; under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995 (RIDDOR) as amended 2013.

The Health and Safety Department are also responsible for

1. Drafting health and safety related policies and progressing them through the Trust's approval and ratification process and publishing these on the intranet so that all staff have access to the policies
2. Providing advice and guidance on undertaking risk assessments associated with violence and aggression and the proactive preventative measures that wards and departments can take
3. Monitoring the adequacy of and compliance with the requirements of this policy
4. Undertake planned weekly ward and department inspections during which the local arrangements for managing aggression and violence incidents are assessed
5. Send Violence and Aggression acknowledgement letters to staff affected by violence or aggression; these letters contain advice and support information.

6 Understanding the causes of violence and aggression in the healthcare environment. Assessing these risks and introducing preventative physical, practical and operational measures; including formal verbal and written warnings.

6.1 Recognising the causes of violence and aggression

It is important that Trust staff can recognise and understand how and when banter, innuendo, raised voices, rude gestures or environmental stressors can arise, escalate and provoke people to become frustrated and angry and this can subtly or very quickly turn into overt aggression or violence.

In making a risk assessment the following factors **(these are not exhaustive lists or examples)** are just some of the multi-faceted ways which may indicate that there is a likely risk of abuse or violence occurring when dealing with members of the public / patients / visitors / relatives i.e. people who are:

1. Angry at waiting times or delays in treatment
2. Afraid / lonely / emotionally charged / cold and hungry
3. Children and teenagers who are immature and/or have limited sense of their responsibilities
4. Confused / disorientated / suicidal / distressed / depressed
5. Intoxicated / drug or medication abusers / people who self-harm, self-mutilate, self-neglect
6. Suffering from mental illness / stress / bereavement / domestic or sexual abuse
7. Alzheimer patients / patients who have had a stroke or a head injury
8. Have a criminal history of violence / recidivists
9. Referred to St George's because they were abusive or violent in other NHS organisations or GP practices

There may well be environmental and operational factors within St George's Hospitals and premises that can contribute to or cause frustration and lead to abuse, such as

1. The hospital environment itself and the sounds and smells therein
2. Cancelled clinics and appointments or delays in ambulance transport
3. Family disputes and disagreements on a patient's care or treatment
4. Inadequate or confusing direction signage and instructions
5. Lack of amenities, parking spaces, toilet facilities, refreshments, disabled access, wheelchairs
6. Overcrowded, hot/cold and noisy waiting rooms, inadequate seating and long delays in clinic appointments

7. Medical or IT equipment failures and cancellation of operations, possibly at short notice and without adequate explanation
8. Poor clinic or ward layout / mixed male/female units which compromises dignity and privacy
9. Shortages of managers and reception staff resulting in a lack of information, poor or absent communications and services
10. Smoking or vaping within the hospital and its grounds

This recognition is an essential part of assessing the potential risks of imminent dangers to staff. The following are just some examples of unacceptable standards of behaviour that may result. These are also examples of the types of abuse incidents that staff must complete a DATIX for; including near-miss and incidents where it is assessed are 'no-harm'.

1. Threatening or abusive language involving swearing or offensive remarks and behaviour
2. A lot of abuse can be face to face, but it may also come by other forms of messaging such as by telephone, letter, Texts, e-mail, graffiti, tweets, Instagram, Facebook, photographs
3. Pointing fingers, staring, inappropriate touching, invading personal space
4. Abusing alcohol or drugs in Trust hospitals and premises
5. Excessive noise e.g. loud or intrusive conversation or shouting; also, abusive telephone conversations, playing loud music, an instrument or mobile phone sounds
6. Throwing acid, any other corrosive substance or any other fluid or object
7. Derogatory racial, ethnic or religious remarks, provocations, signs or actions
8. Offensive sexual gestures or behaviours, openly defecating, urinating or spitting
9. Malicious allegations, stalking or blackmail relating to staff, other patients or visitors
10. Creating noxious fumes, smoking in a waiting rooms, clinics or wards
11. Arson or any other wilful damage to personal property, Trust property, medical equipment, or theft thereof
12. Inciting other people, dogs or animals to attack
13. Any incident where there are weapons (knives or guns) present, or brandishing of articles such as walking sticks, crutches, cricket bats, kitchen cutlery, household furniture, laser pens, which are used to threaten and intimidate
14. Overt violence, conflict, malicious acts or deliberate intentions to commit such acts / kicking, biting, scratching, lashing out
15. Filming, taking photographs or mobile phone videos without permission

6.2 Preventative physical, practical and operational measures

The Trust recognises that it is foreseeable that abuse, violence and aggression will occur on its premises and therefore proactive preventative measures must be put in place. These include risk assessing wards and departments where it is known that abuse is most likely to occur; such as the Emergency Department, Paediatric wards, stroke units. Local risk assessments indicate what preventative and risk reduction measures are required to be in place and these can include:

1. Undertaking patient and local environment risk assessments and sharing the findings during ward or department handover huddles
2. Risk assessing individual patient needs (for example) considering additional one-to-one nursing, the presence of a Registered Mental Health Nurse, additional security presence, putting an abusive patient in a side room but still under observation.
3. Removal of equipment and furniture that could be used as a missile or weapon or a means of self-harming
4. Sharing intelligence on patient risks at the daily Multiple Disciplinary Team (MDT) meetings
5. Communicate waiting times (verbally or on screens) and the reasons for appointment or clinic delays to patients, relatives and staff

6. Providing adequate amenities such as refreshments, TV, voluntary workers to provide advice and directions
7. Providing the deterrent of CCTV cameras, warning posters and signs in high risk areas, Security staff wearing body cameras
8. Controlled access (e.g. swipe cards and digilock access) to prevent unauthorised access
9. Increased vigilance by all members of staff, supported by increased security patrols when required
10. Discrete panic alarm buttons installed under desks in high risk areas
11. 'Flagging' of high-risk patients on the iCLIP patient records system to forewarn other nursing / medical staff; please use the information contained in the Flags and Alert Policy and the iCLIP Flags Alert guide on the Trust intranet.
12. Provision of personal alarms (in ED) and lone worker devices out in the community
13. Heightening the public's awareness of violence and aggression in the hospital / healthcare environment and their responsibilities to help stop it by the Trust providing security campaigns, posters, and talks by the Metropolitan Police, for example
14. Nursing and other therapy staff out in the community (as lone workers) must gather as much 'intelligence' as possible as to whom they are going to treat, when and for what reasons; this is essential to help them risk assess what they are likely to be confronted with
15. Managers of lone workers out in the community must have procedures and means of communication (mobile phones, planned patient visit schedules, flagging on iClip) to inform and keep in contact with their staff and their whereabouts

6.3 Defusing a Situation

In all circumstances it will be necessary for the staff to quickly undertake a dynamic risk assessment of the situation that they are confronted with and assess whether the actions of the patient/perpetrator are deliberate and intended to cause harm or whether the patient's mental or physical condition is compromising their ability to be rational and act reasonably.

In all circumstances it is also best to try to prevent an incident escalating and getting out of hand. Having recognised the signs listed above they must assess the potential of abuse or violence occurring. Trust staff may be able to quickly defuse the situation by using the skills they have learnt on their Conflict Resolution training courses and/or by using a combination of the following behaviours.

1. Identify themselves, presenting their ID, avoid confrontation and arguing back
2. Adopting a sympathetic, empathic, understanding approach, and attempt to show some affinity with the other person's position
3. Speaking and standing calmly with open posture, but always remaining balanced and ready to move away
4. Speaking clearly and slowly and not necessarily stopping talking because the other person does not respond
5. Distracting the person from the immediate cause of concern by changing the course of conversation – buying time to think, to plan, to obtain assistance
6. Trying to identify the source of concern and offering to help if possible
7. Not disagreeing or countering an argument where it is not necessary
8. Not giving orders or using status or authority as a threat
9. Not making threats or promises that cannot be carried out or offering rewards for what probably started out as improper and possibly unlawful conduct
10. Controlling behaviour in body language, feelings, expressions or gesticulations
11. Being alert and sending for assistance and being prepared to leave immediately to avoid an escalation of the situation or possible injury
12. Remain calm and state politely but assertively that the behaviour is unacceptable, pointing out why the particular behaviour is inappropriate or offensive.

6.4 Issuing a Verbal Warning

If the initial tactics to prevent or defuse a situation do not work, a combination of the following preventative actions can be undertaken.

1. If the patient is assessed as having a disorder of the brain or mind which is a significant factor in the aggressive behaviour, immediate action may need to be taken to minimise the risk of harm to the patient and others. This might involve immediate physical or pharmacological restraint, in the patient's best interests: See **Restrictions and Restraints Policy** and **Mental Capacity Act and DOLS Policy** for further details. A documented Care Plan should be simultaneously completed to help manage and minimise the risks going forward, and this may involve a **multidisciplinary and multiagency review,** along with a documented process to review this care plan. Verbal feedback can be given to the patient that their behaviour is unacceptable can still be given and a DATIX completed. However, a formal verbal warning should not be given in such cases.
2. If a disorder of the brain or mind is not a relevant factor in the aggressive act, the perpetrator of the abuse (whomever they are) must initially receive a **verbal warning** from Trust staff; preferably the most senior person on duty in that ward, department or area. They will explain what behaviour is unacceptable and that the Trust, and its staff, has a **zero tolerance** to accepting abuse
3. Such verbal warnings must be stated clearly, politely and assertively. Verbal warnings will not always be appropriate and should only be attempted when it is safe and relevant. Verbal warnings should preferably be delivered when other Trust staff are present, as witnesses
4. If any member of staff (particularly young and inexperienced staff) feels out of their depth in dealing with this type of situation, or if the situation begins to escalate out of control, they must remove themselves from the situation and seek help from their immediate superior manager or supervisor. At this stage, also **consider** calling Security Ext. **3333** at St George's Hospital, Ext. **2222** at Queen Mary's Hospital or **999** in other locations out in the community
5. In any event, even if there is 'No harm' or the incident is regarded as a 'near-miss'. The member of staff who issues the verbal warning must complete an adverse incident DATIX report with as much detail as possible. The reporter must state exactly what has happened, what was said, including any swear words and offensive gestures, and detail of all mitigating actions taken
6. The perpetrator must be warned that if their unacceptable behaviour continues, more formal action may need to be taken
7. If the perpetrator of the abuse is a patient, a note must be placed in the patient's medical notes (iCLIP)**.** The incident must be discussed at shift/team handover so that the oncoming staff are forewarned. If the patient is to be transferred to another ward or clinical area, such incidents must also be communicated to the receiving staff so that they are similarly forewarned
8. If the perpetrator is a visitor, patient's relative, parent or carer or other members of the public then they can also be given a **verbal warning** in the same manner. They must be advised of the consequences of any further infractions, which for them, may include being asked to leave the ward or department, being escorted from the ward or department by a member of the security staff; with the possibility of their further loss of access to Trust premises
9. It may also be necessary for the healthcare professional, ward or department head to discuss a relative's or visitor's inappropriate behaviour with the patient; who may already be a witness to, or the target of the abuse, and in need of protection/comforting.

6.5 Issuing a Written Warning

In response to a verbal warning, the perpetrator of abuse can be offered the opportunity to calm down and apologise, amend, or explain their actions. A verbal warning if conducted early and in the correct way, can possibly stop escalation, calm the situation, and prevent a repeat of the unacceptable behaviour.

However, if the abusive behaviour escalates further into a more serious or persistent situation (possibly a series of abusive incidents over a period of time) then the following actions can be undertaken.

1. Continued failure to comply with reasonable requests to return to acceptable standards of behaviour may result in Security Staff being called to assist and the relevant senior manager of the ward, department or area being informed. Out of hours - the Duty Manager must be informed
2. If a member of staff, working alone out in the community feels threatened in any way, they must not continue to stay (in a patient's residence) and be abused or threatened. They must leave the patient (or the abuse may emanate from another person in the premises) and contact their line manager and/or their base office immediately
3. In all circumstances Patient Safeguarding must not be forgotten, particularly if infants or children are involved
4. A senior manager with a clinical role (This can include the Ward Manager or Nurse in Charge; The Site Practitioner; The Matron; The Consultant; The Clinical Team Leader, or the Duty Manager out of hours) will convene an urgent case patient review along with the nursing or therapy staff treating the patient
5. They will draft and agree a formal written warning letter **(see Appendix 2)** and present this (or post this) to the abusive patient. A similar letter **(see Appendix 3)** will also be sent to the patient's GP, the LSMS and the patient's consultant must similarly be informed.
6. The urgent case review will have taken the following matters into consideration
   - An assessment of the risks that this patient posed to themselves, staff and others
   - Agree a case management plan and alternative or modified methods of healthcare support
   - Consider the patient safeguarding implications of not providing care
   - Agree an ongoing evaluation of the situation and re-engagement with the patient (if possible)
7. Any person behaving in an unlawful manner towards Trust staff will be reported to the police and the Trust will seek the application of the maximum penalties available in law. The Trust will assist in the prosecution of perpetrators of crimes on or against Trust property, its assets, or staff, and seek an injunction against such persons

6.6 Modifying or Withholding Treatment

It will only be in exceptional circumstances that the Trust will issue a formal letter to a patient to modify* the means by which treatment is provided, or in extremis, withhold treatment. Modifying or the withholding of treatment will only apply after a patient has previously received verbal and written warnings and exhausted all other reasonable means of providing them with suitable treatment and care. Any letters sent should include a mechanism for the patient to appeal such a decision at any time. The following procedures will be followed:

1. Confirmation with the patient's Consultant and/or GP that the decision to modify or withhold treatment is appropriate and proportionate to the abuse violations and the findings of any risk assessments
2. Confirmation that the abuse / violent behaviour has been fully documented by the Trust staff and any witnesses involved; see DATIX reports, patient notes, iCLIP, witness statements

3. A senior manager (DDN, DGM) must have investigated (undertaken a root-cause-analysis) of the abuse infractions and been privy to all relevant discussions and reports about the abusive behaviour
4. Ensure that the patient has been made fully aware of and understands (preferably face-to-face) that because of their unacceptable behaviour, their means of receiving treatment needs to be modified or possibly withheld
5. Ensure that the patient has been provided with written notification confirming the rationale for modifying or withholding of treatment; the notification includes a concise summary of the times and dates of the abusive behaviour and a copy of this Violence and Aggression Policy and Procedure
6. A copy of the notification letter will also be sent to the patient's GP, their carer, and/or closest relative; the LSMS and the patient's Consultant
7. Healthcare workers need to work within the requirements of the Human Rights Act 1998 and take care to ensure that the withholding of treatment is done in a way that does not amount to an infringement of the patient's Conventional Human rights.

* Modify, in this context could, for example, mean that a patient who has been abusive to Trust staff in their home setting will be expected to attend a hospital clinic for their treatment where there will be close supervision by clinicians, nursing and possibly security staff. It could also mean that an abusive prisoner will be closely escorted to a Trust clinic by prison warders and/or police officers, to receive their treatment. Alternative care arrangements may also need to be made with other NHS Trusts, GPs or care providers.

If a decision is made to withhold treatment, then it must be made in the context of a defensible decision and the Director of Nursing and the Medical Director must be able to justify their actions. They must consider each case individually to ensure that the need to protect Trust staff is properly balanced against the need to provide health care to the abusive patient. The withholding of treatment will be time limited for a period of no more than 12 months.

The Trust recognises that it would only be appropriate to withhold treatment where violence and abuse are likely to:

1. Prejudice any benefit the patient might receive from the care or treatment being provided
2. Lead Trust staff to believe that they cannot carry out the care effectively
3. Result in damage to property inflicted by the patient or in the process of containing him/her
4. Compromise the safety of Trust staff involved in the provision of clinical care
5. Compromise the safety of other patients or any other relevant person

6.7 Clinical care of abusive or aggressive patients

It is recognised that in emotionally charged situations and/or situations where patients are not in full control of their mental faculties (for example they may have had a head injury, a stroke, or their medication or addiction may be causing a mental disturbance) then a patient may lash out, act aggressively, swear or use sexually provocative words or actions.

Trust staff must use all their professional safeguarding skills and tact when dealing with these sick and possibly disabled patients. This cohort of patients may require very personal and intimate treatment and it is when the nurse or healthcare therapist is providing such care that they are at a higher risk of being abused / assaulted.

Challenging patients in shared ward bays can offend or disturb other patients; consider relocating these patients to a single room, if possible. This must be a balanced decision, as relocating the patient to a single room may place staff at greater risk when doing so. In cases where the patient/offender has a disorder of mind or brain, then the local manager and clinical lead must review the risk to staff and put in place a patient management care plan to reduce the risk of further incidents.

If a doctor decides that sedation of an aggressive patient is inappropriate on the grounds that the violent behaviour is intentional and persuasion or firm cautionary advice fails to persuade the patient to desist, then a breach of the peace has taken place and the security staff and possibly the police may need to be called (as a last resort) to deal with this situation.

Where risk assessments indicate that staff could be expected to hold and control patients in the course of their work, only those who are adequately trained to do so and receive refresher training on a periodic basis in its application and certified as being competent and permitted to effect restraint.

There may be occasions when patient with a disorder of mind and brain require sedation. In these circumstances the attending physician and/or the appropriately trained mental health staff will instigate their clinical protocols and maintain close supervision of the patient until they have been sedated, are calm and more able to engage in their treatment.

6.8 Exceptions to issuing a verbal or written warning to patients who are abusive, violent or aggressive

Those patients who, in the professional judgement of the relevant clinician (Registrar level and above) or senior nurse / therapist, are not competent to take responsibility for their own actions, will not be denied treatment or be presented with a written warning. This is not an exhaustive list, but examples include

1. A patient who unknowingly or unintentionally becomes violent and aggressive as a result of an illness, injury, a disability or a disorder of the mind or brain
2. Patients who require urgent or lifesaving emergency treatment
3. Any patient under the age of 18
4. The patient is so disturbed that sedation by a physician is required

6.9 Removal of an abusive individual from Trust premises

1. A breach of the peace occurs whenever harm is done or is likely to be done to a person or damage done to the Trust's equipment or property. It also occurs when a member of staff is in fear of being so harmed by an assault, affray, unlawful assembly, riot or other disturbance. Where an individual's behaviour is deemed to be causing a breach of the peace, it may be necessary to remove the individual(s) (visitor, relative or other member of the public) from the premises
2. Every citizen whether a police officer or not, in whose presence a breach of the peace is committed has the right to take reasonable steps to make the person who is breaking or threatening to break the peace, refrain from doing so
3. Those reasonable steps may include removing the perpetrator from the premises or detaining him/her against their will, short of arresting them. The Security staff may be able to persuade an abusive perpetrator to be escorted from the premises or the police can be called to assist
4. The expelled individual should be informed that they can appeal against their expulsion by making a complaint in writing, requesting a review as to why they have been excluded. They should direct their request to the to the Chief Executive; the review will be led by an Assistant Director

6.10 Imminent threats, or overt violence and aggression

If there is an imminent or immediate threat to any member of staff or violence has broken out. Trust staff are not expected to stay still and be silent, they must not retaliate, provoke or tackle violent individuals or deliberately place themselves in harm's way, they must:

1. Immediately assess and determine the seriousness of the threat to themselves (and others) and immediately back away or completely decamp from the situation
2. Attempt to disengage themselves from the abuse / attacker and keep their distance from the assailant
3. Not be embarrassed to **SHOUT for HELP** from others
4. If provided, activate a personal attack alarm, or lone-worker device, either the fixed or portable types
5. Call for immediate assistance from the Security Department (Extn. **3333 in St George's Hospital**; Extn. **2222 at Queen Mary's Hospital Roehampton**; or **(9)999** in other hospital locations; or **999** anywhere out in the community) Where this is not possible, staff are entitled by law to use such force as is reasonably necessary to defend themselves and create a window of opportunity to escape
6. Immediately seek or apply First Aid treatment, call 999 for Ambulance / Police / Fire Services as necessary
7. In the rare event of a firearms or weapons attack, adopt **"RUN, HIDE, TELL" (see Appendix 4)** 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).

6.11 Weapons, Firearms and Lone Workers

It is a criminal offence to carry an offensive weapon i.e. any article or device made or adapted for use as a weapon or intended for such use. It is a specific offence to carry in a public place a blade or pointed weapon or a folding pocketknife where the blade exceeds 3 inches.

Where an offensive weapon e.g. knife or firearm is discovered or suspected to be on a patient, their relatives or anyone else associated with a patient. Trust staff must consider the safety of themselves and all other persons in the immediate area. The ward or department manager or supervisor and Security staff must be informed immediately.

If it is safe to do so, warn other staff, prevent people entering the area and begin to move patients and visitors away from the area; seeking local support from other wards and departments as necessary. Ensure the security staff and/or police are met and taken directly to the weapon first (to isolate and secure it) and then the offender. Follow Police instructions until they say it is safe to return to a normal work routine.

If a member of Trust staff is providing care or treatment in a patient's private home or some other place which a Trust controlled property and they discover a firearm or weapon which causes them concern. They must decide whether they need to vacate the premises at the earliest opportunity.

Quite often such items will be on display or may be an antique. There is normally no need for an immediate police response to such situations and advice can be sought from the Police Firearms Licensing Department. For other weapons, Trust staff must inform their line manager and other members of their team, complete a DATIX incident report and make a routine report to their line manager.

6.12 Dealing with abusive or threatening telephone calls

If Trust staff take a phone call and they feel it fits the definition of non-physical assault: i.e. the use of inappropriate words, noises or behaviour causing distress and / or constituting harassment, they should initially try and de-escalate the situation using some of the abovementioned recommendations.

If the situation is not pacified, they could either pass the call on to their manager to deal with the difficult caller, or in the more serious situations, explain to the caller that such behaviour in unacceptable and therefore the conversation will be terminated if it continues. If the abuse continues, the Trust staff should terminate the phone call after stating firmly but politely to the caller that the call is about to be terminated and a letter will be sent to them in relation to their inappropriate conduct (if the caller's address is known).

If the caller makes a threat to any person or makes a bomb threat it is essential that the Trust staff notes/remembers as much detail as possible (times, dates, code words, accent, names or addresses) about what is being said or threatened. In all such cases it is preferable that the call is recorded (if possible) as evidence to be provided to the Police and authorities. Time is of the essence and such calls must be made know to senior managers, security staff and the appropriate authorities for their immediate action.

6.13 Immediate post-incident debriefing and staff support

Incidents of violence and aggression can have a serious detrimental effect on the victim. Trust managers must ensure that their staff are properly cared for and debriefed as soon as is reasonably possible after such incidents.

Depending on the severity of the incident, managers must allow Trust staff (victim) a reasonable amount of time to recover and they must consider allowing them to be relieved of their duties, to go home, be provided with a taxi and/or be escorted home, or taken to a place of safety such as a Hospital Emergency Department.

A debriefing meeting should be held within five working days so that the staff can help to identify the factors that have led up to or contributed to the incident and for them to be able to voice their views about the overall management of the incident. Debriefing meetings can also help to identify additional measures to prevent a reoccurrence and signposting to appropriate sources of support.

Even those staff not directly involved in a violent situation can be distressed and will require information regarding any follow up actions taken, or signposting to appropriate sources of support. It is therefore important that other Trust staff are informed as soon as possible of the basic details of the incident and any counter measures planned.

Managers must offer the counselling services available to all Trust staff via the Occupational Health Department. They must be fully supportive to these staff through any periods of sickness and recuperation and allow them to attend any such Occupational Health Department, GP or other clinic appointments in order for the member of staff to fully recover from their ordeal.

7 Education & Training

The Trust recognises that staff will require different levels of training depending on the level and types of risks that they are likely to face when carrying out their work. All managers, supervisors or those with line management responsibilities for staff must assess what training is actually required to enable them to manage situations of abuse violence or aggression; commensurate with the respective work activity. The risk assessment template in **Appendix 6** will indicate level of training that staff need to attend. The table below

indicates the level of training that staff will require for their various roles within the organisation.

Staff group	Training	Frequency
All staff	Mandatory online conflict resolution training	Every 3 years
All staff who work in public facing role	Enhanced face to face conflict resolution training	Every 3 years
Staff facing specific risk factors		
Staff carrying out lone working within the community	Local induction relating to departmental lone working procedures and device use where required	As determined by risk assessment
Security staff	Advanced breakaway training	Annually
Staff likely to be dealing with specific risks relating to a patient group they are working with	To be determined locally by risk assessment	To be determined locally by risk assessment
Staff likely to be dealing with adults who are deemed not to have capacity	To be determined locally by risk assessment	To be determined locally by risk assessment

Appropriate training is an essential component in enabling staff to confidently manage intimidation, violent or potentially violent patients and situations. Managers must ensure that they themselves, as well as all staff within their area of responsibility, have the level of conflict management awareness training relevant to their area.

8. Relevant Legislation and related Trust Policies

1. The Health and Safety at Work etc. Act 1974
2. The Management of Health and Safety at Work Regulations 1999
3. The Workplace (Health and Safety and Welfare) Regulations 1992
4. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995 (RIDDOR) as amended 2013.
5. Crime and Disorder Act 1988
6. Human Rights Act 1998
7. Mental Capacity Act 2005
8. Adverse Incident Reporting Policy and Procedures
9. Consent Policy
10. Corporate Induction Policy
11. First Aid Arrangements
12. Flags and Alert Policy
13. Guidance on the Risk Scoring Matrix, Risk Register and Risk Assessment Tool
14. Guidelines on Young Persons at Work
15. Health & Safety Policy
16. Lone Working Policy
17. Major Incident Plan
18. MAST Policy
19. Mental Capacity Act and DOLS Policy
20. Personal Protective Equipment (PPE)
21. Policy for Supporting Staff at Difficult Times
22. Restrictions and Restraints Policy

23. Risk Management Policy
24. Safeguarding Adults Policy
25. Safeguarding Children and Young People Policy
26. Security Policy
27. Serious Incident Policy
28. Trust Lockdown Plan

9. References

1. Health and Safety Executive document, Violence in Health and Social Care INDG 69 (Rev) 04/06 http://www.hse.gov.uk/healthservices/violence/index.htm
2. Preventing Workplace Harassment and Violence Health & Safety Executive http://www.hse.gov.uk/violence/index.htm
3.UNISON Violence at Work: A Guide to Risk Prevention
4.Not Alone: A Guide for the better protection of lone workers in the NHS (2009)
5. Offensive Weapons. NHS Security Management Service Guidance (2006)
6.Working alone: Health and safety guidance on the risks of lone working (2009)
7.Preventing workplace harassment and violence: Joint guidance implementing a European social partner agreement (2009)
8. National Audit Office (NAO) (2003) A safer place to work – Protecting NHS Hospital and Ambulance staff from Violence and Aggression

10. Implementation and Monitoring Compliance

The arrangements & requirements of this policy along with the appended procedures will be implemented and monitored for effectiveness through the following mechanisms:

Implementing and Monitoring compliance and effectiveness table					
Element / Activity being monitored	**Lead / Role**	**Methodology to be used for monitoring**	**Frequency of monitoring and Reporting arrangements**	**Acting on recommendations and Leads**	**Change in practice and lessons to be shared**
Monitoring the numbers of security related or other incidents where intimidation, violence & aggression are a feature. This includes 'near miss' incidents and incidents where no-harm to any person has resulted; but there was the potential to do so	Taskforce Working Group. Divisional Governance Managers. DATIX manager. All line –managers who are copied into the Datix reports; as per the DIF 2 module Health and Safety Department	DATIX incident reporting and monitoring looking for trends and high risk areas. Divisional Risk Register reviews. Reports provided to the Violence and Aggression Taskforce Group; from H&S, Security, Occ Health, Training and Education, Divisions, Risk and Governance	Reports produced twice yearly by the Trust Security Managers for the Health, Safety and Fire Group. The Group members are expected to read and interrogate the Security & SI reports to identify deficiencies in their local systems, procedures and act upon them accordingly.	Escalated through to Board, if required. Cascaded through Divisional Governance Managers to the Divisions.	Through the Health, Safety and Fire Group and the corporate communications structure. The Education and Training Department to provide conflict management courses and similar.
The undertaking of Risk Assessments to assess the likelihood of foreseeable violence and aggression Action plans and control measures are developed and	Heads of Departments. The roles and responsibilities of managers are outlined in section 5 above.	Risk assessment process tool as documented in appendix 6	Completion of risk assessments to be monitored through bi-annual Divisional Governance reports. Weekly planned ward and department inspections by the H&S team	Members of Trust Health, Safety and Fire Group and the Violence and Aggression Taskforce Group.	Required changes to practice will be identified and actioned within a specified timeframe. A lead member of the local nursing or department team will be identified to take each action forward as

followed up.					appropriate.

Appendix: 1

Legal options available to a staff victim after an assault

In cases of actual physical assaults on staff, the Trust will work with the police (with the full consent and knowledge of the victim) to achieve a prosecution of the assailant. Staff injured as a result of a violent incident may be able to claim compensation under the Criminal Injuries Act 1968 so long as the incident is reported to police within 24 hours. The LSMS can also assist by referring the staff member to crime victim support services.

The member of staff who has been assaulted (the victim) will need to provide a full and accurate contemporaneous statement to the police if they wish a prosecution to be pursued with any chance of success. When giving the statement the victim has two options on how he/she wishes to be kept informed of subsequent proceedings.

The victim can allow the normal course of events to be followed, in which case he/she would be kept informed of proceedings by the authorities. The Trust would not be involved, in pursuing the prosecution in any legal capacity, nor would The Trust be allowed any access to information regarding the assault from the police, for fear of compromising the prosecution case. In effect, the victim is on their own.

The victim can tell the police officer taking the statement that he/she wishes the Trust to act on their behalf. A nominated Trust senior manager would then maintain communications with the police in order to be kept fully informed of developments regarding the assault and the progress being made through the legal systems.

At a much later date the victim may be called upon to give evidence in court. Giving evidence in court can be stressful; therefore, support will be made available to the Trust staff by a senior Trust manager, the Human Resources Department and the Occupational Health Department.

The Police, CPS and Court will also give Trust staff as much information and help as possible and they will be accompanied by a senior Trust manager to court, if requested by the victim. Assistance will also be provided by the Trust’s Communications Department when dealing with any press enquiries, to ensure that the member of staff’s privacy is maintained.

Additional information on any person’s legal rights

Common Law allows an individual to use reasonable force to protect themselves or others from personal attack. The Criminal Law Act 1967 Section 3 (1) states that ‘a person may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting in the lawful arrest of offenders or suspected offenders or of persons unlawfully at large’. In addition to preventing an assault from taking place it also allows an individual to use reasonable force to prevent criminal damage to, and theft of property.

Defining Reasonable Force and Proportional Response under UK Law

- You may have a right of self defence
- You may exercise ‘minimum use of force’
- You must moderate the ‘proportionality of force used’
- You must consider the ‘seriousness of evil to be prevented’

The Right of Self Defence: The right of any person to defend himself or herself extends to any force used against them. It does not generally extend to verbal abuse; physically defending yourself from verbal abuse may be disproportional to the verbal abuse you face. If, in the process of defending yourself, the assailant becomes injured, then, provided you are the genuine victim and not the aggressor, there should be nothing to fear.

Minimum Use of (proportional) Force: You may only exercise such force as is reasonable under the circumstances in order to prevent or repel an attack. Any force used **must be proportional** to the force being applied against you. It would also not be right if a person who has assaulted you, stops assaulting you, for you to then retaliate and attack the perpetrator as they are walking away or after he or she has desisted.

Seriousness of the evil to be prevented: In considering your self-defence you are perfectly entitled to use such force as is necessary to prevent serious harm to yourself or others. In all cases, provided you act reasonably or in a reasonably held belief that you were in imminent danger, then you are in the right.

Victim Support Line assistance

The ‘Victim Support Line’ is a 24-hour service for anyone who has been the victim of violence, aggression or intimidation and who wishes to discuss their situation impartially and in confidence. This is an independent Registered Charity (No, 298028) that offers help, support and information to those affected by crime, both victims and witnesses.

Tel: 0845 30 30 900

Or contact by e-mail supportline@victimsupport.org

Alternatively, the aggrieved person may wish to discuss the incident **(**during the working day) with the Trust’s

- Staff Counsellor 020 8725 3368
- Chaplaincy Team 020 8725 3070
- Queen Mary’s Chaplain 020 8487 6000
- Security Manager 020 8725 0767
- Security Office 020 8725 0044
- Trade Union representative, who will have a range of information on external victim help organisations

Appendix: 2

VIOLENCE AND AGGRESSION POLICY AND PROCEDURE

Formal warning letter to an aggressive / violent patient

This letter can also be adapted to be sent to a patient's relative/carer/parent/guardian/or visitor

(Delete or reformat the wording as appropriate to the circumstances)

Patient's name
Patient's address
Hospital Number or Community Caseload RIO number

Date

Dear

This is to formally confirm that due to your previous / current / threatened unacceptable abusive behaviour on ………………………………….. at ……………………………………. you are subject to the conditions outlined in the Trust's Violence and Aggression Policy and Procedure (Copy enclosed)

The first stage of the Trust's **Violence and Aggression Policy and Procedure**, a verbal warning, has been applied to you on ……………. and you have not complied with reasonable requests to stop this unacceptable behaviour.

Provide a short statement or explanation as to why Mr / Mrs ……..………… is now subject to this formal warning letter (explain further, as appropriate).

Or

Your behaviour is totally unacceptable and is subject to this direct formal warning letter under the terms of the Trust's Violence and Aggression Policy and Procedure

Should you on any occasion in the future, fail to comply with the expected standards of behaviour explained to you by Dr / Matron ……………………………. you will become subject to the next stage of the procedure which may involve a modification in the manner in which your treatment is provided or an exclusion from the Trust's premises by our Security Staff and / or the Police.

Such an exclusion from Trust premises would not mean that you will not receive any treatment. This is because your Consultant, in consultation with your GP will make alternative arrangements for you to receive treatment and you are still entitled to receive emergency treatment.

If you wish to challenge these procedures or the way they are being implemented you may appeal in writing to the Trust's Complaints and Improvements Department.

Yours sincerely,

Clinical Director (On behalf of the Chief Executive)

A copy of the Violence and Aggression Policy and Procedure, Prevention and Management of Intimidation Violence and Aggression Policy and Procedures should be attached to this letter

Appendix: 3

VIOLENCE AND AGGRESSION POLICY AND PROCEDURE: PATIENT BEHAVIOUR
Formal warning letter for the patient's GP
(Delete or reformat the wording as appropriate to the circumstances)

GP's Name and Address
Date

Dear Dr

Re: Patient's name
Patient's address
Patients date of birth
Patient's hospital health records number / Patient NHS number

The above individual is currently an inpatient (name the ward) / outpatient / community patient under the care of St George's University Hospitals NHS Foundation Trust.

In order to protect the hospital / ward / care environment / other patients and members of staff, it has been necessary to instigate the requirements of the Trust's Violence and Aggression Policy and Procedure, for the above-named patient and issue them with a formal warning letter about their inappropriate behaviour.

The patient has already been subject to a verbal warning about their behaviour on………………….. but their abusive behaviour has now continued / escalated into something more serious warranting a formal warning letter (copy attached).

Or:

The patient's behaviour was so unacceptable as to warrant an immediate formal warning letter. Any further incidents of violence and aggression towards hospital staff or other patients by this patient may involve a modification in the manner in which your patient's treatment is provided, or entail an exclusion from the Trust premises by our Security staff. This matter is also subject to advice being received from the patient's Consultant and senior nursing staff at St George's.

If you have any queries, please do not hesitate to contact ………………… (Name and tel. no. of patient's Consultant)

Or:

………………………………………… (Name and tel. no. of Clinical Director, or Divisional Director of Nursing)

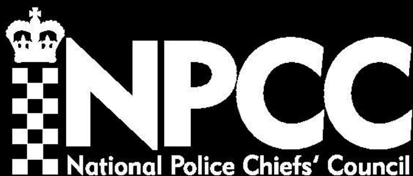
Yours sincerely,

Signature
Name

Clinical Director / Divisional Director of Operations / Divisional Director of Nursing (delete as appropriate)

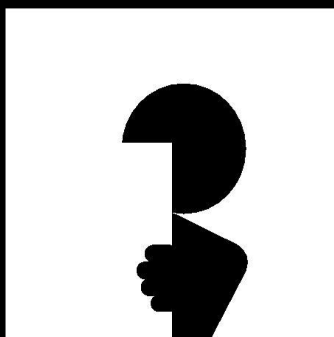
A copy of the Violence and Aggression Policy and Procedure, Prevention and Management of Intimidation Violence and Aggression Policy and Procedures must also be sent with this letter

Appendix 4



IN THE RARE EVENT OF
a firearms or weapons attack

RUN HIDE TELL



RUN to a place of safety. This is a far better option than to surrender or negotiate. If there's nowhere to go, then...

HIDE. It's better to hide than to confront. Remember to turn your phone to silent and turn off vibrate. Barricade yourself in if you can. Then finally and only when it is safe to do so...

TELL the police by calling 999.

Appendix 5

Managing Children and Young People who demonstrate violent, aggressive or challenging behaviour and pose a risk to themselves and/or others

Please follow the steps below:

1. Risk assess patient on admission to ward or department using Trust Risk Assessment documentation.
2. **If immediate risk of harm to self or others**: inform Nurse in charge, Matron, Head of Nursing or Site Manager out of hours. **Call Security and consider need for Police if violence and aggression cannot be managed.**
3. Assessment to be undertaken to ascertain if the young person has Mental Capacity over 16, or is Gillick Competent under 16 (see Child Health website for Gillick competency questions). Do they understand the impact of their actions and the implications/sanctions that may follow?
4. If the young person is assessed as not having capacity or has been sectioned under the Mental Health Act or is awaiting assessment, ensure that in discussion with CAMHS and a senior nurse an RMN Special is provided and transfer to a specialist mental health provider is arranged as soon as possible.
5. If the young person is assessed as having capacity, attempt to de-escalate the situation using calm verbal and nonverbal communication skills and distraction techniques. Changing the person communicating with them can often help de-escalate a situation. Talk in a firm, calm voice and do not hurry them. Do not stand over them, point your fingers at them or keep your arms crossed as these actions imply threat or dominance.
6. Ensure parental presence and involvement if they wish to be included.
7. Inform Safeguarding Team and Social Services.
8. Consider whether the environment plays a part in the aggressive behaviour. A noisy environment can increase aggression in some patients, move to somewhere quieter but keep yourself between the Young person and exit at all times, do not isolate yourself from assistance. Ensure that there is support available within earshot.
9. If violent or aggressive behaviour continues call security and if staff and/or other patients felt to be at risk call police. Inform parents/carers of unacceptable behaviour; ensure Consultant responsible for young person is aware of behaviour.
10. The young person can be prevented from leaving the department if there is deemed a risk to them or others. If the young person leaves the department: contact security to locate and encourage back to the department. If the young person leaves the hospital contact all the following:
    - Police
    - Social Services
    - Parents/carers
    - Safeguarding team
    - Site manager

    Follow missing person policy and complete datix, and document in iCLIP.
11. Restrictive Physical intervention/therapeutic holding can be used to protect young people and /or others from harm and/or to treat them if in patient’s best interest.
12. Ensure that the young person is informed that their behaviour is/was unacceptable and why. When the young person calms down consider introducing a behavioural agreement with them reaching an agreement with them to a standard of behaviour that is acceptable.

13. Visitors under the age of 18 must be accompanied by an adult at all times. If they display violent and/or aggressive behaviour their parents/carers will be asked to remove them from the premises and parents/carers will be informed that they will not be allowed to bring them back onto the ward.
14. Visitors aged 18yrs and over who display aggressive/violent behaviour will be dealt with under the main Trust Violence and Aggression Policy.

Containing and preventing a child or young person from leaving

There are times when a sick child or young person may attempt to leave, such situations can arise when:

- A child or young person presents in the Emergency Department as a result of substance or alcohol abuse
- A child or young person has behavioural difficulties
- A child or young person becomes psychotic because of a medical condition
- A child or young person has attempted self-harm or suicide

Decisions relating to this should be made according to individual circumstances and considering the child or young person's best interest. In such situations reasonable measures need to be taken to contain and prevent them from leaving, this may be in response to an emergency situation and will therefore be short term measure. In all situations the safety and well-being of other patients, visitors and staff must also be considered.

Managing unacceptable behaviour of individuals accompanying infants, children and young people within paediatric areas

If Parent/carer displays unacceptable behaviour, any incident involving verbal or physical abuse or assault, follow the steps below:

1. Politely request parent/carer to modify their behaviour. Offer the opportunity for them to explain their actions and try to resolve any concerns they have.
2. If parent/carer unacceptable behaviour continues the senior nurse on duty will follow the Trust Violence and Aggression quick action flowchart. Give verbal warning and inform them of the expected standards that must be observed, this will be fully documented in the patient's notes and the patient's lead Consultant will be informed. Inform Safeguarding Team and Social services if necessary.
3. Parents/carers should be provided with a copy of the Trust Violence and Aggression procedure and explained the various steps that may be taken against them if their behaviour continues.
4. In extreme cases this may result in parents/carers being removed from the premises and/or reported to the police.
5. Offer a time out or cooling off period away from the ward, consider a behavioural agreement as a way forward.
6. If the unacceptable behaviour continues: inform Security, Matron and Head of Nursing or Site Manager out of hours, to look at temporarily removing the parents/carers from the premises. Remain calm at all times, direct individuals away from patient areas and tell someone where you are. Follow the quick action flowchart and issue a first formal written warning to the parents.
7. This may result in restricting visiting to specific times and if necessary with supervision from a senior member of staff or security. The Safeguarding team must be involved with all decisions regarding restricting parents or carer's to the child or young person.

8. In extreme cases or persistent aggression behaviour we need to consider complete removal or exclusion of the parent/carer from the Trust premises. Any decision to take this course of action must be done in discussion with the lead consultant, Safeguarding team and a senior Nurse (Head of Nursing or Divisional Director of Nursing).
9. Any member of staff who has been subject to significant unacceptable behaviour from parents/carers has the right to opt out of treating the patient. The member of staff must make their concerns known to their line manager and department Matron.

Appendix 6

Violence and Aggression Policy and Procedure Checklist and Risk Assessment.

The 'term abusive' behaviour in this checklist and risk assessment refers to all intentional and non-intentional acts of violence, aggression, threatening and intimidating behaviour, including swearing, spitting and anti-social behaviour exhibited in Trust premises and/or directed towards any member of Trust staff. All parts of this risk assessment must be completed. State NA where sections are Not Applicable.

Directorate being assessed:		Ward / Unit / Area:
Names of those involved in completing the assessment (Block capitals):		Current Date:
Signed:		Review Date:
Assessment of control measures in place	**Yes / No / NA**	**What further actions are required**
Have staff in the ward, department or area attended any training in relation to Security or Conflict Resolution?		(How many staff have actually attended, and how many have yet to attend this training?)
Have all the staff in the ward, department or area (particularly those who are new and inexperienced) been made aware of the likelihood of abuse and what the local arrangements are for them to manage this safely?		(This should initially have taken place during local induction. If not, please arrange this now.)
Are all staff aware of how to call security staff in the event of abuse or threatening behaviour that has or may escalate into a violent situation?		(Ext 3333 at St George's main Hospital and 999 out in the Community. State any local EMERGENCY procedures)
Are staff aware of how to deliver a verbal and a written warning to an abusive patient. And do they know the process to exclude a habitually abusive or aggressive patient?		(These procedures are outlined the Trust's Violence and Aggression Policy and Procedure(to violence and aggression) Policy and Procedures
Are there any particular times of the day/night/week when abusive behaviour is most likely to occur?		(If known, please state when, how often and the possible reasons why)

Assessment of control measures in place	Yes / No / NA	What further actions are required
Do all the staff in the ward, department or area have current and legible personal Trust (or SGUL) ID badges & swipe cards?		
Are safety signs and crime prevention posters prominently displayed in the ward, department or area?		(E.G. Posters that state: Violence and Aggression Policy and Procedure; CCTV IN USE; STAFF ONLY; Authorised Personnel)
Are there any fixtures, fittings, furniture or equipment (medical or non-medical) that could be taken and used as a weapon?		(Consider, walking sticks, sharps, chemicals of any sort)
Are there any alarms in the ward, department or area that staff can activate to call for help?		(Alarms must be tested for their audibility and operation at planned intervals. Please state when, and who tests them)
Is the lighting in the ward, department or area adequate?		(This includes local communal areas, corridors and other access points)
Are there any clinic rooms, cubicles, corridors, parts or the ward, department or areas that are likely to be places of hidden attack/abuse?		
Have the risks to "lone workers" within Trust buildings and those out in the community been assessed, and appropriate control measures and arrangements put in		

place?		
Assessment of control measures in place	**Yes / No / NA**	**What further actions are required**
Are all the windows, skylights (or similar) in good working order and can they be securely fastened?		(Patient areas **must** be fitted with window restrictors; only allowing opening up to 10 centimetres / four inches)
Are there any Closed Circuit Television (CCTV) cameras recording the views of entrances, communal and/or access areas		
Are "controlled" access doors & entrances clearly visible to the door operator? (Either under direct vision or indirectly by CCTV)		(All electronic access control systems (where fitted) must function correctly at all times. Codes MUST NOT be written on doors and walls beside locks. Also consider the frequency of changing entry codes, swipe cards.)
Is there adequate secure storage (lockers & changing rooms) for all Trust staff's personal clothing & belongings in the ward, department or area?		
Are all store rooms, filing cabinets, and storage cabinets locked and secure at all times, when not in use?		(Consider high value items, chemicals, research material, patient notes, IT and medical equipment. Key holder lists and key cabinets must be kept secure and up to date)
Are all controlled drugs, medicines cabinets and drug registers kept secure, when not in use?		
Are all incidents involving breaches of security, assaults, threatening behaviour incidents (and similar near-miss incidents) reported on the DATIX electronic reporting system?		

Do nursing and other staff know how to ‘flag’ a problem in iCLIP In an individual has a history of abusive behaviour		

No.	Hazards and Risks to Staff, Visitors & Patients.	Who might be harmed and How?	What risk controls are currently in place?	Likelihood X Consequences = Risk Score	What further controls / actions are required? Who is responsible to do this and (the date) by when?
1.	Is there a risk that particular individuals or groups of Trust staff are likely to be subject to abusive behaviour in the ward, department or area? Note: Please state who those individuals or groups are and how many of them are there? Consider all Trust staff such as, receptionists, front line nursing staff, doctors, porters, etc.				
2.	Is there a risk that individual patients or groups of patients are likely to exhibit or use abusive behaviour? Note: Please state who these individuals or groups are and how many of them are there? Consider high risk patients (e.g. those with a known history of violence; those in custody under police escort or				

No.	Hazards and Risks to Staff, Visitors & Patients.	Who might be harmed and How?	What risk controls are currently in place?	Likelihood X Consequences = Risk Score	What further controls / actions are required? Who is responsible to do this and (the date) by when?
	accompanied by a Registered Mental Health Nurse; intoxicated or perpetrators of domestic abuse). These patients must have been adequately assessed and suitable control measures put in place?				
3.	Is there a risk that visitors, groups of visitors or patient's relatives are likely to exhibit or use abusive behaviour? Please state who these individuals or groups are and how many of them are there?				
4.	Is there a risk that people (trespassers and other unauthorised persons) can gain access or 'tailgate' into a ward, department or area that they should not be in? (Consider all access and egress routes, fire escapes and openable windows)				
5.	Insert any other local or specific risks.				

SEVERITY INDEX		LIKELIHOOD INDEX*		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Divisions; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Score	Incident / Risk Grade (NPSA Cat.)	Communicated to and overseen by	Investigation Level
15 - 25	Catastrophic	Immediately alert Head of Governance Board of Directors	SI Procedures RCA – 60 working days (Board notification)
10-14	Major	Alert Clinical Director Risk Management Committee	RCA – 45 working days
8 - 9	Moderate	Inform Service Manager	Care Group Analysis – 10 days
4-6	Minor	Ward/Departmental Management	Ward/Department Analysis – 10 Days
1-3	None	Ward/Departmental Management	Ward/Department Analysis – 10 Days

X	LIKELIHOOD					
SEVERITY		1	2	3	4	5
	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5