University Hospitals of Leicester NHS
NHS Trust

Restraint Guidance

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Trust Lead:	**Vincent Smith, Local Security Management Specialist** **Simon Daley, Local Security Management Specialist**
Board Director Lead:	**Andrew Furlong, Medical Director**
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Next Review Date:	**March 2022**

No.	Procedure for Initiating or Utilising Restraint – Management of the Incident
6.4	**The member of staff identifying the violent or aggressive behaviour or intent will**:- a) Report the incident to the designated Person in Charge of the area. b) Wherever possible and if it is safe to do so, move other patients away from the vicinity. Obtaining assistance of other staff to do this if necessary. c) Attempt to de-escalate by reassurance and other means. d) Maintain dialogue with the patient where possible e) Provide a full explanation of the circumstances of the incident to the person in charge of the ward or department.
6.5	**The Designated Person in Charge of the area (Clinical) will assume the role of Incident Manager, until the Duty Manager or their Deputy arrive and take over responsibility for Incident Management. The incident manager will**:- a) If they consider restraint is likely, request (without delay) the presence of the security response team and Duty Manager and/or the Police, as appropriate. In all instances where the assailant is in possession of a weapon the police must be summoned. b) Ensure that clinical advice is sought and taken into consideration before any restraint practice is initiated, and that a clinical lead is identified to provide leadership and support. c) Adopt the role of Incident Manager for any restraint that does take place, and conduct the risk assessment (Dynamic Risk Assessment in the case of live incidents) of the circumstances that will determine whether restraint is appropriate and justified. d) Have a sufficient understanding of restraint processes, of the law, and of this policy to ensure a satisfactory outcome for all involved. e) Inform appropriate medical staff and the Duty Manager with appropriate urgency. f) Ensure that wherever possible de-escalation techniques are used throughout a restraint process. g) Arrange for the family, friends or carer to be contacted/be involved if they may have a calming influence on the person. h) Arrange and lead the de-brief and participate in any subsequent follow up and support. i) Ensure the incident is reported via Datix and in accordance with Trust Policy. j) Take charge and be responsible for the management of the incident until its conclusion. k) Consult with sufficient staff to make an informed judgement that restraint is necessary and appropriate under the existing circumstances l) Consider whether alternative behaviour management measures may be more effective and appropriate than the use of restraint. m) Seek clinical advice (where possible), before using any form of restraint to identify if there are health or medical conditions that would prevent the use of restraint, or necessitate close medical observation during the restraint. n) Ensure that only those staff who have successfully completed the approved training course and who are in date for their training are expected to take part in incidents requiring the application of restraint. o) Staff who are not directly involved in restraint to other duties (for example comforting

No.	Procedure for Initiating or Utilising Restraint – Management of the Incident
	other patients or controlling access to the scene)
6.6	**Care of the patient during the procedure** Physical Monitoring is important during and after restraint. This should be documented as part of the risk assessment and also in the Plan of Care. Monitoring must be undertaken by the Clinical Team in attendance and must include observations using the Early Observations EObs criteria. This is especially important:- a) Following a prolonged or violent struggle. b) If the person has been subject to enforced mediation or rapid tranquilisation. c) If the person is suspected to be under the influence of alcohol or illicit substances. d) If the person has a known medical condition which may inhibit cardiopulmonary function e.g. obesity (when face down), asthma, heart disease etc.
6.7	**Post Incident Support** The aim of a post-incident review should be to seek to learn lessons, support staff and patients and encourage the therapeutic relationship between staff, patients and their carers. (NICE 2015)NG10. A de-brief should take place as soon as practicably possible post-incident unless there are exceptional circumstances which prevent this. Reflective reviews and root cause analysis are essential after restraint. The review should address:- a) What happened during the incident? b) Any trigger factors. c) Each person's role in the incident. d) Their feelings at the time of the incident, at the review and how they may feel in the near future. e) What can be done to address their concerns? As soon as practicably possible following the use of physical interventions the staff involved will meet together. This time will be used to discuss any issues anyone may have as well as reviewing the details of the incident itself. Any significant points raised must be documented and discussed with the LSMS. All persons involved in the use of physical interventions must be offered post-incident support by the appropriate line manager, and be involved in any support or feedback process. The person leading the team must ensure the Trust's Incident Reporting form and process is completed. All staff engaging in Physical Intervention and restraint practice will be fully supported by the Trust in accordance with the Trust policy on Violence and Aggression Part 1 - Statement of Intent.
6.8	**Post Incident Investigation** Following every incident where physical intervention and restraint had been applied by staff, there will be a post incident investigation. The aim of this is to establish the facts, analyse the cause, identify triggers and any necessary improvements to the safety management system or staff practice. Responsibility for post incident investigation lies with the Trust Health and Safety Advisor supported by the relevant CMG Staff and the Local Security Management Specialist.

No.	Summary of recognised methods of restraint
7.1	**Behaviour management guidance** A key principle of using de-escalation techniques is to calm a situation and avoid the need for restraint by applying techniques including communication and distraction. Conflict Resolution Training (Personal Safety) is mandatory for all Front line NHS staff. Booking details can be found on the UHL. Managers must ensure all staff within their area of responsibility attend this training.
7.2	**Physical Interventions/Restraint** Any staff using physical restraint should:- a) Wherever possible use de-escalation techniques irrespective of the stage of the restraint. b) Ensure that one member of staff leads the team and assumes control of the person being restrained throughout the process. He or she should ensure that the restrained person's: o head and neck is appropriately supported and protected. o airway and breathing are not compromised. o vital signs (pulse, Blood Pressure and Respiratory rate Rate) are monitored. c) Monitor the person's overall physical and psychological well-being throughout. For safety reasons, during a restraint it is only permissible to hold/apply pressure to the person's limbs. Under no circumstances must direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. (See also face down/prone restraint – 7.3). d) To avoid prolonged physical intervention/immobilisation, consider rapid tranquillisation or seclusion (which may be safer where appropriate) as alternatives. e) Every effort should be made to use skills and techniques that do not use the deliberate application of pain. f) The level of force applied must be reasonable and necessary and proportionate to a specific situation, and be applied for the minimum possible amount of time. p) Any person subject to restraint must be physically monitored throughout the incident. Post-restraint, the person who has been restrained will be reviewed for placement on the appropriate observations level, for a period of up to 48 hours. During this time physical observations must be recorded and the observing nurse be fully aware of the possibility of restraint/positional asphyxia
7.3	**Prone Restraint** a) Restraining patients on the floor in the prone position presents an increased risk of death due to positional asphyxiation and should be avoided wherever possible. If staff should find the person in the prone position, restraint should only be maintained for the shortest amount of time necessary to bring the situation under control. Where prone restraint occurs, care must be taken to monitor the patient for signs of positional asphyxiation, excitable delirium and hypothermia. b) Prolonged restraint and prolonged struggling will result in exhaustion, possibly without subjective awareness of this, which can result in sudden death." c) Techniques that increase the risk of death should not be used. The following actions are necessary to avoid or reduce that risk. o Do not use neck locks. o Restrict the use of prone restraint unless absolutely necessary for control. o Once controlled move subject onto their side, or into a standing or seated position as soon as possible. o Monitor breathing and pulse rates and seek medical examination immediately - especially if the subject should become very passive or calm. o If possible contain rather than restrain;

No.	Summary of recognised methods of restraint
	o If possible, avoid situations in which prolonged restraint and prolonged struggling become necessary; o If restraint becomes unmanageable, Staff Must contact the Police immediately on 999.
7.4	**Rapid Tranquilisation/Chemical Restraint** a) In carrying out rapid tranquilisation the patient should be able to respond to communication throughout the period of rapid tranquilisation. The aim of the rapid tranquilisation is to achieve a state of calm sufficient to minimise the risk posed to the patient or to others (NICE 2015)NG10. b) Medication for rapid tranquilisation, particularly in the context of physical intervention, should be used with caution owing to the following risk:- o Loss of consciousness instead of tranquilisation. o Sedation with loss of alertness. o Loss of airway. o Cardiovascular and respiratory arrest. o Interaction with medicines already prescribed or illicit substances taken. o Possible damage to patient-staff relationship. o Underlying coincidental physical disorders. c) After rapid tranquilisation is administered, staff should recognise the importance of nursing the patient in the recovery position (where safely possible). Staff should monitor and record pulse, blood pressure, hydration, SPO2, (Peripheral Capillary Oxygen saturation) GCS (Glasgow Coma Scale) including Respiration.

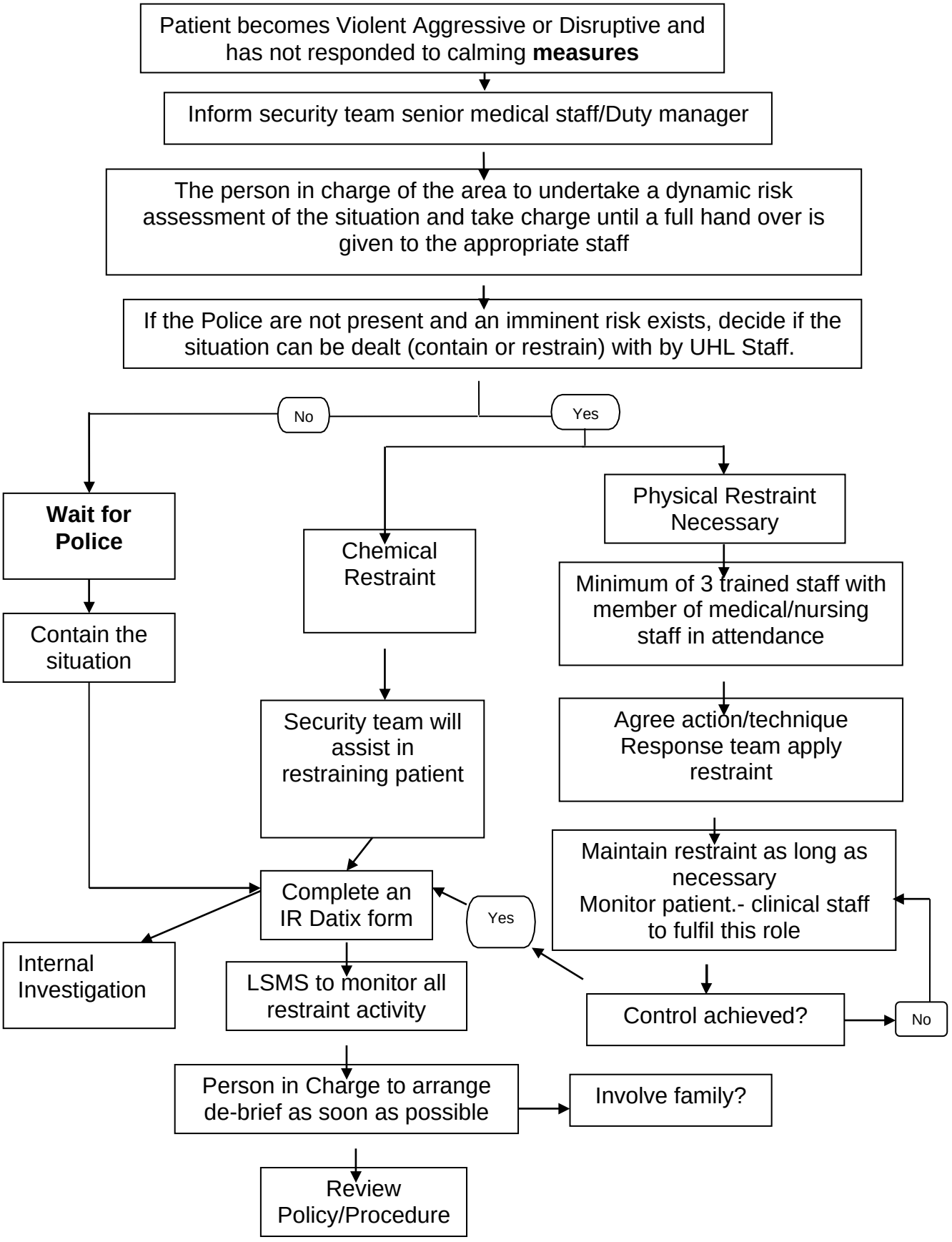
No	Use of Force to hold or restrain patients lacking capacity when acting in the patients best interest to carry out medical procedures, treatment or examination
8.1	**Mental Capacity and acting in Patients best interests including Decision Maker** There may be occasions where a patient refuses a medical examination, intervention and/or treatment, without which they are likely to suffer serious harm or detriment to their health. On such occasions and in accordance with the provisions of the Mental Capacity Act, medical or nursing practitioners (Decision makers) may assess that the person lacks capacity to consent to examination or treatment. See definitions for 'decision maker'. Having considered and tried less restrictive options, the decision maker may as a last resort, (or in emergency/life threatening situations as a first resort) assess it is necessary to carry out the examination or treatment against the persons wishes, acting in the patients best interests. To do this safely it may be necessary and appropriate to apply safe holding and/or physical restraint techniques to the patient. When doing so the amount of force used to achieve the outcome must be necessary and proportionate to the risks of harm to the patient and others.
8.2	**Use of force to carry out treatment, medical procedures and/or examination** Where the patient becomes violent or aggressive towards staff (or is likely to become violent and aggressive) when acting in the patients best interests, and it is necessary to

	restrain the patient to prevent harm, the medical or nursing staff may call upon the assistance of security staff this will include all staff who have been trained in restraint to carry out, or assist with, physical holding or restraint of the patient whilst the procedures are carried out. When requesting security staff to use physical force for the purposes above, the' decision maker' (UHL medical or nursing staff) will provide those staff with sufficient instruction and information to ensure they have lawful excuse to use reasonable force.
8.3	**Vicarious Liability** When Agency security staff is acting under the instructions of UHL medical or nursing staff, to apply safe holding or restraint techniques, in the best interests of the patient, UHL will accept vicarious liability for the lawful actions of those staff.
8.4	**Documenting decisions** At the earliest opportunity following the medical intervention, the 'decision maker' will record the 'best interests decision' and reasons for assessing the use of safe holding or restraint of the patient was lawful, necessary and proportionate.

Flowchart for Initiating or Utilising Restraint

University Hospitals of Leicester NHS Trust

Management of Violence and Aggression Policy



1. Introduction

The purpose of this guideline is to provide all clinical staff with the required information related to the clinical holding of babies, children and young people for clinical procedures. The guideline is intended as a set of principles and key methods and recognises that on occasion children may need to be held in a safe and controlled manner for a variety of procedures. The child's safety and welfare are of paramount importance and staff must continue to support the ethos of caring and respect for the child's rights. Clinical holding or containing without the child/parent/carer's consent is a last resort and must not be used as the first line of intervention.

2. Scope

This policy applies to all staff working with University Hospitals of Leicester NHS Trust

3. Professionals Duty of Care

Registered nurses are bound by a 'duty of care' and are accountable for promoting and protecting the rights and best interests of their patients'. Where the use of restraint, holding still and containing children and young people is concerned, all professionals must consider the rights of the child and the legal framework surrounding children's rights. This includes the Human Rights Act (1998) and the European Conventions on the Rights of the Child, Consent and Capacity Assessment (1989). Although regularly used in hospitals for procedure such as Blood Sampling and Cannulation, reports have commented that the restraint has caused more distress to the child than the pain of the procedure itself (Pearch 2005)

4. Definitions

4.1. Restraint The Department of Health for England defines restraint as:

'The positive application of force with the intention of overpowering the child'. Restraint is, by definition, applied without the child's consent. There is also the Department of Health for England's specific guidance on restrictive physical interventions for people with learning disabilities and autism.

4.2. Clinical Holding : Is the proactive immobilisation of a part of the body to which a procedure is being carried out. It may be a method of helping children, with their permission, to manage a painful procedure quickly or effectively for example holding an arm from which blood is being taken in order to prevent reflex withdrawal and thus unnecessary pain or distress or injury to the child. Holding is distinguished from restraint by the degree of force required and the intention.

4.3. Containing and preventing from leaving: This is defined as physical restraint or Barriers that prevent the child leaving, harming itself, or causing serious damage to property. All restriction of liberty in health authority/board settings is governed by the 1991 Children (Secure Accommodation) Regulations, the Children Act 1989, the Children (Northern Ireland) Order and the Children (Scotland) Act.

4.4. De-escalation techniques: These are techniques to reduce the level and intensity of a difficult situation. De-escalation means making a risk assessment of the situation and using both verbal and non-verbal communication skills in combination to reduce problems.

5. Guideline Statements and Procedures

It is likely that for clinical procedures such as Blood Sampling or Cannulation the nurse will at most hold the child still for the procedure therefore:

Clinical Holding a child for a particular clinical procedure also requires nurses to:-

a) Give careful consideration of whether the procedure is really necessary, and whether urgency in an emergency situation prohibits the exploration of alternatives.

b) Anticipate and prevent the need for holding, through giving the child information, encouragement, distraction and control by talking and listening to the child and their parent/carer.

c) In all but the very youngest children, obtain the child's consent or assent (*expressed agreement*) for any situation, which is not a real emergency. A judgment will need to be made by the healthcare professional as to whether the child is competent to give their own consent. Please seek advice from child safe guarding teams.

d) Seek the parent's/guardian's consent, or the consent of an independent advocate. The procedure should be explained to the child and or parent/carer in a language that can be understood by them.

e) Make an agreement beforehand with parents/guardians and the child about what methods will be used, when they will be used and for how long. Explore all methods available, for example play, distraction & local anesthetic cream/spray. The agreement should be clearly documented in the plan of care and any event fully documented.

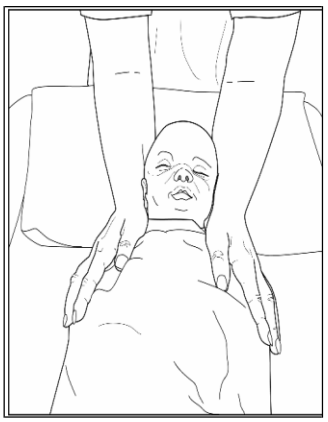
f) Ensure parental presence and involvement - if they wish to be present and involved. (Parents/guardians should not be made to feel guilty if they do not wish to be present during procedures. Health Care professionals should explain parents' roles in supporting their child, and provide support for them during and after the procedure).

g) Make skilled use of minimum pressure and other age-appropriate techniques, such as wrapping and splinting, explaining and preparing the child/parents beforehand as to what will happen?

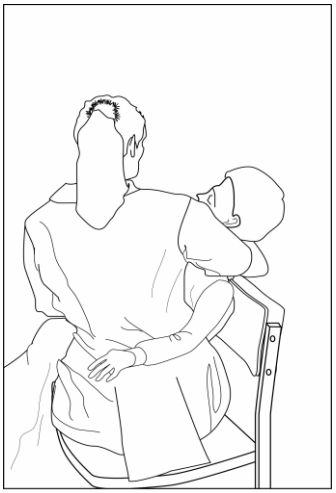
h) Comfort the child or young person where it hasn't been possible to obtain their consent, and explain clearly to them why restraint was necessary.

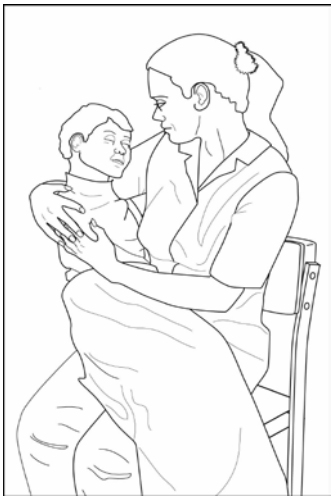
5. Holding Techniques for Infants and Children

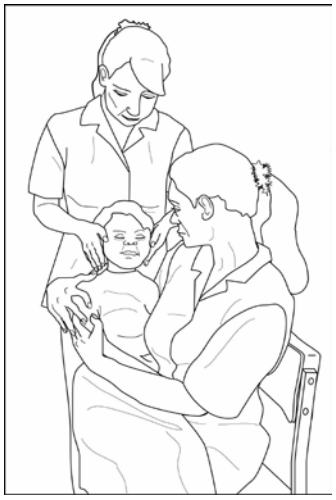
Infants, under the age of 1 year, should be wrapped securely in a blanket



Older children may sit in an upright position on an adult's knee or supported by pillows, if appropriate







For younger children with complex needs, discuss position with parents / carer.

NB: Refer to **RCN (2003)** guidelines Restraining, holding still and containing children and young people.

Pearch J (2005) Restraining children for clinical procedures Paediatric Nursing Vol 17 No 9 November

Name of Patient or Visitor:

Patient number: (If applicable)

Ward/department:

IDENTIFICATION OF RISK

Describe the foreseeable risk (types of behaviour)	
Known triggers	
Is the risk potential or actual?	
List who is affected by the risk	

ASSESSMENT OF RISK

In which situations does the risk occur?	
How likely is it that the risk will arise?	
If the risk arises, who is likely to be injured or hurt?	
What kinds of injuries or harm are likely to occur?	
How serious are the adverse outcomes?	
Level of Risk (High, Medium, Low)	** Likelihood: Severity: Risk Rating =

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements

AGREED BEHAVIOUR MANAGEMENT PLAN

Focus of measures	Measures to be employed	Level of risk
Proactive interventions to prevent risks		
Early interventions to manage risks		
Reactive interventions to respond to adverse outcomes		

Agreed by: Title/position:

Date:

OBSERVATION RECORD

Date	Person reporting	Ward/department	Behaviour observations	Action taken

BEHAVIOUR PLAN REVIEW(S)

Date	Name	Job title	Outcome

Physical Intervention and Restraint Technique Feedback form

University Hospitals of Leicester NHS
NHS Trust

Management of Violence and Aggression Policy

1. What techniques did you use (you may tick more than one)

Restraint Hold	☐	Straight Arm immobilisation	☐
Sitting position	☐	Recovery position	☐
Disengagements	☐	Other – please identify :	

_____

2. Did you find the technique effective (i.e. was the subject brought under control) ?

Yes ☐

No ☐ State your reasons why :

_____

3. Where did the incident take place

Site: LRI LGH GH

Ward ☐ Dept ☐ Internal Public Area ☐ External Public area ☐

Exact Location :

_____

4. Was it difficult to gain control ? Yes ☐ No ☐

If YES, was it because: (tick all that applies)

The subject was violent	☐
The subject was strong	☐
Was not complying with any verbal instruction	☐
Your partner couldn't get a controlling hold / lock	☐
You were in fear of being assaulted	☐
You were in fear of others being assaulted	☐
Other reason (explain)	☐

5. Did the subject appear to be under the influence of drink or drugs ?

Yes ☐ Drink/ Drugs / Both No ☐

6. Was a weapon involved ?

Yes ☐ (Describe) No ☐

7. If there are any other comments that you would like to add which can help us devise or modify your training please state them in the space below

** On completion return the form to: Health and Safety Services Red Brick Building, Leicester General Hospital.

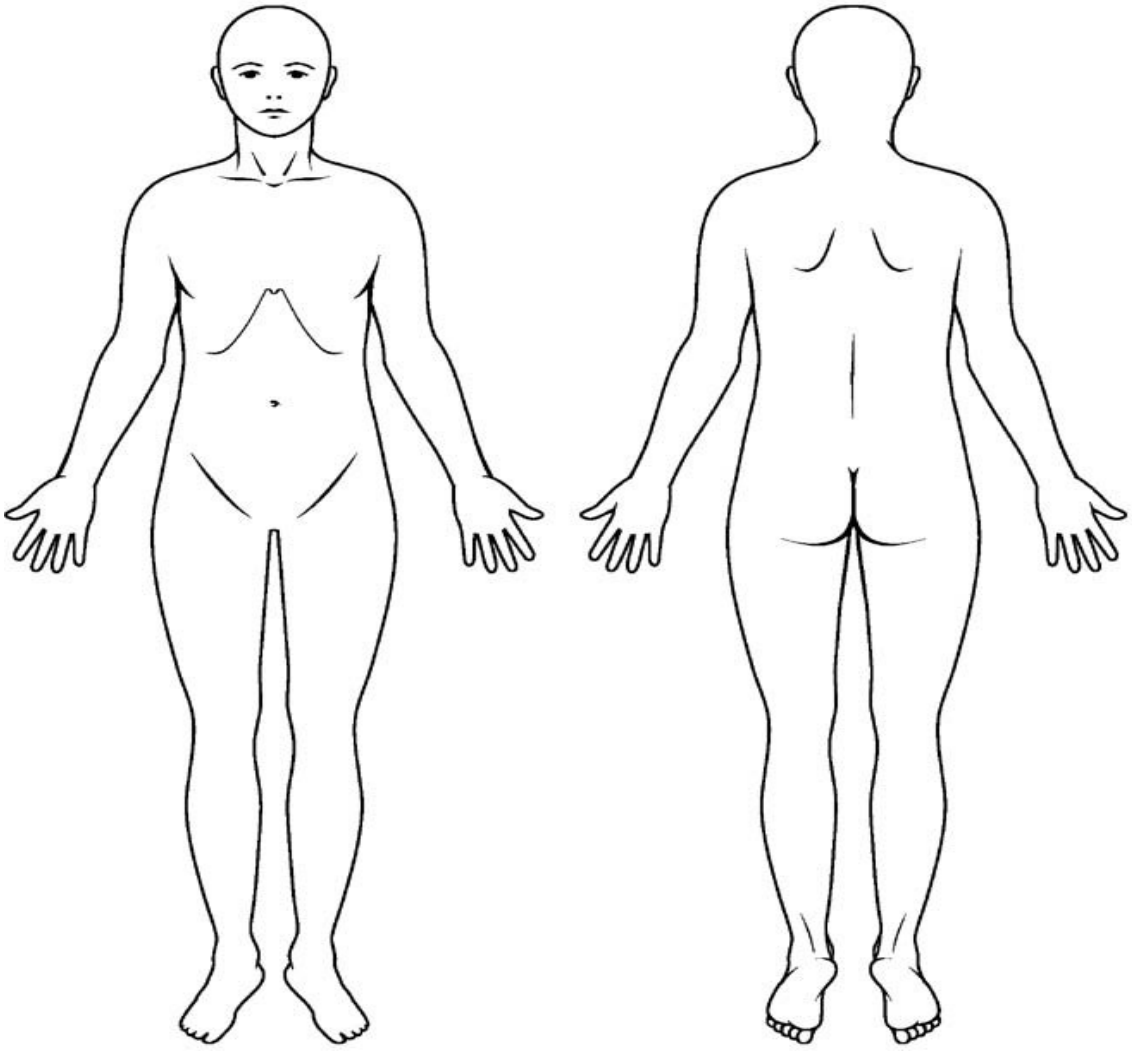
Appendix 12

Physical Intervention and Restraint Body Map

University Hospitals of Leicester NHS
NHS Trust

Management of Violence and Aggression Policy

Patient Details	***Staff Details***
Full Name	**Name:**
DOB	**Title:**
Unit Number	**Date:**
	Signature



Appendix 13

This is a risk assessment checklist. Once completed, a Trust Risk Assessment should be completed

Violence Aggression and Disruptive Behaviour Risk Assessment Checklist

Department:	**Location:**
Assessment Date:	**Review Date:**

1. LIKELIHOOD OF VIOLENCE

Issue	Analysis	Comments	Action to be Taken
Do staff have direct contact with service users or members of the public as part of their work?	Yes/No		
Do staff consider themselves threatened or at risk of violence during their work? (Issue personal questionnaire)	Yes/No		
Have there been reported incidents of violence and how frequently do they occur?			
Physical Assault □ Daily Δ Weekly Δ Monthly Δ Rarely Δ Never	Yes/No		
Verbal Abuse/Threatening Behaviour □ Daily Δ Weekly Δ Monthly Δ Rarely Δ Never	Yes/No		
Do staff ever have to use physical force:			
□ In self/defence	Yes/No		
□ To restrain	Yes/No		

Are staff exposed to significant risk factors such as:			
☐ Working in isolation	Yes/No		
☐ Working alone in the Community	Yes/No		
☐ Working out of hours	Yes/No		
☐ Having to give bad news	Yes/No		
☐ Dealing with controversial issues (ie child protection issues, etc)	Yes/No		
THE OVERALL LIKELIHOOD OF VIOLENCE OCCURRING IN THE DEPARTMENT IS: Rare / Unlikely / Possible / Likely / Almost Certain			

2. SEVERITY OF VIOLENCE

Issue	Analysis	Comments	Action to be Taken
Have any of the following assaults ever occurred in the Depart:			
□ Verbal Abuse Face to Face	Yes/No		
□ Verbal Abuse over the Phone	Yes/No		
□ Punched	Yes/No		
□ Kicked	Yes/No		
□ Slapped	Yes/No		
□ Grabbed by Wrists/Arms	Yes/No		
□ Grabbed by the Throat	Yes/No		
□ Spat at	Yes/No		
□ Bitten	Yes/No		
□ Head Butted	Yes/No		
□ Strangled from Front	Yes/No		
□ Strangled from Rear	Yes/No		

□ Bear Hugged from Front	Yes/No		
□ Bear Hugged from Rear	Yes/No		
□ Struck by Objects held by Assailant	Yes/No		
□ Struck by Objects thrown by Assailant	Yes/No		
Where violence has occurred, identify the injuries caused to staff or patients:			
□ Minor Injury (injuries requiring First Aid (ie bruise, small cuts etc))	Yes/No		
□ More significant injury (eg injuries requiring treatment, ie stitches etc.)	Yes/No		

□ Serious injury (Injury requiring time off work for 7 days or more)	Yes/No		
□ Very Serious (Injuries requiring hospital attendance)	Yes/No		
□ Life Threatening	Yes/No		

Issue	Analysis	Comments	Action to be Taken
Were any of the following weapons used against staff or patients:			
☐ Syringe, scalpel, scissors	Yes/No		
☐ Bottle or other glass objects	Yes/No		
☐ Knife	Yes/No		
☐ Stick, furniture	Yes/No		
☐ Dog	Yes/No		
☐ CS Spray	Yes/No		
☐ Screwdriver	Yes/No		
☐ Walking stick	Yes/No		
☐ Gun	Yes/No		
☐ Other items *(please specify)*			
Have incidents required the assistance of the Police/ Security?	Yes/No		

THE POTENTIAL SEVERITY RESULTING FROM VIOLENCE OCCURRING IN THE DEPARTMENT IS: Insignificant /Minor / Moderate / Major / Extreme

3. EXISTING CONTROLS

Issue	Analysis	Comments	Action to be Taken
Is the entry to the Department controlled?	Yes/No		
If **Yes**, indicate the manner of control:			
☐ Reception Desk	Yes/No		
☐ Lock and Key	Yes/No		
☐ Coded Security Locks	Yes/No		
☐ Card Reader Entry	Yes/No		
☐ Buzzer Entry	Yes/No		
☐ CCTV Controlled Entry	Yes/No		
☐ Other *(please specify)*			
Is there a reception desk?	Yes/No		
If **Yes**:			
☐ Is it clearly signposted?	Yes/No		
☐ Have a wide counter to separate receptionist from visitors?	Yes/No		

□ Have a raised floor on staff side?	Yes/No		
□ Have a screen to protect staff?	Yes/No		
□ Have a panic alarm fitted?	Yes/No		
Are staff areas within the Department secured from unauthorised access?	Yes/No		
If **Yes**, indicate manner of control:			
□ Lock and Key	Yes/No		
□ Coded Security Locks	Yes/No		

Issue	Analysis	Comments	Action to be Taken
Δ Card Reader Entry	Yes/No		
Δ Buzzer Entry	Yes/No		
Δ CCTV Controlled Entry	Yes/No		
□ Other (please specify)	Yes/No		
Are there waiting areas in the Department?	Yes/No		
If **Yes**:			
□ Is there sufficient seating?	Yes/No		
□ Is the environment well-lit?	Yes/No		
□ Is the fabric of the Department clean and in good repair?	Yes/No		
Are you aware of the Directorate policy on Violence and Aggression?	Yes/No		
Are there local emergency response procedures for dealing with violence against staff, including means for summoning assistance?	Yes/No		
Have staff received training for dealing with violence?	Yes/No		
Identify the type of training provided:			

□ Physical Intervention/Restraint	Yes/No		
□ Disengagements/Self-defence	Yes/No		
□ General Awareness Training	Yes/No		
□ De-escalation Skills Training	Yes/No		
□ Understanding Anger, Aggression & Violence	Yes/No		
□ Legal Training with regard to the use of physical force	Yes/No		

Who provided the training? Please identify the name and system of training provided:

□ Internal – (Name and Department)

□ External –

□ Other –

Issue	Analysis	Comments	Action to be Taken
If **Yes**, when was the training last given: □ 1 month ago Δ 1-3 months Δ 3-6 months □ 6-12 months Δ 1-2 years Δ 2 years + **Was the training based on a local departmental risk assessment?** **In your opinion was the training received:** □ Very Effective Δ Effective Δ Not Effective □ Useless □ **Is there a system for pre-assessing the risk of violence from individual clients?** □ **Is there a detailed whereabouts and call-back system?** □ **Have all staff access to mobile phones/** □ **Do staff carry personal attack alarms?** □ **Have all staff received specific training for working off-site or lone working?**	Yes/No Yes/No Yes/No Yes/No Yes/No		
Are all incidents of violence reported and recorded? □ Always			

☐ Sometimes ☐ Rarely ☐ Never	
How are incidents of violence reported and recorded? ☐ On an Incident Form ☐ Verbally to the Department Manager ☐ To the Health & Safety Department ☐ On Datix	

RISK RATING TAKING INTO ACCOUNT EXISTING RISK CONTROL MEASURES = **Low / Moderate / High / Extreme**

1. Introduction

1.1 This guideline has been developed as a proactive measure to protect staff, patients and others from the risk of violence and abuse and minimise disruption to the delivery of services.

1.2 It is intended to enable the Trust to manage and prevent workplace violence, aggression and disruptive behaviour and fulfil the Trust's duty to the health and safety of its staff, patients, visitors and other users of trust services.

2. Scope

2.1 The guidelines apply to clinical and non-clinical staff who have direct contact with patients or who are involved in making patient care arrangements, which involve contact with Trust staff. The guideline covers the provision of alerts in relation to actual or potential risks of violent, abusive or disruptive behaviour.

2.2 The Trust recognises that some patients may, due to clinical conditions, display violent, abusive and/or disruptive behaviours. Whilst consideration will be given to such factors it may still be appropriate to apply a warning marker for this patient, to protect staff and others who may come into contact with the patient in future visits.

2.3 This guidance applies to all out-patient, inpatient and emergency departments within UHL.

3. Aim

3.1 The aim of this guideline is to provide an early warning to Trust staff, of a particular individual or situation that represents a risk to themselves, colleagues, patients or other members of the public.

3.2 This is not to attribute blame but is intended to alert staff to the risk of violence and enable the Trust to provide security warnings and advice to staff to avoid or minimise risk, and to ensure their safety.

3.3 The provision of a warning marker procedure should ensure that key staff within the Trust are aware of potential risks and assist in creating a safe and secure environment for staff, patients and visitors.

4. Applying and Managing Patient Warning Markers

4.1 <u>Reporting concerns</u>

Where a member of staff is subjected to or witnesses an incident of violence, abuse or other form of unacceptable behaviour toward another member of staff,

patient or visitor they should report the circumstances using the Datix Incident reporting system.

4.2 Warning Marker approval

4.2.1 On receipt of the report the Datix **'handler'** should enquire into the circumstances and gather sufficient information to assess whether the offending person is likely to present a future risk to staff, hospital services, or other persons accessing the premises.

*4.2.2 Where a future risk is identified the handler should refer the incident and supporting information the departmental **'authorised person(s)'** requesting a review and decision on the appropriateness of a warning marker.*

4.2.3 Where the 'authorised person' assesses that it is appropriate to apply a warning marker, they should complete the warning marker assessment form authorising the marker to be placed onto the patient electronic record and passed to the **'data entry administrator'**

4.2.4 The 'date entry administrator' will enter the warning onto the patient electronic notes (Patient Centre/HISS) in the Special Register section. The Emergency Department may also make an entry on Nerve Centre.

4.2.5 All warning marker entries will remain on the patient record for a period of 12 months, unless otherwise instructed. Where it is felt a warning marker should remain in place for longer than 12 months the 'authorised person' should make a continuation request to the LSMS. Upon receipt of such a request the LSMS and Privacy Lead will carry out a review of the circumstances and approve or deny the request.

4.2.6 Where an extension is approved the warning marker will be reviewed every 6 months by LSMS and Privacy Lead to ensure it is necessary and lawful.

4.3 Appeal Procedure

4.3.1 Patients/visitors may appeal against a decision to place a warning marker on their record. The appeal process will consist of two stages.

4.3.2 Stage 1 appeal - The initial appeal should be made to the 'authorised person'. The authorised person will consider the appeal and take into account any new information presented by the patient. The review will be carried out within 14 days of receipt of the appeal.

4.3.3 Stage 2 appeal - Where a stage 1 appeal is unsuccessful and the patient expresses a wish for further review the patient should contact the (PILS) team, who will carry out a Stage 2 review of the circumstances. The review will be carried out within 21 days of receipt of the appeal request. The decision of the stage 2 reviewer will be final and there will be no further review carried out within the trust.

4.3.4 Managers may request specialist advice and support throughout all stages of the process from the LSMS/Privacy Lead.

4.4 Record Management

4.4.1 Each CMG will be responsible for ensuring that warning markers are applied and maintained lawfully and only for as long as necessary. The authorised person will be responsible for ensuring entries are removed from the electronic record at the expiry period or at the point of successful appeal.

4.5 Specialist Advice and Support

4.5.1 LSMS will carry out an annual audit of the warning marker procedure and report the findings to the SMPLG and Audit Committee.

4.5.2 The LSMS/Privacy Lead will conduct periodic announced and unannounced sampling of warning marker applications and entries to monitor the integrity of lawful application and fair processing.

4.6 Monitoring and Review

4.6.1 Each CMG will maintain a record of all warning marker requests and entries. They will provide a quarterly report of warning marker approvals to the CMG Board and LSMS.

4.6.2 The LSMS will audit use of the procedure review its findings and provide a quarterly report to the SMPLG and relevant CMG boards

5. Monitoring and Audit Criteria

Key Performance Indicator	Method of Assessment	Frequency	Lead
Appropriate training of staff across CMGs • Authorised Person • Data entry administrator	Facilitator to obtain and maintain records of all staff trained/familiarised in each CMG and provide information to CMG Heads of Nursing	Annually	LSMS
Compliance with procedure	Review of applications and approvals by CMG	Quarterly	Ward/Departmental Authorised Person ?
Application of procedure and Compliance with legislation.	Audit and Review by LSMS and Head of Privacy	6 month post introduction and then Annually	LSMS/Head of Privacy

1 Supporting Documents and Key References

1.1 Related Documents

- NHS Protect guidance on Patient Warning Markers

- Data Protection Act including GDPR (General Data Protection Regulations)
- Mental Capacity Act Policy (B23/2007)
- UHL Deprivation of Liberty Safeguards Policy & Procedures (SharePoint Document Number: 7152502235)
- UHL Policy for Assessment and Care Management of Patients At Risk of Wandering in the Acute Setting (SharePoint Document Number: 5686082514)
- UHL Management of Violence, Aggression and Disruptive Behaviour Policy – Including Restraint Guidance (SharePoint Document Number: 4310540010)
- UHL Security Policy (SharePoint document number: 4593279182)
- UHL Policy for the Reporting and Management of Incidents (including the investigation of serious incidents) (SharePoint Document Number: 9002638140)
- Guidance on the prevention and management of clinically related challenging behaviour in NHS settings (Meeting the needs and reducing distress) NHS Protect. www.nhsprotect.uk/reducingdistress