Standard **O**perating **P**rocedure: Managing Violence, Aggression, Disruptive Behaviour and use of Seclusion & Restrictive Interventions in the Emergency Department: University Hospitals of Leicester

Violence, Aggression, Disruptive Behaviour and Use of Seclusion & Restrictive Interventions Standard Operating Procedure UHL Emergency Department Guideline Dec 21 Trust Ref: C60/2022
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Section 1: Scope

1.1. This Standard Operating Procedure (SOP) sets out the standard procedures for the management of all persons attending the Emergency Department at LRI who display **'Violence, Aggression or Disruptive Behaviour' (VADB), or when restrictive interventions are being used such as; using a cubicle or door to prevent a patient from leaving under appropriate legislation.**

1.2. This SOP applies to all staff (Clinical, Non-clinical including Security, whether substantive, temporary or contracted) working within the Emergency Department (ED) and is based on agreed principles and guidance in existing UHL policies and will be referenced accordingly.

1.3. This SOP aims to bridge the gap between clinical and security staff formalising the expectations and requirements set out in existing key UHL policies.

Section 2: Key Principles & Summary of Legislation

At a Glance:

- Ensure personal safety first
- Exclude medical causes of violence / aggression in patients and treat as appropriate.
- Ensure early senior involvement (EPIC/NIC/Consultant)
- Restrictive Techniques and restraint as a last resort after de-escalation has failed
- Use cubicles with shutters if possible for restrictive techniques, maintain patient dignity with screens if necessary.
- Restrictive techniques for minimum necessary time possible with regular reviews, consider early rapid tranquilisation if appropriate
- Police contact when necessary
- If patient has capacity then manage as per other relevant UHL guidelines or police involvement.

Key Principles of SOP

2.1. Dealing with patients that display violence, aggression or disruptive behaviour should be a joint approach with both clinical and security staff utilising their own areas of expertise to facilitate a joint working approach.

2.2. Physical restraint or other restrictive interventions should be a last resort after de-escalation techniques have been employed and failed.

2.3. Any patient who is thought to require restrictive measures for their own safety or safety of others in the department should be reviewed by a middle grade clinician to ensure

that appropriate decisions are made in a robust way in relation to their capacity, treatment plan, or if tranquilisation is more appropriate.

2.4. Any physical restraint in the ED of patients should be overseen clinically by a middle grade clinician to mitigate the risks to patients and staff. The senior clinician retains the clinical responsibility for that patient.

2.5. The Emergency Physician in Charge (EPIC) & Nurse in Charge (NIC) retain the overall clinical and strategic responsibility for the department and as such may redeploy ED security staff within the department according to the real time security needs of the department (ie. They may re-deploy security staff where needed) whilst abiding by the minimum standards set out in security protocols/agreed working practices. (eg. Will not remove staff when a specific number is required for a specific task such as restraint.)

Key Principles of Restraint & Restrictive Interventions

2.6. Physical restraint should generally be a last resort and in each case should be reasonable and proportional to the circumstance. Use of force is typically justified to:

- Prevent harm to self or others
- Prevent serious damage to property
- Effect a lawful arrest
- Prevention of crime
- Facilitate medical intervention / detention where this is covered under specific legislation (eg. Mental Capacity Act 2005 / Mental Health Act 1983 etc)

2.7. Core principles: See 6.1.1 VADB policy: http://insitetogether.xuhl-tr.nhs.uk/pag/pagdocuments/Violence%20Aggression%20and%20Disruptive%20Behaviour%20UHL%20Policy.pdf

2.8. The use of force is applying deprivation of a person's liberty. The lawful authority for this is covered in legislation below. This includes specific legislation covering use of force and a brief summary. For full details on guidance on legislation then further guidance should be sought. https://www.legislation.gov.uk/

2.9. Any restrictive technique should be used for the sole purpose of facilitating patient assessment, investigation treatment, or lawful detention under appropriate act of parliament and in any case for the shortest time possible. Seclusion should never be used as coercion, punishment, threat or because of staff shortage.

2.10. In some rare situations it may be appropriate to gain legal advice from the trust legal advisors. In such circumstances advice from the most senior staff clinical and managerial should usually be sought first.

Summary of Legislation:

2.11. **Common Law:** This permits anyone to use reasonable force to prevent harm to self or others.

2.12. **Section 3 Criminal law act**: 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.

2.13. **Section 117 PACE**: Police powers to use reasonable force to exercise the powers of constable.

2.14. **Section 119 & 120 Criminal Justice & Immigration Act**: Provides NHS staff and police power to remove any person who without lawful authority or reasonable excuse causes a nuisance on NHS property. (eg. Angry abusive relatives / friends not related to care). Does not apply to patients seeking medical advice (up until the point that they cease to be a patient. After no longer a patient then applies.)

2.15. **Section 4 Mental Capacity Act (MCA) 2005:** Patients can be treated in their best interests if they lack capacity. General principles include taking reasonable steps to aid them gaining capacity and also where treating against wishes the least restrictive option should be used (principles of proportionality). This should typically be where the intended treatment is urgent. The MCA still applies to people detained under the Mental Health Act (MHA). See guidance here Page 12 of link for examples of how the two acts cross over.
https://www.rcem.ac.uk/docs/RCEM%20Guidance/RCEM%20Mental%20Capacity%20Act%20in%20EM%20Practice%20-%20Feb%202017.pdf

2.16. **Article 2 Human rights Act 1998**: Everyone has the right to life, however this article is not contravened if someone is lawfully detained (ie under another act). (Human rights act applies to public authorities, i.e. A person cannot commit an offence to another person under the human rights act))

2.17. **Article 5 Human rights Act 1998**: Right to liberty and security

2.18. **Mental capacity act 2005 & Derivation of liberty safeguards 2009:** People who are in a care home or hospital that need to be detained under a DOLS for their own protection.

2.19. **Childrens Act 1989:** Covers welfare of children – see legislation for details.

2.20. **Mental health Act:** Covers various areas; typically in relation to detention for assessment and treatment. (Section 2,3- i.e.- 'being sectioned' and S136 – police powers are those most commonly seen in ED.) A person can be treated for a medical condition against their will under Section 63 of MHA if it is thought to be as a result of their mental disorder.

2.21. **S135 MHA-** Police power to enter a private place after a warrant granted by a magistrate and remove to place of safety for mental health assessment. Needs Doctor and AMHP to be present.

2.22. **NICE GUIDANCE:** Restrictive interventions for managing violence and aggression in adults. https://pathways.nice.org.uk/pathways/violence-and-aggression/restrictive-interventions-for-managing-violence-and-aggression-in-adults.pdf

Section 3: Roles and Responsibilities

3.1 All staff have a duty to ensure the right response is made to any person that is displaying VADB. This means that both senior clinical (person running the area-nursing and medical) are made aware of the situation. Security must be requested to attend immediately at each incident. Notification to these staff can be made by any staff member to ensure the safety of staff and patients.

3.2 Clinical staff will ensure that security staff are promptly called and attend any incident of VADB. The overall responsibility lies jointly with the nursing and medical lead for the area.

3.3 Any significant restraint should be clinically overseen. This should be by a middle grade clinician, so robust decisions on capacity, legality of MCA/MHA or need for tranquillisation can be promptly made. Security staff may request clinical staff presence if not already, this will typically be facilitated by senior nursing staff or NIC if medical staff are not present at the time.

3.4 Violent or aggressive patients should be reviewed by a senior or middle grade clinician (ST3+) as soon as practicable (typically this will be the area clinical lead). They must attend to ensure appropriate capacity assessment is completed, documented and if there is justification to detain them against their will under MCA or other legislation. In patients felt to lack capacity then a prompt decision should be made on the clinical plan and if tranquilisation is appropriate. If there is uncertainty regarding a patient's capacity then this should be escalated to a consultant. If not available the most senior clinician available should attend (this should in any case be a doctor of ST4+ grade)

3.5 Body worn cameras **must** be activated at the earliest opportunity in any use/anticipated use of force or any situation that involves violence or aggression as per UHL policy.

Section 4: Procedure for dealing with VADB

4.1 All reasonable efforts to de-escalate any VADB should take place immediately as a priority. This should be seen as the focus to try and avoid any evolving behaviour escalating unnecessarily.

4.2 Any available background information eg. Regular attender care plans should be obtained and reviewed.

4.3 A security team member will lead any restraint from security team perspective.

4.4 A clinician or SnR nurse / NIC must be informed if any restraint is occurring at the earliest opportunity

4.5 Any restraint should be overseen by a clinician to mitigate the risk to the patient and staff, including potential complications of restraint, ideally this should be senior or middle grade clinician of ST3+ or equivalent. (eg. Ensure airway safety, minimal time prone, other injury etc)

4.6 The senior clinician should make a prompt decision on capacity of the patient to oversee and advise that any restraint is legal and proportional to the patient's clinical or mental health risk.

4.7 The decision on capacity (particularly around capacity to self-discharge) should be communicated to the security team along with a summary of the believed risk of the

patient to themselves or staff, so security team can respond proportionately. (Patient details may be supplied to security for their reports.)

4.8 In the event of a medical emergency occurring during restraint then the senior clinician will immediately become the team leader and will direct staff appropriately to deal with the medical emergency. Security personnel should be guided by the senior clinician as to how best support in the new circumstance.

4.9 If a patient is deemed to have capacity this should be clearly communicated to security personnel so that the offender can be removed from the department under common law / Section 119&120 of CJIA or police called if required.

4.10 After any restraint has finished and aggression has been defused any restrained person should be offered a clinical assessment to assess possible injuries. Any injury sustained should be recorded in the clinical notes on a body map by the clinician. **APPENDIX** 6

4.11 Any staff injured in any incident of VADB should follow the process in Section 7.4

4.12 Any concerns regarding any incident on either security or clinical side should be raised with the EPIC/NIC.

4.13 If police attend to specifically restrain a patient then they will use their own powers and procedures. The senior clinician overseeing should continue to act in charge of the medical needs for the patient and advise police of any concerns relevant. Eg. Airway compromise / injury etc. Once the patient has been discharged they cease to be the responsibility of UHL / ED staff. If being discharged to police custody a police discharge letter must be completed. http://insitetogether.xuhl-tr.nhs.uk/cmgs/EASM/ed/Pages/testprint.aspx?loadpdf=/cmgs/EASM/ed/Documents/Patients%20in%20Police%20custody/Sharing%20information%20about%20patients%20in%20police%20custody%20-%20discharge%20letter.pdf

Section 5: Procedure for Patients requiring Restrictive Interventions

5.1 All reasonable efforts to de-escalate any violence and aggression should take place immediately as a priority.

5.2 Information eg. Regular attender care plans should be obtained and reviewed.

5.3 The patient must be seen / reviewed by a clinician and clinical plan formulated. If the patient is severely disturbed and it is felt they are at risk to themselves, others or would be at high risk of absconding then consideration must be given if rapid tranquilisation is a more appropriate intervention. This decision lies with the senior clinician responsible for the patient.

5.4 If a restrictive technique that falls under the criteria of Seclusion is employed, it should be used as a last resort and in any case for the shortest time possible to facilitate assessment, investigation, treatment or lawful detention under the mental health or mental capacity act.

5.5 All patients being secluded should be regularly reviewed by both clinical and nursing teams at a frequency appropriate for their current clinical situation.

5.6 If at all possible use cubicle with shutters to assist in safety of patient/staff and reduce damage to equipment.

5.7 If cubicle curtains need to be removed (eg. due to safety) then portable screens should be used to maintain patient dignity and privacy.

5.8 Any patient detained pending a bed for mental health admission under 'Section' should be moved to the appropriate facility as soon as practicable.

5.9 Security team will lead on the most appropriate method of restraint / seclusion (eg. Use of closing the door) in accordance existing security protocols with input from the clinical team where appropriate.

Section 6: Incidents involving knife or gun crime

6.1. Any incident involving knife or gun crime, or, where a patient presents to the ED with injuries where there is a suspicion that this is a result of either knife or gun crime, this should be reported to the police as soon as possible. The principles of breaching medical confidentiality in the interest of public safety should be followed. If in doubt seek advice from NIC/EPIC. Reporting will typically be completed by nursing staff but can be reported by any member of staff authorised to discuss the incident in question.

6.2. Any weapons surrendered to ED staff should be handed to security for storage in the security safe. (Follow the Patients presenting with Weapons Flow chart) Any sharp object should be placed in a 'knife tube'. Whilst likely a very rare event, any firearm should typically be left in situ if in a safe and securable area and police called immediately, security to ensure firearm remains secured. If in a non-secure area of ED or surrendered to staff then security to remove and place in security safe.

6.3. At no time should any UHL member of staff attempt to 'make safe', 'de-activate', 'tamper with' or 'unload' any firearm, regardless of any previous firearms experience.

6.4. When handling any firearm always point this in a safe area (towards the ground).

Section 7: Post Incident Actions

7.1. Security to complete the security report and any other required documentation as per the security policy. **APPENDIX 10.2**

7.2. Body worn cameras must be downloaded as soon as practicable

7.3. A datix must be completed by security and/or clinical staff. If possible the security incident number should be cross references in the datix.

7.4. If a member of staff is injured in an incident of VADB then they should be booked into ED as a patient and assessed by a clinician as a priority.

7.5. Any serious incidents should be recorded in a statement by clinical staff as soon as practicable to ensure the best recollection of the incident is obtained. If an urgent statement is required by police then any member of staff required to provide this should be released from current duties in order to provide this and support offered to them as required.

7.6. Following physical restraint any patient should be offered a further clinical assessment to assess, treat, record or exclude any injuries that may have been sustained. The details of this assessment should be recorded in the clinical notes and the 'Body map' **APPENDIX 6** should be completed and entered into the clinical notes.

7.7. Following any restraint or other significant incident where there has been 'significant disruption' to the department a debrief should occur for **all** staff involved (including police if attending for shared learning). This should typically be led by a senior member from both the clinical and security sides. (Consider triggers, roles, concerns, anything that could have been done differently to improve the situation). - This should very much be a joint approach from both security and clinical staff. It is recognised that ideally debriefing should occur after any incident involving restraint. However, this is unlikely to be realistic in a busy ED so as minimum should be targeted for the incidents that that are the more serious.

7.8. If any member of staff feels they have been unduly affected emotionally, physically or psychologically then they should be given a period of time off the shop floor if required before continuing clinical work. Follow up should be offered with a supervisor or formal debriefing modality eg. TRIM/counselling procedure if required.

Section 8: Related Policies and useful links:

8.1. Management of Violence, Aggression and Disruptive Behaviour Policy: http://insitetogether.xuhl-tr.nhs.uk/pag/pagdocuments/Violence%20Aggression%20and%20Disruptive%20Behaviour%20UHL%20Policy.pdf

8.2. UHL Rapid Tranquillisation policy: http://insitetogether.xuhl-tr.nhs.uk/pag/pagdocuments/Rapid%20Tranquilisation%20of%20Disturbed%20Adult%20Patients%20UHL%20Guideline.pdf

8.3. ED Patients presenting with Weapons Flow chart: http://insitetogether.xuhl-tr.nhs.uk/pag/pagdocuments/Weapons%20Brought%20in%20by%20Patients%20–%20Safety%20Management%20UHL%20Emergency%20Department%20Guideline.pdf

8.4. UHL Lockdown Policy: http://insitetogether.xuhl-tr.nhs.uk/pag/pagdocuments/Lockdown%20UHL%20Policy.pdf

8.5. UK legislation: https://www.legislation.gov.uk/

8.6. Body Worn Camera SOP: http://insitetogether.xuhl-tr.nhs.uk/pag/pagdocuments/Digital%20Recording%20UHL%20Policy.pdf

8.7. Police discharge letter: http://insitetogether.xuhl-tr.nhs.uk/cmgs/EASM/ed/Pages/testprint.aspx?loadpdf=/cmgs/EASM/ed/Documents/Patients%20in%20Police%20custody/Sharing%20information%20about%20patients%20in%20police%20custody%20-%20discharge%20letter.pdf

8.8. Police handover form: http://insitetogether.xuhl-tr.nhs.uk/cmgs/EASM/ed/Pages/testprint.aspx?loadpdf=http://insitetogether.xuh

l-tr.nhs.uk/cmgs/EASM/ed/Documents/General%20Documents/Police%20-%20ED%20handover%20form.pdf

8.9. Body Map:http://insitetogether.xuhl-tr.nhs.uk/cmgs/EASM/ed/Pages/testprint.aspx?loadpdf=http://insitetogether.xuhl-tr.nhs.uk/cmgs/EASM/ed/Documents/General%20Documents/Body%20map%20-%20ED%20documentation%20tool.pdf

RCEM Specific Guidance

8.10. RCEM guidance Mental capacity act: https://www.rcem.ac.uk/docs/RCEM%20Guidance/RCEM%20Mental%20Capacity%20Act%20in%20EM%20Practice%20-%20Feb%202017.pdf

8.11. RCEM guidance Acute behavioural disturbance: https://www.rcem.ac.uk/docs/College%20Guidelines/5p.%20RCEM%20guidelines%20for%20management%20of%20Acute%20Behavioural%20Disturbance%20(May%202016).pdf

Section 9: Purpose and background

9.1. The Emergency Department is the primary route of unplanned attendance, assessment and admission of both medical and mental health patients. As such it has unique needs around the management and security of people attending who display Violent, Aggressive or Disruptive Behaviour (VADB).

9.2. These people are usually patients within the department, often with presentations involving alcohol, substance misuse or acute mental health disturbance. As such, they need a specialised approach in order to facilitate de-escalation of behaviour, mitigate the risks to staff and visitors whilst also facilitating assessment of their medical or mental health needs.

9.3. This SOP seeks to provide the core principles and working practice in order to combine a holistic approach by providing medical assessment whilst maintaining necessary security measures.

9.4. This combined medical & security approach to people with violence, aggression and disruptive behaviour ensures early decision making in terms of medical needs, capacity, prompt de-escalation techniques and clinical oversight when any use of force is employed.

9.5. The use of the cubicle or room door to prevent a patient leaving when their clinical presentation is due to acute mental disturbance falls under the criteria of 'restrictive intervention' & 'Seclusion'. It is recognised that most current guidance is not written with the use of this intervention in the context of Emergency Departments. It is also recognised that Seclusion in Emergency Departments is against NICE guidance. However, the presence of doors on cubicles in Leicester ED is in some ways unique to our department. Therefore, guidance is required to fulfil legislative and national

guidance standards in situations where the door is used to facilitate lawful detention and safety to the patient, staff and others within the department.

9.6. Seclusion is defined in accordance with the Mental Health Act 1983 Code of Practice: 'the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others'.

9.7. This SOP is to provide guidance and standards to ensure safety for patients, staff and others within the department when such techniques are used.

Section 8: Definitions

CAD	Computer aided dispatch
Control	EMAS Control room at Horizon Place
ED	Emergency Department
EDU	Emergency Decisions Unit
EPR	Electronic Patient Records
EF	Emergency Floor
LSMS	Local Security Management Specialist
LRI	Leicester Royal Infirmary
Non-physical assault	Use of inappropriate words or behaviour causing harassment or distress
PACS	Picture Archiving and Communication System
Physical Assault	The intentional or reckless application of force to another person without lawful authority, whether causing injury or not.
Restrictive intervention	Deliberate acts on the part of other PERSON (s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: ... contain or limit the person's freedom for no longer than is necessary.
SpR	Specialist Registrar
Violence	Behaviour, gestures, language or aggression that may lead to another subject feeling threatened or afraid.
VADB	Violence, aggression, disruptive behaviour

Section 9: Document control

Directorate	**Emergency & Specialist Medicine**
Department and Sub Department	**Emergency Department -**
Clinical Medical Lead	**Dr David Ridley**

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Version control

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APPROVALS REQUIRED: EXAMPLE

This document requires the following approvals.

Name	Title/Responsibility	Signature	Issue Date	Version
Dr D Ridley	ED Security Liaison		6/7/21	1.2
Dr V Pillai	ED Head of Service		6/7/21	1.2
Julie Dixon	ED Manager		25/8/21	1.2
Dr Scott Knapp	Clinical governance lead		25/8/21	1.2
Baldeep Virdee	Security Manager		18/7/21	1.2
Simon Daley/ Vince Smith	LSMS		9/7/21	1.2

Review dates and owners

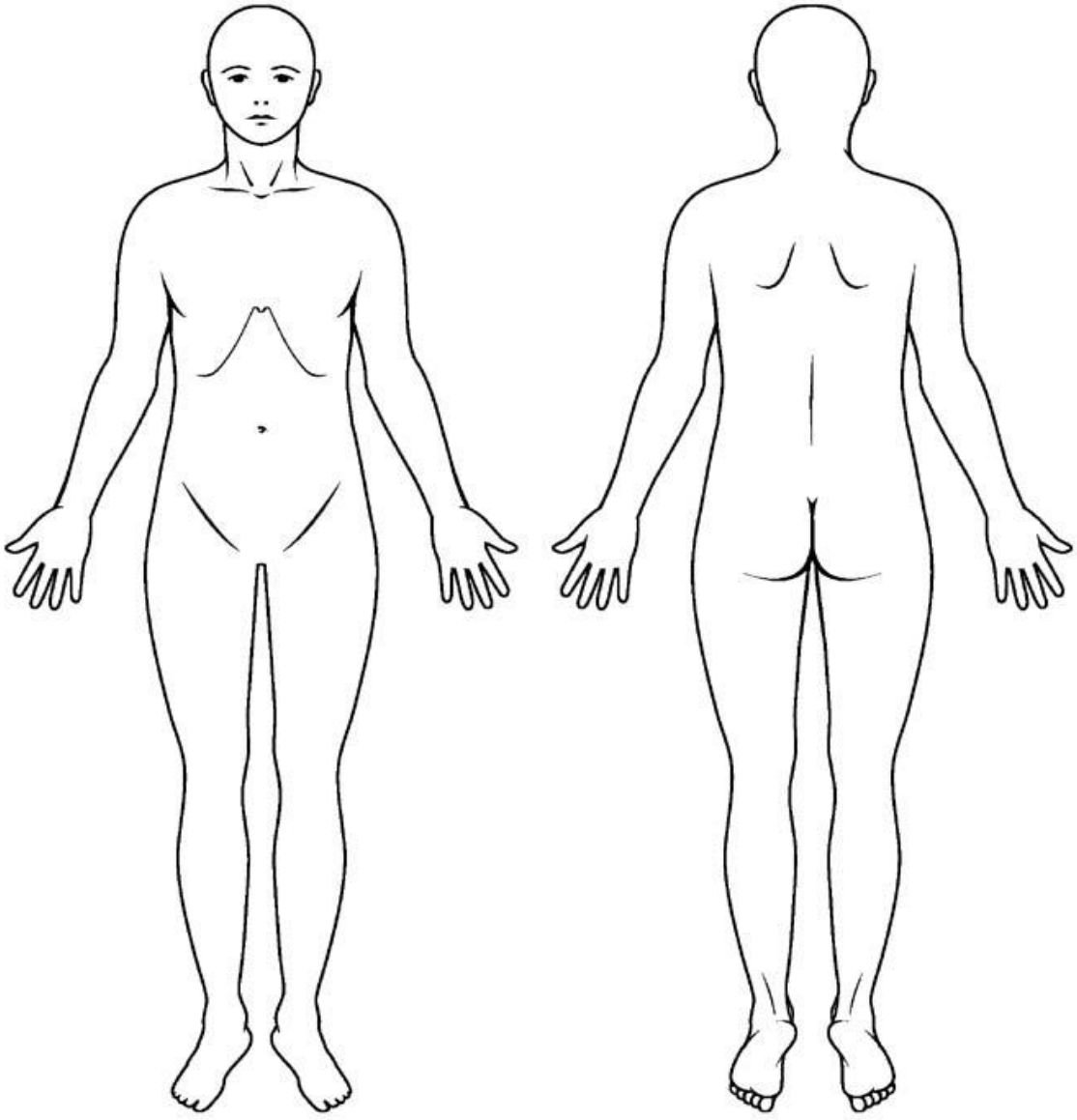
Reviewers	
Review Date	December 2024

Section 10: Appendices

10.1 Body Map

Emergency Department Post Restraint Body Map clinical Assessment

Patient Details:	Assessor Details:
Name…….	Name……..
DOB……	Designation……
Unit Number……	Registration number……



10.2 Appendix - Restraint form

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 ?	6. Was a weapon involved ?
Yes ☐ Drink/ Drugs / Both No ☐	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.