# NICE Clinical Guideline

## Violence

### Stakeholder Scoping Workshop Notes

### Tuesday 27th November 2011

1. **Scope - Are we on the right track? Have we struck an appropriate balance between the need to keep the scope manageable and covering the most important clinical issues?**

   Stakeholders feel that the scope needs to cover the following:

   - Settings:
     - **A**,**B**&**C:** Must include community settings
     - **B**&**C:** All settings should be covered
     - **B:** Primary Care – it is the start of some pathways

   - Population:
     - **A**&**C:** Consider under 18s: they are often excluded and guidelines needs to focus on adolescents in order to support the professionals working with these individuals
     - **B**: Aged 18 year and over, but may still be relevant to 16 and 17 year olds, especially when other guidance is not yet available

   - Prison health:
     - **C:** An NHS patient in prison is still under the governance of the NHS

   - Risk assessments and risk tools:
     - **A**&**B**: Consider personal history, recommend particular evidence based tools, different tools for different stages of assessment and/or condition

   - Witnesses:
     - **A**&**B**: The identification of, and impact on, other service users or staff who witness violent acts
     - **A**&**B**: Managing fear and trauma incident management

   - Debriefing:
     - **A**&**B**: For staff, witnesses and patients, providing a support structure

   - Information sharing:
     - **B**: Across multi disciplinary teams, different settings and clusters

- Learning disabilities:
  - B: Should be included especially as funding cuts are leading to more people with LD being cared for in generic settings

- Address different stages separately:
  - B: A cycle of:
    i. anticipation (anxiety and agitation);
    ii. emergency response and medication (rapid tranquilisation, inter-muscular injections, PRN medication) and;
    iii. follow up post incident

**Group A** felt that the following areas that should be added to the scope:

- Assessment of use of technology in the prevention and management of violent behaviour
- Post traumatic stress disorders
- Staff and supporting staff; look at staff training for anger and stress management
- Older adults
- Recognising the individual's needs throughout the pathway
- Quality of the relationship between service users and staff

**Group B** considered the following but ultimately decided that they were not suitable for inclusion:

- Teaching of different techniques: may lead to a quality improvement network instead
- CAMHS and communication across different teams: too broad to cover

2. **We would like comments on the title of the guideline: is it appropriate? Does it reflect what we need to cover? One topic we have considered is "Behaviour that challenges: managing physically threatening behaviours in health and social care".**

Current title:

- **A:** *Violence:* term is unacceptable to service users
- **C:** The word *aggression* is missing. Staff encounter a lot more than just violence; verbal abuse, threats.
- **C:** The current title defines by setting, but the actual document defines by intervention; using the setting in the title is not helpful and this should be removed

Other titles considered:

- **A**,**B**&**C:** *Behaviour that Challenges: managing physically threatening behaviours in health and social care:* unclear, has a much wider meaning, too much overlap with learning disabilities, violence is only one part of challenging behaviour
- **B:** *Promoting Safer Services:* too broad

Preferred titles:

- **A:** ***Prevention*** should be included in the guideline title (no alternative title put forward).
- **B:** ***Violence and Aggression: managing violence and physically threatening behaviours in health and social care*** – user friendly, clear and to the point, accessible to voluntary organisations. *Violence*: clear; *Aggression*: wider remit.
- **C:** ***Therapeutic Management of Violence and Aggression*** – it was acknowledged that service users might not like the term violence, but it needs to be explicit so that staff know exactly what the guideline relates to.

3. **Do the topics listed in the scope (section 4.3.1) cover the most important areas? Are there any omissions or any topics on the list that should be deleted?**

- **B:** (*b) de-escalation* is not just short-term: change to *de-escalation methods*

- **B:** *(a) identification... (g) anticipation...* and *(i) primary prevention* are very similar: consider amalgamating

- **B:** Consider regrouping all into:
  i. triggers
  ii. responses / behaviours
  iii. debriefing / post- incident management

- **C:** *(f) Training...*: Regulations: there is a lack of information on the standards and regulation of the training of restraint and accreditation of the trainers. General governance of restraint is missing; a potential recommendation from this guideline could be that an independent governing body is created, purely to focus on the use of restraint.

- **C:** *(f) Training...*: There's a culture of staff being trained by the security industry, but they are without healthcare training and lack knowledge around healthcare standards. Healthcare staff should be trained by healthcare professionals, with a

knowledge of mental illness and the patients they are dealing with. There is a lack of focus on training providers and coordinators (including physical skills and techniques).

- **C:** *(h) Environmental influences/impact:* organisational features leading to violence (e.g. management of wards; patients being moved around regularly). There is an evidence base in support of 'restraint free' areas, but are they using more seclusion or medication instead of restraint? The application of tools like Root Cause Analysis may play a part in reducing the use of restraint.

**Group A** felt the following had been omitted:

- Psychiatric intensive care units
- Guidance on restraint: emergency and mechanical
- Prevention:
  - Therapeutic activities to prevent the escalation of violent acts
  - Communication
  - De-escalation
- Adapting long & medium term management of violence to immediate violent outbreaks
- Short term management checklist
- Monitor care in an individualised approach and adapt to the specific scenario
- Re-evaluate the licensing process (specifically the license application)
- Potentially violent staff
- Extend debrief from staff to all involved (witnesses)

**Group B** felt the following had been omitted:

- Mechanical restraint
- Pathways and care planning: including advance directives

**Group C** felt the following had been omitted:

- 'Pain compliance': the term needs to be explicitly defined; an assumption by some staff that it can't be used, breach of human rights, but in some high-risk situations it can be successful. Help staff to understand the term so that they do not have concerns about using it.
- Safeguarding issues: staff management of situations of patient on patient violence, both on wards and in the community setting. The level of patient on patient violence in the community is unknown; research required.
- Near misses: lessons to be learnt from these too. Issues of reporting make it difficult to know when and why they occur; no true count available.
- Staffing competencies: who is preventing and managing violence; e.g. competencies and age concerns around frontline staff.

- Reporting rules: how to record/report restraint; staff need to know what has to be reported and to who; information on when the restraint was applied, by who and what techniques were used. Considerations need to be made for different settings; how should reporting, feeding back and debriefing be done in the community?
- Partnership working tools: care plans, restraint plans, advance directives. There needs to be a multi-professional approach to managing violence. Lack of connection between care teams (e.g. a lack of doctors and psychologists helping to manage violent situations) which has implications for patients in terms of medication and management, as doctors do not have a real understanding of the incidents that occur.
- Staff safety: staff personal safety, how to disengage and breakaway
- Restraint of someone who is naked: previously staff have been told not to do this (due to potential previous traumas the patient has experienced), but health care staff do not know what to use instead. Staff are required to protect a person's dignity at all times.
- Police:
  - Accountability: who is accountable when a person is being restrained by healthcare professionals *and* police? Police receive different training and use different force and expect healthcare staff to allow them to take over and deal with the situation. But if a patient later becomes ill, will healthcare staff be held responsible?
  - Tasers: used by police on wards (or when patients are on their way to hospital). Need an after-care policy as staff are unclear of risks of medicating a patient following use of a taser. Similarly, if mechanical restraint is used by police, what after-care should be applied? Agreement between healthcare professionals and police is needed.
  - When to involve police?: guidance needed around level of violence healthcare professionals are expected to manage before police intervention. Staff need a hierarchy of responses to follow, which includes when the police should be called.

**4. How can we best reflect and consider issues around social care settings, given the limitations of what we can manage and of the brief?**

- **A:** The settings are not sufficient: needs to capture emergency settings and the acute, short-term management of violence as well; undecided as to how settings should be best captured.
- **B&C:** Social care is intertwined with healthcare: cannot be separated; the main issues around violence in social care settings are the same as inpatient settings.
- **B:** Lone working to be looked at under community settings.
- **B:** Primary Care to be included: include what GPs should be looking for when making referrals, initial identification of triggers.
- **C:** List of settings on what that guideline will cover should be added.

5. **What are your views on the various terminology used, especially challenging behaviour, violent behaviour and threatening behaviour?**

- **A&B**: Challenging behaviour: unclear, has too wide a meaning, significant overlap with learning disabilities.
- **A:** Violence: majority of group A were in favour as this captures the essence of what the guideline needs to focus on, however this was opposed by 2 stakeholders representing service users who find this term disempowering.
- **A:** Threatening: considered inappropriate as contains implicit judgement about the intention behind the behaviour.
- **A:** Physically threatening behaviour: considered inadequate because not all threatening behaviour is physical.
- **C:** Definition of terms required for: physical restraint, manual restraint, mechanical restraint, PRN.
- **C:** Rapid tranquilisation: needs to be defined, lots of different interpretations.
- **C:** Control and Restraint: generally, health care professionals prefer not to use this term as it's used in prisons and tends to be more forceful. However, courts understand this term. In some services 'prevention and management of violence and aggression' (PMVA) is used as an alternative.

6. **Equalities – how do inequalities impact on the management of physically threatening behaviours? Should any particular subgroups of the population be considered within the guideline?**

- **A&C:** Gender differences: higher rate but lower intensity of incidents in women; fewer incidents at greater intensity (e.g. using weapons) in men.
- **A&C:** Race differences: statistically, restraint used more on black patients than patients of any other race.
- **B&C:** Pregnant women (potential overlap with APMH)
- **A&B:** Mental health capacity: including people with mild learning disabilities in in-patient settings.
- **A&B:** Physical disabilities: physical health and pre-existing health conditions.
- **A&B:** Sensory impairments
- **A:** Coercive interventions
- **A:** Substance misuse
- **A:** Legal domains
- **A:** Patients who have experienced trauma
- **A:** Older adults
- **A:** Staff
- **B:** Afro-Caribbean men: x6 more likely to be physically restrained

- **B:** Religious and cultural subgroups: considerations such as eye contact, physical contact, colours
- **B:** Friends and relatives: information sharing, Respect Training / Respect Campaign
- **B:** Illiteracy: how info is shared, overlap with education sector?
- **B:** English not spoken / English not as a first language

7. **Regarding the suggested guideline development group composition – are all the suggested members appropriate? Should we be including any other types of members for this guideline? Could there be a role for expert advisers in this guideline?**

**Group A** feel it is important that the professional contingent of the GDG have experience working within the community and in health care settings.

Suggested GDG composition:

- **A**,**B**&**C**: Pharmacist
- **A**,**B**&**C**: Police officer
- **A**,**B**&**C**: Psychiatrist
- **A**&**B**: Psychologist
- **B**&**C**: Trainers: generic or research based, specialising in restraint (more than one so that different views can be sought); (**C**) include higher education trainers/tutors (e.g. those who teach nurses, as they have the most up-to-date knowledge)
- **A**&**C**: Someone with legal knowledge, such as a (mental health) lawyer
- **A**: CID (Criminal Investigation Department) officer
- **A**: A psychiatric intensive care professional (either several who work in different settings or one professional who has experience across settings)
- **A**: A&E professional/paramedic
- **A**: Senior nurse/psychiatric nurse
- **A**: Occupational therapist
- **A**: Social worker
- **B**: Psychiatric social worker
- **B**: Pharmacologist
- **B**: GP
- **B**: Psychiatric nurse
- **B**: Community nurse
- **B**: In-patient nurse
- **B**: Voluntary Organisations
- **B**: PICU

- **B**: ASD services (for high functioning autism)
- **B**: NHS Protect (new body who have researched environmental factors)
- **B**: Local security management specialists
- **C:** Prison worker
- **C:** Nurse
- **C:** Someone from each of the headings within the scope
- **C:** Community-based practitioner
- **C:** Independent sector
- **C:** NHS representatives
- **C:** Social care representative
- **C:** Registered clinician
- **C:** Emergency department/paramedic
- **C:** CAMHS professional
- **C:** Chief executive(s)
- **C:** Professional union/council members
- **C:** Heath Care workers and other 'unqualified' staff who are actually at grass roots level and can offer valuable insight.

**Other Comments:**

**Group A:**

- One member of the group was concerned about the interface between this guideline and current/upcoming technology appraisals.

**Group C:**

- 'Three minute rule': This raised concerns, but following the David Bennett enquiry, this is now no longer recommended; restraint should be done for the shortest time possible, with no specific time limit.

- 2011 report on deaths from restraint: may provide valuable information.

- Previous guideline not thorough enough:
  - People were disappointed; huge requirement for information.
  - Led to conflict between information in NICE guideline and what CQC say; even conflict *within* CQC over how issues should be dealt with. New guideline needs to be explicit to avoid this happening again.