Violence and aggression

NICE quality standard

Draft for consultation

January 2017

This quality standard covers short-term management of violent and physically threatening behaviour among adults, children and young people with a mental health problem. It applies to settings where mental health, health and social care services are provided. This includes community settings and care received at home.

This quality standard will not specifically address violence and aggression among people with primary diagnosis of learning disability because this group has already been covered in learning disabilities: challenging behaviour.

It is for commissioners, service providers, health and social care practitioners, and the public.

This is the draft quality standard for consultation (from 24 January to 20 February 2017). The final quality standard is expected to publish in June 2017.

Quality statements

Statement 1 People in contact with mental health services who have been violent or aggressive are involved in identifying their triggers and early warning signs.

Statement 2 People in contact with mental health services who have been violent or aggressive are involved in identifying successful de-escalation techniques and make advance statements about the use of restrictive interventions.

Statement 3 People with a mental health problem who are manually restrained have their physical health monitored during and after restraint.

Statement 4 People with a mental health problem who are given rapid tranquillisation have side effects, vital signs, hydration level and consciousness monitored after any rapid tranquillisation.

Statement 5 People with a mental health problem who experience restraint, rapid tranquillisation or seclusion have an immediate post-incident debrief that addresses physical harm, ongoing risks and the emotional impact of the incident.

NICE has developed guidance and a quality standard on patient experience in adult NHS services and service user experience in adult mental health services (see the NICE pathway on patient experience in adult NHS services and service user experience in adult mental health services), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing services where violence and aggression is likely to occur include:

- Learning disabilities: challenging behaviour (2015) NICE quality standard 101
- Personality disorders: borderline and antisocial (2015) NICE quality standard 88
- Antisocial behaviour and conduct disorders in children and young people (2014) NICE quality standard 59.

A full list of NICE quality standards is available from the quality standards topic library.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

Question 3 Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Question 4 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Questions about the individual quality statements

Question 5 For draft quality statements 1 and 2: Draft quality statements 1 and 2 cover people in contact with mental health services. Do you think these statements could apply to people with a mental health problem using other types of services? If so, please describe the setting, the type of service and how the statements could be measured.

Question 6 For draft quality statement 3: Should monitoring of physical health during and after manual restraint include more than monitoring pulse, respiration and complexion?

Quality statement 1: Identifying triggers and warning signs

Quality statement

People in contact with mental health services who have been violent or aggressive are involved in identifying their triggers and early warning signs.

Rationale

Identifying triggers and warning signs can help people using mental health services to understand their behaviour. It can also give staff providing care the opportunity to implement actions that may help to prevent violence or aggression.

Quality measures

Structure

Evidence of local arrangements to ensure that people in contact with mental health services who have been violent or aggressive have any identified triggers and early warning signs included in their care plan.

Data source: Local data collection.

Process

Proportion of people in contact with mental health services who have been violent or aggressive whose care plan includes any identified triggers and early warning signs.

Numerator – the number in the denominator with a care plan that includes any identified triggers and early warning signs.

Denominator – the number of people in contact with mental health services who have been violent or aggressive.

Data source: Local data collection.

Outcome

a) Service user reported experience of involvement in identifying triggers and early warning signs of violence and aggression.

Data source: Local surveys capturing service user experience.

b) Number of restrictive interventions including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation.

Data source: Local data collection. Information on restrictive interventions is recorded in the National Mental Health Minimum Data Set.

What the quality statement means for different audiences

Service providers (such as mental health trusts, mental health community services and primary care mental health services) ensure that systems are in place for people with mental health problems who have been violent or aggressive to be involved in identifying triggers and early warning signs, which are recorded within the person's care plan.

Health and social care practitioners (such as mental health nurses, psychiatrists and social workers) encourage and support people with mental health problems who have been violent or aggressive to identify triggers and early warning signs. They should record any identified triggers and early warning signs in the person's care plan.

Commissioners (clinical commissioning groups, local authorities and NHS England) ensure that they commission services in which people with mental health problems who have been violent or aggressive are involved in identifying triggers and early warning signs, which are recorded within the person's care plan.

People in contact with mental health services who have been violent or aggressive are encouraged to think about what may have caused the behaviour (for example, feeling jealous or disappointed or angry about something), and what the first signs usually are. The person discusses this with their care team and any identified triggers or possible warning signs are recorded in their care plan.

Source guidance

Violence and aggression: short-term management in mental health, health and community settings (2015) NICE guideline NG10, recommendation 1.3.16

Definitions of terms used in this quality statement

Violent or aggressive

A range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear. [NICE's guideline on violence and aggression]

Question for consultation

Question 5: Draft quality statements 1 and 2 cover people in contact with mental health services. Do you think these statements could apply to people with a mental health problem using other types of services? If so, please describe the setting, the type of service and how the statements could be measured.

Quality statement 2: Planning how to handle violent or aggressive behaviour

Quality statement

People in contact with mental health services who have been violent or aggressive are involved in identifying successful de-escalation techniques and make advance statements about the use of restrictive interventions.

Rationale

A calm, measured and reasonable approach has the potential to reduce violent or aggressive behaviour at any point. Identifying de-escalation techniques that have worked in the past, and finding out and recording the person's preferences increases the likelihood that de-escalation will be effective.

Quality measures

Structure

Evidence of local arrangements to ensure that people in contact with mental health services who have been violent or aggressive have any identified de-escalation techniques that have been successful and advance statements about the use of restrictive interventions included in their care plan.

Data source: Local data collection.

Process

a) Proportion of people in contact with mental health services who have been violent or aggressive whose care plan identifies de-escalation techniques that have been successful.

Numerator – the number in the denominator with a care plan that includes any identified de-escalation techniques that have been successful.

Denominator – the number of people in contact with mental health services who have been violent or aggressive.

Data source: Local data collection.

b) Proportion of people in contact with mental health services who have been violent or aggressive whose care plan includes advance statements about the use of restrictive interventions.

Numerator – the number in the denominator with a care plan that includes advance statements about the use of restrictive interventions.

Denominator – the number of people in contact with mental health services who have been violent or aggressive.

Data source: Local data collection.

Outcome

a) Service user reported experience of involvement in identifying successful de-escalation techniques.

Data source: Local surveys capturing service user experience.

b) Number of restrictive interventions including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation.

Data source: Local data collection. Information on restrictive interventions is recorded in the National Mental Health Minimum Data Set.

What the quality statement means for different audiences

Service providers (such as mental health trusts, mental health community services and primary care mental health services) ensure that systems are in place to involve people with mental health problems who have been violent or aggressive in identifying de-escalation techniques that have been successful, and to ensure that the person's care plan includes advance statements about the use of restrictive interventions.

Health and social care practitioners (such as mental health nurses, psychiatrists and social workers) encourage and support people with mental health problems who have been violent or aggressive to identify de-escalation techniques that have been successful and to make advance statements about the use of restrictive interventions, which are recorded in their care plan.

Commissioners (clinical commissioning groups, local authorities and NHS England) ensure that they commission services in which people with mental health problems who have been violent or aggressive are involved in identifying de-escalation techniques that have been successful and make advance statements about the use of restrictive interventions, which are recorded in their care plan.

People in contact with mental health services who have been violent or aggressive are encouraged to think about how they calmed down and what has worked well in the past. They discuss what helped them to calm down (such as talking with someone or taking a medication) with their care team and explain how they wish to be helped in the future if they are violent or aggressive. This information is recorded in the person's care plan. It may also include making a written statement (called an advance statement) that explains their preferences about the use of 'restrictive interventions' such as physically holding the person to prevent them harming themselves or others, or an injection of a medication to calm them down.

Source guidance

Violence and aggression: short-term management in mental health, health and community settings (2015) NICE guideline NG10, recommendation 1.3.16

Definitions of terms used in this quality statement

Violent or aggressive

A range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear. [NICE's guideline on violence and aggression]

De-escalation

The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. 'When needed' (p.r.n.) medication can be used as part of a de-escalation strategy but 'when needed' medication used alone is not de-escalation. [NICE's guideline on violence and aggression].

Advance statement

A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding. [NICE's guideline on violence and aggression]

Restrictive interventions

Interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation. [NICE's guideline on violence and aggression]

Question for consultation

Question 5: Draft quality statements 1 and 2 cover people in contact with mental health services. Do you think these statements could apply to people with a mental health problem using other types of services? If so, please describe the setting, the type of service and how the statements could be measured.

Quality statement 3: Physical health during and after manual restraint

Quality statement

People with a mental health problem who are manually restrained have their physical health monitored during and after restraint.

Rationale

Restrictive interventions should only be used if de-escalation and other preventive strategies have failed. Monitoring physical health during and after manual restraint is paramount for the person's safety. There is a risk of death from obstructing airways during manual restraint, but harm can also occur after the event. People with mental health problems are at increased risk of coronary heart disease, cerebrovascular disease, diabetes, epilepsy and respiratory disease; all of which can be exacerbated by the effects of manual restraint.

Quality measures

Structure

Evidence of local arrangements to ensure that people with a mental health problem who are manually restrained have their physical health monitored during and after manual restraint.

Data source: Local data collection.

Process

a) Proportion of incidents involving manual restraint of a person with a mental health problem for which there is a record of monitoring physical health during the restraint.

Numerator – the number in the denominator for which there is a record of monitoring physical health during the restraint.

Denominator – the number of incidents involving manual restraint of a person with a mental health problem.

Data source: Local data collection.

b) Proportion of incidents involving manual restraint of a person with a mental health problem for which there is a record of monitoring of physical health after manual restraint.

Numerator – the number in the denominator for which there is a record of physical health being monitored after manual restraint.

Denominator – the number of incidents involving manual restraint of a person with a mental health problem.

Data source: Local data collection.

Outcome

Proportion of incidents involving manual restraint of a person with a mental health problem where harm to the person occurred.

Data source: Local data collection, such as organisation patient safety incident reports.

What the quality statement means for different audiences

Service providers (such as mental health trusts, secondary care services, forensic healthcare services) ensure that systems are in place for people with a mental health problem who are manually restrained to have their physical health monitored during and after manual restraint until there are no further concerns.

Health care practitioners (such as mental health nurses, healthcare staff and people working in forensic services) use manual restraint only when de-escalation techniques have not worked for people with a mental health problem who are being violent or aggressive. If they do manually restrain a person, they monitor the physical health of the person during and after restraint until there are no further concerns.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission services in which manual restraint is used only when de-escalation techniques have not worked for people with a mental health problem who are being violent or aggressive. They also ensure that the services they commission keep the

person safe by monitoring their physical health during and after manual restraint until there are no further concerns.

People with a mental health problem who are being violent or aggressive are only manually restrained (a way of holding the person so that they can't hurt themselves or others) if all other attempts to stop the behaviour have failed. If manual restraint is used, the person has checks during and after the restraint to make sure that they stay safe and well.

Source guidance

Violence and aggression: short-term management in mental health, health and community settings (2015) NICE guideline NG10, recommendations 1.4.32 and 1.4.33

Definitions of terms used in this quality statement

Manually restrained

Use of a skilled, hands-on method of physical restraint by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilize the service user. [NICE's guideline on violence and aggression]

Physical health monitored

Monitoring of vital signs such as pulse, respiration and complexion (with special attention to pallor or discolouration). [Expert consensus]

Question for consultation

Question 6: Should monitoring of physical health during and after manual restraint include more than monitoring pulse, respiration and complexion?

Quality statement 4: Physical health after rapid tranquillisation

Quality statement

People with a mental health problem who are given rapid tranquillisation have side effects, vital signs, hydration level and consciousness monitored after any rapid tranquillisation.

Rationale

Restrictive interventions should only be used if de-escalation and other preventive strategies have failed, and there is potential for harm to the person or other people if no action is taken. Rapid tranquillisation is potentially a high-risk intervention that can result in a range of side effects linked to the medication and dose. Any person given rapid tranquillisation needs to be monitored to ensure that their health is not compromised. People with mental health problems are at increased risk of coronary heart disease, cerebrovascular disease, diabetes, epilepsy and respiratory disease; all of which can be exacerbated by the effects of rapid tranquillisation.

Quality measures

Structure

Evidence of local arrangements to ensure that people with a mental health problem who are given rapid tranquillisation have side effects, vital signs, hydration level and consciousness monitored.

Data source: Local data collection.

Process

Proportion of incidents involving rapid tranquillisation of people with a mental health problem for which there is a record of monitoring of side effects, vital signs, hydration level and consciousness after the intervention.

Numerator – the number in the denominator for which there is a record of monitoring of side effects, vital signs, hydration level and consciousness after the intervention.

Denominator – the number of incidents involving rapid tranquillisation of people with a mental health problem.

Data source: Local data collection.

Outcome

Proportion of incidents involving rapid tranquilisation of a person with a mental health problem where harm to the person occurred.

Data source: Local data collection, such as organisation patient safety incident reports.

What the quality statement means for different audiences

Service providers (such as providers of mental health services and secondary care services) ensure that systems are in place for people with a mental health problem who are given rapid tranquillisation to have their side effects, vital signs, hydration level and consciousness monitored until there are no further concerns about their physical health status.

Health care practitioners (such as mental health nurses, doctors, healthcare staff working in forensic services) use rapid tranquillisation only when de-escalation techniques have not worked for people with a mental health problem who are being violent or aggressive. If they give rapid tranquillisation to a person, they monitor side effects, vital signs, hydration level and consciousness until there are no further concerns about their physical health status.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission services in which rapid tranquillisation is used only when de-escalation techniques have not worked for people with a mental health problem who are being violent or aggressive. They also ensure the services they commission keep people safe after giving rapid tranquillisation by monitoring side effects, vital signs, hydration level and consciousness until there are no further concerns about their physical health status.

People with a mental health problem who are being violent or aggressive are only given an injection of medication to calm them down quickly (called rapid

tranquillisation) if all other attempts to stop the behaviour haven't worked. If rapid tranquillisation is given, the person has checks after the injection for any side effects and to make sure that they stay safe and well.

Source guidance

Violence and aggression: short-term management in mental health, health and community settings (2015) NICE guideline NG10, recommendation 1.4.45

Definitions of terms used in this quality statement

Rapid tranquillisation

Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed. [NICE's guideline on violence and aggression]

Quality statement 5: Immediate post-incident debrief

Quality statement

People with a mental health problem who experience restraint, rapid tranquillisation or seclusion have an immediate post-incident debrief that addresses physical harm, ongoing risks and the emotional impact of the incident.

Rationale

Restraint, rapid tranquillisation and seclusion should only be used to manage violence or aggression if de-escalation and other preventive strategies have failed, and there is potential for harm to the person or other people if no action is taken. Post-incident debriefing can be used to identify and address any physical harm; and to understand what led up to the incident, what could have been done differently, how the intervention impacted on the person and what could be done differently in future. Involving the person who had the intervention gives them the opportunity to discuss their experience and give their perspective of the event.

Quality measures

Structure

Evidence of local arrangements to ensure that people with a mental health problem who experience restraint, rapid tranquillisation or seclusion have a post-incident debrief that includes addressing physical harm, ongoing risks and the emotional impact of the event.

Data source: Local data collection.

Process

Proportion of incidents involving a person with a mental health problem where the person received an immediate post incident debrief.

Numerator – the number in the denominator where the person received an immediate post-incident debrief.

Denominator – the number of incidents involving a person with a mental health problem.

Data source: Local data collection.

Outcome

Service user reported experience of post-incident debriefs.

Data source: Local surveys capturing service user experience.

What the quality statement means for different audiences

Service providers (such as providers of mental health services and secondary care services) ensure that systems are in place for people with a mental health problem who experience restraint, rapid tranquillisation or seclusion to have an immediate post-incident debrief that includes addressing physical harm, ongoing risks and the emotional impact of the incident.

Health care practitioners (such as mental health nurses, nurses, doctors and healthcare staff working in forensic services) use restraint, rapid tranquillisation or seclusion only when de-escalation techniques have not worked. Immediately after an incident, they conduct or take part in a post-incident debrief that includes addressing physical harm, ongoing risks and the emotional impact of the incident.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission services in which restraint, rapid tranquillisation and seclusion are used only when de-escalation techniques have not worked. They also ensure the services they commission provide an immediate post-incident debrief that includes addressing physical harm, ongoing risks and the emotional impact of the incident to service users.

People with a mental health problem who have had a method used for calming them down called 'restraint', 'rapid tranquillisation' or 'seclusion' are given a chance to talk about what happened, why it was used and how they feel about it. This should happen straight away. Manual or mechanical restraint (holding the person or using handcuffs or a special belt to hold them), rapid tranquillisation (giving an injection of medication) and seclusion (taking the person to a room away from everyone else) are used to help calm someone down quickly when all other methods haven't worked.

Source guidance

Violence and aggression: short-term management in mental health, health and community settings (2015) NICE guideline NG10, recommendation 1.4.55 and 1.4.58

Definitions of terms used in this quality statement

Incident

Any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (but not observation) – to manage violence or aggression. [NICE's guideline on violence and aggression].

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Information about how NICE quality standards are developed is available from the NICE website.

See quality standard advisory committees on the website for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage.

This quality standard has been incorporated into the NICE pathway on violence and aggression.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- rates of manual restraint

- rates of rapid tranquillisation
- rates of injury among service users
- rates of injury among members of staff
- experience of service users and carers
- prioritisation of de-escalation by service providers.

It is also expected to support delivery of the Department of Health's outcome frameworks:

- Adult social care outcomes framework 2015–16
- NHS outcomes framework 2016–17
- Public health outcomes framework for England, 2016–19.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the costing statement for the source guidance to help estimate local costs.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and equality assessments are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

For all statements, good communication between health and social care practitioners and people with mental health problems and their carers (if appropriate) is essential. Treatment, care and information should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with mental health problems and their carers (if appropriate) should have access to an interpreter or advocate if needed. Carers should be involved in decision‑making for people with a mental health problem who lack mental capacity, in accordance with the Mental Capacity Act 2005.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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