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Quick reference guide

Violence

The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments

Clinical Guideline 25

Developed by the National Collaborating Centre for Nursing and Supportive Care

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This guidance is written in the following context:
This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Health professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

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Grading of the recommendations

The recommendations in this quick reference guide are based on the best available evidence. Recommendations are graded A, B, C, D or good practice point D(GPP) depending on the type of evidence they are based on.

For more information on the grading system, see the NICE guideline (www.nice.org.uk/CG025NICEguideline)

This guideline makes recommendations on the short-term management of disturbed/violent behaviour in adult in-patient psychiatric settings and emergency departments. This management takes place within a multi-faceted legal framework, compliance with which is a core measure of quality and good practice. Failure to act in accordance with the guideline may not only be a failure to act in accordance with best practice, but in some circumstances may have legal consequences. For example, any intervention used must be a reasonable and proportionate response to the risk it seeks to address.

All those involved in the short-term management of disturbed/violent behaviour should be familiar with, in particular:

- the relevant sections of the Mental Health Act 1983 and its Code of Practice
- the principles underlying the Common Law doctrine of 'necessity', and
- the requirements of the relevant articles of the European Convention on Human Rights, including Articles 2, 3, 5, 8 and the principle of 'proportionality'
- the Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations 1992.

For full details, please refer to the Legal preface in the NICE guideline.

About this quick reference guide

This quick reference guide summarises key practical recommendations to enable healthcare professionals working within acute psychiatric settings and emergency departments to safely and effectively manage actual or threatened violence. It also refers to the training necessary to manage such situations. It does not include supportive recommendations made by the Guideline Development Group, in such areas as organisational policies. To read the full set of recommendations on the short-term management of disturbed/violent behaviour in these settings, please refer to the NICE guideline, available at www.nice.org.uk/CG025NICEguideline

Key priorities for implementation

The following recommendations have been identified as priorities for implementation. To read the commentaries associated with these key priorities, please refer to the NICE guideline, available at www.nice.org.uk/CG025NICEguideline

Prediction

- Measures to reduce disturbed/violent behaviour need to be based on comprehensive risk assessment and risk management. Therefore, mental health service providers should ensure that there is a full risk management strategy for all their services.

Training

- All service providers should have a policy for training employees and staff-in-training in relation to the short-term management of disturbed/violent behaviour. This policy should specify who will receive what level of training (based on risk assessment), how often they will be trained, and also outline the techniques in which they will be trained.
- All staff whose need is determined by risk assessment should receive ongoing competency training to recognise anger, potential aggression, antecedents and risk factors of disturbed/violent behaviour and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalating or coping with disturbed/violent behaviour.
- All staff involved in administering or prescribing rapid tranquillisation, or monitoring service users to whom parenteral rapid tranquillisation has been administered, should receive ongoing competency training to a minimum of Immediate Life Support (ILS – Resuscitation Council UK) (covers airway, cardio-pulmonary resuscitation [CPR] and use of defibrillators).
- Staff who employ physical intervention or seclusion should as a minimum be trained to Basic Life Support (BLS – Resuscitation Council UK).

Working with service users

- Service users should have access to information about the following in a suitable format:
  - which staff member has been assigned to them and how and when they can be contacted
  - why they have been admitted (and if detained, the reason for detention, the powers used and their extent, and rights of appeal)
  - what their rights are with regard to consent to treatments, complaints procedures, and access to independent help and advocacy
  - what may happen if they become disturbed/violent.

  This information needs to be provided at each admission, repeated as necessary and recorded in the notes.
- Service users identified to be at risk of disturbed/violent behaviour should be given the opportunity to have their needs and wishes recorded in the form of an advance directive. This should fit within the context of their overall care and should clearly state what intervention(s) they would and would not wish to receive. This document should be subject to periodic review.

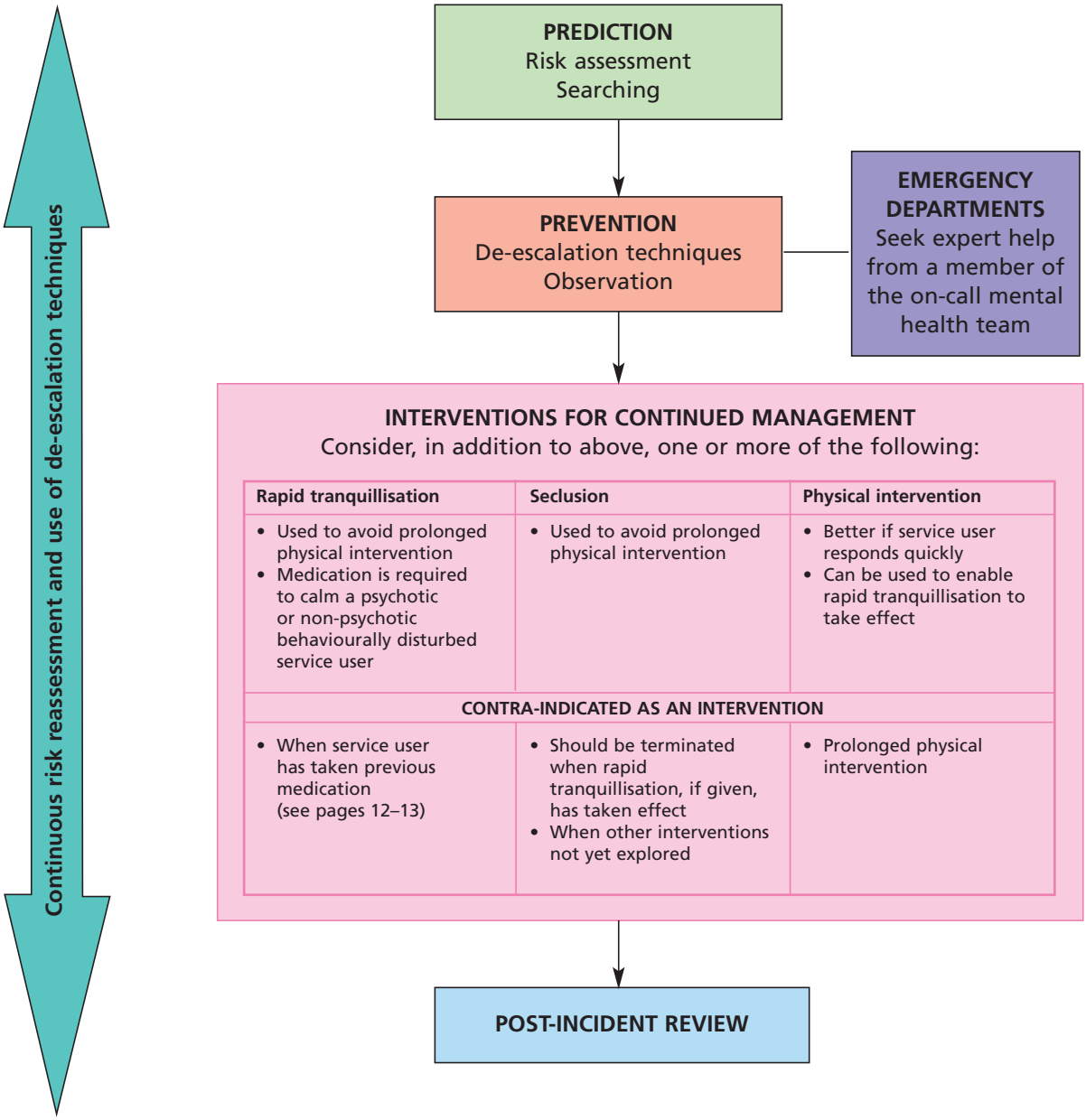
Rapid tranquillisation, physical intervention and seclusion

- Rapid tranquillisation, physical intervention and seclusion should only be considered once de-escalation and other strategies have failed to calm the service user. These interventions are management strategies and are not regarded as primary treatment techniques. When determining which interventions to employ, clinical need, safety of service users and others and, where possible, advance directives should be taken into account. The intervention selected must be a reasonable and proportionate response to the risk posed by the service user.

Physical intervention

- During physical intervention one team member should be responsible for protecting and supporting the head and neck, where required. The team member who is responsible for supporting the head and neck should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.
- A number of physical skills may be used in the management of a disturbed/violent incident.
  - The level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible amount of time.
  - Every effort should be made to utilise skills and techniques that do not use the deliberate application of pain.
  - The deliberate application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, service users and/or others.

Overview algorithm for the short-term management of disturbed/violent behaviour



Prediction

Prediction

See also Training, pages 21–22.

Risk factors

Certain factors can indicate an increased risk of physically violent behaviour. The following lists are not intended to be exhaustive and these risk factors should be considered on an individual basis.

Demographic or personal history

- History of disturbed/violent behaviour
- History of misuse of substances or alcohol
- Carers reporting service user's previous anger or violent feelings
- Previous expression of intent to harm others
- Evidence of rootlessness or 'social restlessness'
- Previous use of weapons
- Previous dangerous impulsive acts
- Denial of previous established dangerous acts
- Severity of previous acts
- Known personal trigger factors
- Verbal threat of violence
- Evidence of recent severe stress, particularly a loss event or the threat of loss
- One or more of the above in combination with any of the following:
  - cruelty to animals
  - reckless driving
  - history of bed-wetting
  - loss of a parent before the age of 8 years D(GPP)

Clinical variables

- Misuse of substances and/or alcohol
- Drug effects (disinhibition, akathisia)
- Active symptoms of schizophrenia or mania, in particular:
  - delusions or hallucinations focused on a particular person
  - command hallucinations
  - preoccupation with violent fantasy
  - delusions of control (especially with a violent theme)
  - agitation, excitement, overt hostility or suspiciousness
- Poor collaboration with suggested treatments
- Antisocial, explosive or impulsive personality traits or disorder
- Organic dysfunction D(GPP)

Situational variables

- Extent of social support
- Immediate availability of a potential weapon
- Relationship to potential victim (for example, difficulties in relationship are known)
- Access to potential victim
- Limit setting (for example, staff members setting parameters for activities, choices, etc)
- Staff attitudes D(GPP)

Antecedents and warning signs

Certain features may serve as warning signs to indicate that a service user may be escalating towards physically violent behaviour. The list is not intended to be exhaustive and these warning signs should be considered on an individual basis.

- Tense and angry facial expressions
- Increased or prolonged restlessness, body tension, pacing
- General over-arousal of body systems (increased breathing and heart rate, muscle twitching, dilating pupils)
- Increased volume of speech, erratic movements
- Prolonged eye contact
- Discontentment, refusal to communicate, withdrawal, fear, irritation
- Unclear thought processes, poor concentration
- Delusions or hallucinations with violent content
- Verbal threats or gestures
- Replicating, or behaviour similar to that which preceded earlier disturbed/violent episodes
- Reporting anger or violent feelings
- Blocking escape routes D(GPP)

Risk assessment

- All staff should be aware of the following factors that may provoke disturbed/violent behaviour:
  - attitudinal
  - situational
  - organisational
  - environmental. D(GPP)
- There should be a regular and comprehensive general risk assessment to ensure the safety of the clinical environment. D(GPP)
- Risk assessment (of the environment and the service user) should be ongoing, because risk may change according to circumstance. Care plans should be based on an accurate and thorough risk assessment. D
  - Use risk assessment to establish whether specific interventions should be included in the plan. D(GPP)
- Risk assessment should include a structured and sensitive interview with the service user and, where appropriate, carers.
  - Try to get the service user's views about their trigger factors, early warning signs and other vulnerabilities, and their management.
  - Complete the process with sensitive and timely feedback. D(GPP)
- Take care not to make negative assumptions based on ethnicity. Be aware that cultural mores may manifest as unfamiliar behaviour that could be misinterpreted as being aggressive. Risk assessment should be objective, and should consider the degree to which the perceived risk can be verified. D(GPP)
- Take a multidisciplinary approach that reflects the care setting where risk assessment is taking place. Communicate the findings across relevant agencies and care settings, in accordance with the law relating to patient confidentiality. D
- Where a risk of disturbed/violent behaviour is discussed or identified as a possibility in the risk assessment interview, record intervention and management strategies (and the service user's preferences regarding these) in the care plan and healthcare record. A copy of the care plan should be given to the service user, and to their carer if the service user agrees. D(GPP)

Searching

Based on an assessment of risk, it may be necessary to search some service users to ensure a safe and therapeutic environment.

Policy

- All facilities should have an operational policy on searching that includes the points below:
  - searching service users, their belongings and the environment in which they are accommodated
  - searching visitors
  - rub down or personal searching (ordinarily), together with procedures for their authorisation in the absence of consent
  - the circumstances in which a service user physically resists being searched
  - the routine and random searching of detained service users.

  Where necessary, it should refer to related policies, such as those for substance misuse and police liaison. D

Carrying out searches

- The intrusiveness of a personal search must be a reasonable and proportionate response to the reason for the search. D
- Undertake searches with due regard to the service user's dignity and privacy. The search should be done by member(s) of staff of the same sex as the service user. D
- If a service user physically resists, a multidisciplinary decision should be made as to the need to carry out a search using physical intervention. If the decision is not to proceed, the searching policy should set out the options available to deal with the situation. D
- If consent is withheld, a post-incident review should be undertaken that includes an advocacy service or hospital managers visiting the service user who has been searched. D

Prevention

See also Training, pages 21–22.

De-escalation

All services should provide a designated area or room that staff may consider using, with the service user's agreement, specifically for the purpose of reducing arousal and/or agitation. In services in which seclusion is practised, this area should be in addition to the seclusion room. D

- A service user's anger needs to be treated with an appropriate, measured and reasonable response. D(GPP)
- Use de-escalation techniques before other interventions. Continue to use verbal de-escalation even if other interventions are necessary. D(GPP)
- In a crisis situation, staff are responsible for avoiding provocation. They should be aware of and monitor their own verbal and non-verbal behaviour. D(GPP)
- Staff should learn to recognise what generally and specifically upsets and calms the service user. This should be noted in the care plan. D(GPP)
- Where possible and appropriate, encourage the service user to understand their own triggers.
  - Note these in the care plan and give a copy to the service user.
  - Encourage the service user to discuss and negotiate their wishes should they become agitated. D(GPP)

De-escalation techniques

- One staff member should assume control of a potentially disturbed/violent situation. This staff member should:
  - consider which de-escalation techniques are appropriate for the situation
  - manage others in the environment (for example, removing other service users from the area, getting colleagues to help and creating space) and move towards a safe place
  - explain to the service user and others nearby what they intend to do, giving clear, brief, assertive instructions
  - ask for facts about the problem and encourage reasoning (attempt to establish a rapport; offer and negotiate realistic options; avoid threats; ask open questions and ask about the reason for the service user's anger; show concern and attentiveness through non-verbal and verbal responses; listen carefully; do not patronise and do not minimise the service user's concerns)
  - ensure that their own non-verbal communication is non-threatening and not provocative. D(GPP)
- Where there are potential weapons, the service user should be relocated to a safer environment, where possible. D(GPP)
- If a weapon is involved, ask for it to be put in a neutral location rather than handed over. D(GPP)
- Consider asking the service user to make use of the designated area or room to help them calm down. The seclusion room (in services where seclusion is practised) should not routinely be used for this purpose. D(GPP)

Observation

Policy

- Each service should have a policy on observation and engagement, adhering to the terminology and definitions used in this guideline (see Levels of observation, below) that includes:
  - who can instigate observation above the general level and who can change the level of observation
  - who should review the level of observation and when reviews should take place (at least every shift)
  - how the service user's perspectives will be taken into account
  - a process through which a review by a full clinical team will take place if observation above the general level continues for more than 1 week. D

Levels of observation

- The terminology adopted in this guideline should be adopted across England and Wales. D

General observation D

- This is the minimum acceptable level for all service users
- The location of the service user should be known to staff at all times but they are not necessarily within sight
- Positive engagement with the service user should take place at least once a shift
- Evaluate the service user's moods and behaviours associated with disturbed/violent behaviour, and record these in the notes

Intermittent observation D

- This level is appropriate for service users potentially at risk of disturbed/violent behaviour, including those who have previously been at risk but are in the process of recovery
- The service user's location should be checked every 15–30 minutes (specify exact times in the notes)
- Intrusion should be minimised and positive engagement with the service user should take place

Within eyesight observation D

- Service users who could, at any time, make an attempt to harm themselves or others should be observed at this level
- The service user should be within eyesight and accessible at all times, day and night
- Any possible tools or instruments that could be used should be removed, if deemed necessary
- Searching of the service user and their belongings may be necessary, which should be conducted sensitively and with due regard to legal rights
- Positive engagement with the service user is essential

Within arms length observation D

- Service users at the highest levels of risk of harming themselves or others may need to be observed at this level
- The service user should be supervised in close proximity
- More than one staff member may be necessary on specified occasions
- Issues of privacy and dignity, consideration of gender issues, and environmental dangers should be discussed and incorporated into the care plan
- Positive engagement with the service user is essential

Warning signs for observation

In addition to the warning signs shown on page 7 (Prediction), the following may indicate that observation above the general level should be considered.

- History of previous suicide attempts, self-harm or attacks on others
- Hallucinations, particularly voices suggesting harm to self or others
- Paranoid ideas where the service user believes that other people pose a threat
- Thoughts or ideas that the service user has about harming themselves or others
- Threat control override symptoms
- Past or current problems with drugs or alcohol
- Recent loss
- Poor adherence to, or non-compliance with, medication programmes
- Marked changes in behaviour or medication
- Known risk indicators D(GPP)

Carrying out observation

- Carry out designated levels of observation only if the risk of disturbed/violent behaviour has not been reduced by positive engagement with the service user. D(GPP)
- Ensure that the least intrusive level of observation that is appropriate is adopted. D(GPP)
- Explain the aims and level of the observation to the service user's nearest relative, friend or carer (if appropriate and with the service user's agreement). D(GPP)
- Record decisions about observation levels in the service user's notes (both medical and nursing entries), clearly specifying the reasons for using observation. D(GPP)
- When making decisions about the specific level of observation, take into account the following:
  - the service user's current mental state
  - any prescribed medications and their effects
  - the current assessment of risk
  - the views of the service user, as far as possible. D(GPP)
- Clear directions should be recorded that specify the name/title of the persons who will be responsible for carrying out the review and its timing. D(GPP)
- Use observation skills to recognise, prevent and therapeutically manage disturbed/violent behaviour. Specific observation tasks should be carried out by registered nurses who may delegate to competent persons. D
- Nurses and other staff who carry out observation should:
  - engage positively with the service user
  - be appropriately briefed about the service user's history, background, risk factors and needs
  - be familiar with the ward, ward policy for emergency procedures and potential environmental risks
  - be able to increase or decrease the level of engagement according to the level of observation
  - be approachable, listen to the service user, understand how to use self-disclosure and silence, and be able to convey to the service user that they are valued. D(GPP)
- An individual staff member should not carry out observation above the general level for more than 2 hours. D
- Ensure that the service user's psychiatrist/on-call doctor is informed of any decisions concerning observation above the general level as soon as possible. D(GPP)
- A nominated hospital manager should be made aware when observation above the general level is implemented, so that adequate numbers and grades of staff can be made available for future shifts. D(GPP)

Rapid tranquillisation (RT) algorithm

This algorithm should be read in conjunction with the recommendations in the guideline and the Summary of Product Characteristics (SPC) chart for rapid tranquillisation, available at www.nice.org.uk/CG025

See also page 15 of this quick reference guide

All staff involved in RT should be trained according to the recommendations set out on pages 21–22
Continue to use de-escalation techniques throughout

- **Service users should be able to respond to communication throughout** D
- **Prescribe oral and i/m doses separately** D
- **Don't use o/i/m abbreviation** D
- **Don't use two drugs of same class for RT** D
- **Don't mix medications in same syringe** D(GPP)

Potential risks

- Over-sedation causing loss of consciousness
- Over-sedation causing loss of alertness
- Loss of airway
- Cardiovascular and respiratory collapse
- Interaction with medication (prescribed or illicit)
- Damage to the therapeutic relationship
- Underlying coincidental physical disorders D

- Prescribers and those who administer medicines should be familiar with:
  - the properties of benzodiazepines; flumazenil; antipsychotics; antimuscarinics and antihistamines
  - risks (including cardio-respiratory effects, particularly if with high arousal, possible drug misuse, dehydration or physical illness)
  - the need to titrate doses to effect D
- Prescriber and medication administrator should pay attention to:
  - the total dose prescribed
  - arrangements for review
  - consent, *British National Formulary* (*BNF*) and SPC requirements, physical and mental status D

Caution

Take extra care in presence of:
- congenital prolonged QTc syndromes
- medications that lengthen QTc intervals directly or indirectly
- hypo/hyperthermia, stress/extreme emotions, extreme physical exertion D

There are specific risks with different classes of medication. Risks may be compounded if used in combination.

Benzodiazepines: loss of consciousness; respiratory depression or arrest; cardiovascular collapse when receiving both clozapine and benzodiazepines
Antipsychotics: loss of consciousness, cardiovascular/respiratory complications and collapse; seizures; akathisia; dystonia; dyskinesia; neuroleptic malignant syndrome; excessive sedation
Antihistamines: excessive sedation; painful injection; additional antimuscarinic effects D(GPP)

Consult

Advance directives if available D

Preferred method of drug administration (1 = preferred D)

1 Oral

Allow sufficient time for clinical response between doses B

- Non-psychotic context → **Consider oral lorazepam** B
- Psychotic context → **Consider oral lorazepam + oral antipsychotic** D

Consider all medication as part of RT (including pro re nata from agreed RT protocol or advance directive) D

2 Intramuscular (i/m)

Allow sufficient time for clinical response between doses B

- Non-psychotic context → Oral therapy is:
  - refused or has failed
  - not indicated by previous clinical response
  - not a proportionate response

  → **Consider i/m lorazepam (if oral route inappropriate)** B

- Transfer to oral route at earliest opportunity D

Psychotic context

Oral therapy is:
- refused or has failed
- not indicated by previous clinical response
- not a proportionate response

Consider i/m lorazepam + i/m haloperidol B

May also consider i/m olanzapine* for moderate disturbance B

! Don't give i/m lorazepam within 1 hour of i/m olanzapine. Use oral lorazepam with caution B

* The manufacturer has issued a warning that use outside of the details contained within the SPC may increase the risk of fatality

- When using haloperidol:
  - procyclidine or benzatropine should be immediately available to reduce risk of dystonia or other extrapyramidal side-effects D
- Give procyclidine or benzatropine i/m or i/v as manufacturer's instruction D

3 Intravenous (i/v)

(Exceptional circumstances only)

Immediate tranquillisation essential

Consider i/v benzodiazepines or haloperidol D

- Decision to use not to be made by junior staff in isolation D
- Specify and record circumstances for use D

- Be aware of symptoms of:
  - respiratory depression
  - dystonia
  - cardiovascular compromise D
- Crash bag must be available within 3 mins D
- Staff must be trained to Immediate Life Support (ILS) D
- Never leave service user unattended D

After RT

- Monitor vital signs D
- Record blood pressure, pulse, temperature, respiratory rate and hydration at intervals agreed by multidisciplinary team until service user active again D
- Pulse oximeters should be available D

- Intensive and frequent monitoring by trained staff required if:
  - service user is/appears sedated/asleep
  - i/v administration used
  - *BNF* limit or SPC exceeded
  - in high-risk situations
  - illicit substances/alcohol ingested
  - presence of relevant medical disorder/taking prescribed medication
- Pay particular attention to respiratory effort, airway and level of consciousness
- Record in care plan D

If verbal responsiveness is lost:
- use level of care as for general anaesthesia D

Post-incident review within 72 hours D(GPP)

Drugs NOT recommended for RT

- Oral or i/m chlorpromazine C
- i/m diazepam C
- Thioridizine C
- i/m depot antipsychotics D
- Olanzapine (dementia-related disturbance) C
- Risperidone (dementia-related disturbance) C

Zuclopenthixol acetate**

- Not recommended for RT due to long onset and duration of action, but may be considered as an option when:
  - service user will be disturbed/violent over extended time period
  - past history of good/timely response
  - past history of repeated parenteral administration
  - cited in an advance directive
- Never administer to those without previous antipsychotic exposure
- Consult *BNF* and manufacturer's SPC regarding its use B

** Zuclopenthixol acetate is commonly known as 'acuphase' by staff and service users

- When transferring a service user between units, the following should also be sent:
  - a full medication history (including the service user's response to medications) and any adverse effects
  - an advance directive
  - the service user's account of their experience (where possible)
- On discharge, file all such information in their healthcare record to be reviewed regularly. D(GPP)

Interventions for the management of disturbed/violent behaviour

Alarms

- Agree collective responses to alarm calls before incidents occur. These should be consistently applied and rehearsed. D(GPP)

Rapid tranquillisation, physical intervention and seclusion: overarching recommendations

See also Training, pages 21–22, and Post-incident review, page 18.

- Rapid tranquillisation, physical intervention and seclusion are management strategies and are not regarded as primary treatment techniques. If employed:
  - they should only be considered once de-escalation and other strategies have failed
  - clinical need, the safety of service users and others and, where possible, advance directives should be taken into account when making decisions on which interventions to use
  - the intervention selected must be a reasonable and proportionate response to the risk posed by the service user. D

Equipment

- A crash bag should be available within 3 minutes in healthcare settings where these interventions might be used. This equipment should:
  - include an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line resuscitation medications
  - be maintained and checked weekly. D

Personnel

- At all times, a doctor should be available to quickly attend an alert by staff members when these interventions are implemented[1]. D

Legal concerns

- All staff need to be aware of the legal framework that authorises the use of these interventions.
  - The guidance of the Mental Health Act Code of Practice (chapter 19) should be followed (www.dh.gov.uk/assetRoot/04/07/49/61/04074961.pdf).
  - Any departures from that guidance should be clearly recorded and justified as being in the service user's best interest. D(GPP)

[1] The Bennett report recommended that a doctor should be available within 20 minutes. The Guideline Development Group considers quick attendance to mean within 30 minutes of an alert.

Service user concerns

- If using these interventions:
  - try to ensure that the service user does not feel humiliated (for example, respecting their need for dignity and privacy commensurate with the needs of administering the intervention)
  - explain the reasons for using the interventions to the service user at the earliest opportunity
  - reassess the service user's care plan and help them to reintegrate into the ward milieu at the earliest safe opportunity following the intervention. D(GPP)
- Service users should be given the opportunity to document their account of the intervention in their notes. D(GPP)

Rapid tranquillisation

See also the Rapid tranquillisation algorithm, pages 12–13.

- The aim of rapid tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the service user or to others. D

Doses

It is recognised that clinicians may decide that the use of medication outside of the Summary of Product Characteristics (SPC) is occasionally justified, bearing in mind the overall risks. However, where the regulatory authorities or manufacturer issues a specific warning that this may result in an increased risk of fatality, the medication should only be used strictly in accordance with the current marketing authorisation.

- In certain circumstances, current *British National Formulary (BNF)* uses and limits and the manufacturer's SPC may be knowingly exceeded (for example, for lorazepam).
  - This decision should not be taken lightly or the risks underestimated.
  - Record a risk–benefit analysis in the case notes and a rationale in the care plan. Where the risk–benefit is unclear, advice may be sought from clinicians not directly involved in the service user's care. D
- If current *BNF* doses or SPC are exceeded:
  - it is particularly important to undertake frequent and intensive monitoring of a calmed service user
  - pay particular attention to regular checks of airway, level of consciousness, pulse, blood pressure, respiratory effort, temperature and hydration. D
- Individualise the dose of antipsychotic medication for each service user. This will be dependent on several factors including the service user's age (older service users generally require lower doses); concomitant physical disorders (such as renal, hepatic, cardiovascular or neurological); and concomitant medication. D(GPP)

Interventions for the management of disturbed/violent behaviour

Physical intervention

- There are real dangers with physical intervention in any position. (D)
- Physical intervention should be avoided if at all possible. (D)
- Physical intervention should not be used for prolonged periods, and should be brought to an end as soon as possible. (D)
- Remember the level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation, and applied for the shortest possible time. (D)

Carrying out physical intervention

- Continue to employ de-escalation techniques throughout. (D)
- One staff member should assume control throughout the process. He or she should be responsible for:
  - protecting and supporting the service user's head and neck, where required
  - ensuring their airway and breathing are not compromised
  - ensuring vital signs are monitored
  - leading the team through the process. (D)
- Monitor the services user's overall physical and psychological well-being throughout. (D)
- Under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. (D)
- To avoid prolonged physical intervention, consider rapid tranquillisation or seclusion (where available) as alternatives. (D)
- Every effort should be made to use skills and techniques that do not use the deliberate application of pain.
  - The application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, other service users or others. (D)

Seclusion

In services where seclusion is practised, there should be a designated room fit for purpose. This seclusion room should:

- allow clear observation
- be well insulated and ventilated
- have access to toilet/washing facilities
- be able to withstand attack/damage. D

Carrying out seclusion

- The use of seclusion should be recorded in accordance with the guidance in the Mental Health Act Code of Practice. D
- Seclusion should be for the shortest time possible.
  - It should be reviewed at least every 2 hours in accordance with the guidance in the Mental Health Act Code of Practice.
  - Staff should explain to the service user that a review will take place at least every 2 hours. D
- An observation schedule should be specified. D(GPP)
- A service user in seclusion should keep their clothing and any personal items, including those of religious or cultural significance (such as some items of jewellery), provided this does not compromise their safety or the safety of others. D(GPP)

Rapid tranquillisation and seclusion

- This is not absolutely contraindicated, providing that the points below are followed.
  - If the service user is secluded, take the potential complications of rapid tranquillisation particularly seriously (see Rapid tranquillisation, pages 12–13 and 15).
  - Monitor the service user by 'within eyesight' observation (see Observation, page 10).
  - End the seclusion when rapid tranquillisation has taken effect. D(GPP)

Post-incident review

Post-incident review

- Record any incident requiring rapid tranquillisation, physical intervention or seclusion contemporaneously, using a local template. D

Carrying out post-incident reviews

The aim of a post-incident review should be to seek to learn lessons, support staff and service users, and encourage the therapeutic relationship between staff, service users and their carers. D(GPP)

- A post-incident review should take place as soon as possible and at least within 72 hours of an incident ending. D(GPP)
- If possible, a person not directly involved in the incident should lead the review. The review should address:
  - what happened during the incident
  - any trigger factors
  - each person's role in the incident
  - their feelings at the time of the incident, at the review and how they may feel in the near future
  - what can be done to address their concerns. D(GPP)

Emergency departments

See also Training, pages 21–22.

- Emergency department staff should seek specialist advice from the relevant mental health professional if an initial assessment suggests a patient requires a mental health assessment. D

Rapid tranquillisation in emergency departments

See also Rapid tranquillisation, pages 12–13 and 15.

- In an emergency setting, a senior medical staff member should take the decision to use rapid tranquillisation, where at all possible. D(GPP)
- If rapid tranquillisation is thought necessary, consider lorazepam as the first-line drug of choice:
  - when prior to formal diagnosis
  - where there is any uncertainty about previous medical history (including history of cardiovascular disease, uncertainty regarding current medication, or the possibility of current illicit drug/alcohol intoxication).
- If there is a confirmed history of previous significant antipsychotic exposure, and response, haloperidol in combination with lorazepam is sometimes used. D(GPP)

Working with service users

- Treat all service users with dignity and respect, regardless of culture, gender, diagnosis, sexual orientation, disability, ethnicity or religious/spiritual beliefs. (D)
- Ensure that service users have access to the information below, in a suitable format. This should be provided at each admission, repeated as necessary and recorded in the notes.
  - The staff member assigned to them, and how and when they can be contacted.
  - The reason for admission (and if detained, the reason for detention, the powers used and their extent, and rights of appeal).
  - Their rights with regard to consent to treatments, complaints procedures, and access to independent help and advocacy.
  - What may happen if they become disturbed/violent. (D)
- Ensure that service users identified as being at risk of disturbed/violent behaviour have the opportunity to record their needs and wishes in an advance directive. This should:
  - fit within the context of their overall care
  - clearly state what intervention(s) they would and would not wish to receive
  - be subject to periodic review. (D)
- Ensure that the service user's physical needs are assessed on admission (or as soon as possible after admission) and are regularly reassessed. These should be reflected in the care plan. (D(GPP))
- Help to establish therapeutic relationships by taking time to listen to service users, including those from diverse backgrounds (be aware that this may take longer when using interpreters). (D(GPP))
- Ensure confidentiality when administering or supplying medicines to service users. Prescribers should be available for and responsive to requests from the service user for medication review. (D(GPP))

Service users with disabilities

- Staff responsibilities (for de-escalation, rapid tranquillisation, physical intervention and seclusion) should be detailed in the individual care plans of service users with disabilities (this includes service users with physical or sensory impairment and/or other communication difficulties). (D(GPP))

Managing the risk of HIV or other infectious diseases

- If staff are aware that a service user has HIV, hepatitis or other infectious or contagious diseases, they should seek the advice of the Trust infection control officer or relevant officer in the service. (D(GPP))
- Follow the local infection control policy if any service user or staff member is injured during the management of disturbed/violent behaviour where blood is spilt or the skin is broken, or there has been direct contact with bodily fluids (all bodily fluids should be treated as potentially infectious). (D(GPP))

Pregnant women

- Special provision should be made for pregnant women in the event that interventions are needed. These should be recorded in the service user's care plan. (D(GPP))

Environment

- The environment should take into account the service user's needs.
  - Ensure that service users can engage in activities and individual choice. There should be an activity room and a dayroom with a television, as boredom can lead to disturbed/violent behaviour.
  - There should be single sex toilets, washing facilities, sleeping accommodation and day areas.
  - There should be a space set aside for prayer and quiet reflection. (D)

Training

Specific staff training needs

Diversity issues

- There should be an ongoing programme for all staff in racial, cultural, spiritual, social and special needs issues, to ensure staff are aware of and know how to work with diverse populations and do not perpetuate stereotypes. The courses should also cover any relevant local special populations, such as migrant populations and asylum seekers. (D)

Antecedents and risk factors

- All staff whose need is determined by risk assessment should receive ongoing competency training to recognise anger, potential aggression, antecedents and risk factors of disturbed/violent behaviour and to monitor their own verbal and non-verbal behaviour. This should include methods of anticipating, de-escalating or coping with disturbed/violent behaviour. (D)

Observation

- Staff members responsible for carrying out observation and engagement should receive ongoing competency training in observation so that they are equipped with the skills and confidence to engage with service users. (D)

Life support

- All staff involved in administering or prescribing rapid tranquillisation, or monitoring service users to whom parenteral rapid tranquillisation has been administered, should receive ongoing competency training to a minimum of Immediate Life Support (ILS – Resuscitation Council UK) (covers airway, cardio-pulmonary resuscitation [CPR] and use of defibrillators). (D)
- Staff who employ physical intervention or seclusion should as a minimum be trained to Basic Life Support (BLS – Resuscitation Council UK). (D)

Physical intervention

- All staff whose level of need is determined by risk assessment should receive training to ensure current competency in the use of physical intervention which should adhere to approved national standards[2]. (D)

Seclusion

- All staff whose level of need is determined by risk assessment should receive ongoing competency training in the use of seclusion. This should include appropriate monitoring arrangements for service users placed in seclusion. (D)

[2] The NHS Security Management Service (SMS) is developing a training curriculum for the management of violence. The National Institute for Mental Health in England (NIMHE) is drawing up an accreditation scheme for trainers. The work is due for completion in 2005.

Training

Rapid tranquillisation

- All staff involved in rapid tranquillisation should be trained in the use of pulse oximeters. (D)
- Prescribers and those who administer medicines should be familiar with and have received training in rapid tranquillisation, including:
  - the properties of benzodiazepines; their antagonist, flumazenil; antipsychotics; antimuscarinics and antihistamines
  - associated risks, including cardio-respiratory effects of the acute administration of the drugs, particularly when the service user is highly aroused and may have been misusing drugs; is dehydrated or is possibly physically ill
  - the need to titrate doses to effect. (D)

Searching

- All staff involved in undertaking searches should receive appropriate instruction which is repeated and regularly updated. (D)

Incident recording

- All appropriate staff should be trained to ensure that they are aware of how to correctly record any incident using the appropriate local templates. (D)

Emergency department staff

- In addition to ongoing competency training in the management of disturbed/violent behaviour, appropriate staff groups in emergency departments should receive training in the recognition of acute mental illness and awareness of organic differential diagnoses. Service user involvement should be encouraged. (D)

Service user training/involvement in training

- There should be opportunity for service users and/or service user groups to become actively involved in training and setting the training agenda, for example groups with potential vulnerabilities such as:
  - service users with a sensory, physical or cognitive impairment
  - Black and minority ethnic service users
  - female service users
  - service users with communication difficulties. (D)

Implementation

Local health communities should review their existing practice for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments against this guideline. The review should consider the resources required to implement the recommendations set out in Section 1 of the NICE guideline, the people and processes involved and the timeline over which full implementation is envisaged. It is in the interests of service users that the implementation is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

Information on the cost impact of this guideline in England is available on the NICE website and includes a template that local communities can use (www.nice.org.uk/CG025costtemplate).

This guideline should be used in conjunction with the NICE guideline on schizophrenia (see Section 6 of the NICE guideline) and the Commission for Health Improvement audit material created by the Royal College of Psychiatrists (2004).

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Further information

Distribution

This quick reference guide to the Institute's guideline on the short-term management of disturbed/violent behaviour contains the key priorities for implementation, summaries of selected recommendations from the guidance, and notes on implementation. The distribution list for this quick reference guide is available from www.nice.org.uk/CG025distributionlist.

NICE guideline

The NICE guideline, *Violence: the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments* is available on the NICE website (www.nice.org.uk/CG025NICEguideline).

The NICE guideline contains the following sections: Key priorities for implementation; Introduction; Legal preface; 1 Guidance; 2 Notes on the scope of the guidance; 3 Implementation in the NHS; 4 Research recommendations; 5 Full guideline; 6 Review date. It also gives details of the scheme used for grading the recommendations, membership of the Guideline Development Group and the Guideline Review Panel, and technical details on criteria for audit.

Full guideline

The full guideline includes the evidence on which the recommendations are based, in addition to the information in the NICE guideline published by the National Collaborating Centre for Nursing and Supportive Care; it is available from its website (www.rcn.org.uk/resources/guidelines.php), the NICE website (www.nice.org.uk) and the website of the National Library for Health (www.nlh.nhs.uk).

Information for the public

A version of this guideline for service users, their advocates and carers, and for the public is available, in English and Welsh, from the NICE website (www.nice.org.uk/CG025publicinfo). Printed versions are also available – see below for ordering information.

Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

Ordering information

Copies of this quick reference guide can be obtained from the NICE website at www.nice.org.uk/CG025quickrefguide or from the Department of Health Publications Order Line by telephoning 0870 1555 455 and quoting reference number N0828. Information for the public is also available from the NICE website or from the Department of Health Publications Order Line (quote reference number N0829 for the English version, and N0830 for the version in English and Welsh).

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