Policy No: 46.00

Policy and Procedure on

Management of Violence & Aggression (MVA)

WHINFELL SCHOOL

Contents

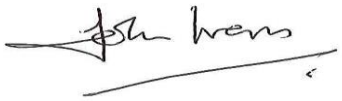
1. Monitoring and Review

1.1. The Proprietor will undertake a formal review of this policy for the purpose of monitoring and of the efficiency with which the related duties have been discharged, by no later than three years from the date of approval shown above, or

earlier if significant changes to the systems and arrangements take place, or if legislation, regulatory requirements or best practice guidelines so require.

1.2. The local content of this document will be subject to continuous monitoring, refinement and audit by the Head of Service.

Signed:



John Ivers
Proprietor, Cambian Group

Paddy Sandham
Principal

2. Terminology

2.1. Our aim is to use consistent terminology throughout this policy and all supporting documentation as follows:

'Establishment' or 'Location	this is a generic term which means the Children's Whinfell School. Whinfell School is a Residential School
Individual	means any child or young person under the age of 18 or young adult between the ages of 18 and 25. At Whinfell School we have 18 young people attending and/or residing between the ages of 7-19.
Service Head	This is the senior person with overall responsibility for the School. At Whinfell this is the Principal who is Paddy Sandham for the school and the Registered Manager Jenny Carradus for the Children's home.
Key Worker	Members of staff that have special responsibility for Individuals residing at or attending the Establishment.
Parent, Carer, Guardian	means parent or person with Parental Responsibility
Regulatory Authority	Regulatory Authority is the generic term used in this policy to describe the independent regulatory body responsible for inspecting and regulating services. At Whinfell School this is Ofsted.
Social Worker	This means the worker allocated to the child/family. If there is no allocated worker, the Duty Social Worker or Team Manager is responsible.
Placing Authority	Placing Authority means the local authority/agency responsible for placing the child or commissioning the service
Staff	Means full or part-time employees of Cambian, agency workers, bank workers, contract workers and volunteers.

3. Definitions

Violence

3.1. The use of physical force which is intended to hurt or injure another person.

Aggression

3.2. A disposition, a willingness to inflict harm, regardless of whether this is behaviourally or verbally expressed and regardless of whether physical harm is sustained.

Physical Assault

3.3. The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort.

Non-Physical Assault

3.4. The use of inappropriate words or behaviour causing distress or constituting harassment.

4. Legislation

4.1. To ensure compliance with:

- Essential Standards of Quality and Safety.
- The National Minimum Standards for Independent Health Care Services in Wales.

4.2. Ensure that the management of violence and aggression is based on current national guidance/standards and within a legal framework including:

- The Mental Health Act (1983 amended 2007) and it's Code of Practice.
- The Health & Safety at Work Act 1974.
- The Management of Health & Safety at Work Regulations 1992, (Amended 1999).
- The European Convention on Human Rights, including: Article 2, (The Right to life), Article 3, (The Right to be free from torture or inhuman or degrading treatment or punishment), Article 5, (The Right to liberty and security of a person save in prescribed cases), Article 8, (The Right to respect for private and family life).
- NICE guidance 25 "violence".

5. Procedure (How)

5.1. In this section of the paperwork include an overview of the procedures required to ensure that the policy is followed an maintained. Wherever possible you should use a flowchart. Detail can include:

5.2. Step by step process by which the policy will be implemented (wherever possible use a flowchart)

5.3. Who is responsible

5.4. What records need to be kept if applicable

5.5. Any sanctions for not following policy e.g. disciplinary

5.6. Supporting documents such as forms, posters, guidance that should be used etc.

6. Accountability

6.1. Clearly specify the responsibilities/accountabilities in order of seniority and their role in ensuring that this policy / procedure is effectively implemented.

7. Standard Forms, Relevant Documents, Letters & References

7.1. List all supporting documents and other policies which support this policy

7.2. Also list any external references or guides which may be provided by legislation, regulators or other governing bodies.

7.3. List any regulations that are referring to in the policy (not covered in section 1.1)

8. Introduction

8.1. This policy deals with how staff identify, de-escalate and manage violence and aggression (MVA) in our CAMHS locations.

8.2. It affects all individuals and staff – including Agency and Bank Staff.

8.3. Make sure that you are familiar with the detail and what is expected of you under the policy

9. Purpose

9.1. This document is a guide for staff who may have to deal with violent and aggressive situations. Whilst the policy addresses the continuum of violent and aggressive behaviour, it is primarily concerned with the short-term management, (72-hours) of disturbed/violent behaviour

- Individualised risk assessment and care planning.
- De-escalation.
- Intervention, (not necessarily physical).
- Post incident review.

9.2. Staff will use the guidance in this policy and procedure to ensure that their actions will be deemed reasonable and proportionate in response to the risk being posed. Cambian is empowered to respond to disturbed/violent behaviour in certain circumstances defined by the Mental Health Act Code of Practice. Failure to act in accordance with best practice may have legal consequences.

10. Policy

10.1. Provide staff and individual s with guidance on the management of aggression and violent incidents which incorporates high standards of practice and care.

10.2. Ensure that risks are minimised in the management of violence and aggression.

10.3. This policy requires all staff to manage disturbed/violent behaviour within the following processes:

Prediction

10.4. Risk Assessment - There should be an on-going, multi-disciplinary risk assessment with well communicated risk management plans. This should include individual and carer interviews to ascertain their views regarding the management of risk, including trigger factors, early warning indicators etc.

De-Escalation

10.5. Care plans should set out the early use of individualised low arousal non-aversive techniques. De-escalation techniques should be employed prior to other interventions being used.

Team Physical Intervention

10.6. Additional interventions may be necessary where de-escalation has failed. Techniques such as physical intervention and rapid tranquilisation should only be considered once de-escalation and other early strategies have not been

successful in calming the individual down. They should not be attempted by individuals alone, but need to be carried out by an appropriate team of staff to ensure both safety and effectiveness.

Post Incident Review

10.7. Support and review within a learning lessons framework should take place as soon as practicably possible following the incident.

10.8. This policy is one component of the Company's approach to provide safe and individualised care. It should be viewed within this wider context and implemented in conjunction with all other relevant policies including:

- Observation and Engagement Policy.
- Resuscitation Policy.
- Rapid Tranquilisation Policy.
- Safeguarding policy.

10.9. Dealing with aggressive situations is only a small part of individual care. Under our duty of care, the way violence and aggression is dealt with is of the greatest importance, badly handled, it may lead to the individual or staff member being injured, the emotional climate may deteriorate and constructive care may be jeopardised.

11. Procedures

11.1. Cambian recognises the need to ensure that services remain as safe as possible and is committed to providing services that are safe for both individuals and employees. There will be some occasions however when individuals may behave in such a way as to disturb others around them, or their behaviour may present a risk to themselves or others around them or those charged with their care. In such situations, it is necessary for staff to take immediate control of a dangerous situation; contain or limit the individual's freedom for no longer than is necessary and end or reduce significantly, the danger to the individual or others" Whilst the above applies solely for the purpose of restraint, in practice, the effective management of violence and aggression will require a range of skills and strategies to be used.

11.2. These include:

- Personal safety awareness.
- Conflict resolution.
- Disengagement.
- Physical interventions; and
- Specialist interventions.

11.3. Any physical intervention used should:

- Be reasonable and proportionate in the circumstances.
- Apply the minimum force necessary to prevent harm to the individual or others.
- Not include the use of mechanical restraint.
- Be used for only as long as is absolutely necessary.
- Be sensitive to gender and race issues.
- Staff should be aware of the alternative methods of restraint to be used with frail individuals.

11.4. As with all care interventions, the need for these will be assessed, planned on an individual basis and evaluated. Planning and evaluation should involve individual and/or carers, (especially where mental capacity issues affect the individual 's ability to be directly involved).

Environment/activity

11.5. Individuals should be involved in the design and arrangement of their care environment facilities and organisation of their day. This can be facilitated through community meetings, suggestion boxes and representation at clinical governance meetings. The occupational therapy department will lead on the development of therapy programmes

linked to the individuals preferred activities/ goals. The location will actively engage with individuals through activities that allow the individual to engage in physical exercise, group interaction, therapy and recreation.

11.6. Individuals should be provided treatment and care in the least restrictive care setting possible.

11.7. Staff will monitor and address, through the daily walkthrough and health and safety audits adverse environmental issues such as high temperature, ventilation, noise and light. High temperature, low levels of ventilation (access to fresh air) and high noise levels are positively associated with an increase in disturbed/aroused behaviour inpatient settings. This will be checked via audit by the Audit Quality and Compliance Team.

11.8. The locations have been designed/ decorated to incorporate a feeling of space and light, whilst ensuring the accessibility, privacy and dignity of the individual. For example individuals have their own bedroom which can be personalised and en-suite facilities. All areas are cleaned daily and recorded in cleaning schedules to demonstrate compliance with this.

11.9. Communal lounges including a quiet lounge are accessible at all times by individuals. Individuals have access to the locations garden providing them with fresh air.

11.10. Each location has a multi faith room for spiritual needs/quiet reflection.

11.11. Individuals have access to telephones. Please refer to policy SSCM 08.

11.12. All staff carry an alarm with them at all times SSCM 15. There are also nurse call alarms in the location, including communal areas and individual's bedrooms, which are readily accessible by staff and the individual. The Cambian personal alarm systems should be fit for purpose and maintained/serviced appropriately as per policy.

11.13. The use of mirrors in "blind spot" areas have been installed.

11.14. Should there be a need for police escorts, then the reception area can be locked off to provide a restricted area for this purpose.

Information for individuals

11.15. On admission each individual will be given a patient guide and welcome leaflet. This will include information on:

- Staff allocated to them during their stay.
- Their legal rights – including access to solicitors, mental health act administrator etc.
- How to complain.
- Advocacy services.
- What may happen if they become disturbed/violent.

11.16. The above information will be repeated during the individuals stay.

11.17. To ensure individuals are aware of the outcome of their risk assessments, when the level of daily risk assessment changes, staff are to discuss the reasons for this with the individual and ask them to sign the risk assessment.

Prediction, (Antecedents, Warning Signs and Risk Assessment)

11.18. Staff should ensure that a comprehensive risk assessment is undertaken with each individual, (START, daily risk assessment and other assessments as required) as part of the "Active Care" care planning process for the person that addresses any short-term and/or long-term management of disturbed/aggressive/violent behaviour, where such needs are identified.

11.19. NICE guidance states – "When assessing for risk of disturbed/violent behaviour, care needs to be taken not to make negative assumptions based on ethnicity. Staff members should be aware that cultural mores may manifest as

unfamiliar behaviour that could be misinterpreted as being aggressive. The assessment of risk should be objective, with consideration being given to the degree to which the perceived risk can be verified."

11.20. Some risk factors that indicate that a person could be violent or aggressive are:

11.21. Many of the components identified above are dynamic and changing and need to be reassessed frequently to ensure care and risk management plans remain accurate and effective. Staff should maintain on-going risk assessment with respect to violence/disturbed behaviour.

Historical/Static	Clinical and Dynamic Variables
• Current young age • Young age/First Offence • History of violent behaviour • Early social maladjustment • History of substance misuse • History of Mental Illness • Diagnosis of Personality Disorder • Previous unstable relationships • Social restlessness • Previous use of weapons • Previous dangerous/impulsive acts • Employment difficulties • Psychopathy	• Lack of impulse control • Anti-social attitudes and beliefs • Anger and hostility • Suicidal/self-harm intent • Sadistic/violent fantasy • Homicidal ideation • Active symptoms of Mental Illness • Substance misuse • Unwillingness to engage in treatment • Evidence of recent severe stress, particularly loss event • Therapeutic drug effects, (disinhibition, akathisia) • Delusions of control • Agitation, excitement, suspiciousness • Physical illness and toxic states • Poor collaboration with treatment • Organic dysfunction/impairment
Situational / Attitude	**Organisational / Environmental**
• Extent of a social network • Immediate availability of a potential weapon • Relationship and access to a potential victim • Limit setting • staff attitudes	• Restrictive rules • Overcrowding • Limited activity • Excessive heat • Poor light

11.22. Staff will communicate the outcomes of violence and aggression risk assessment to involved agencies in accordance to Cambian guidance on the sharing of individual related information and individual confidentiality.

11.23. Staff should assess and monitor potential antecedents, these will include:

- Anxiety and fear associated with medical situations. These are quite often linked as an antecedent to aggressive situations. The individual may be in a new, frightening or unwanted situation. He/she may be suffering from

some perceptual disturbance, thus colouring their judgement and misinterpretation may result. This may induce the fight or flight syndrome.

- Pain that is present, be that continuing or unrelieved, is debilitating and may contribute to frustration, irritation and if not relieved, aggression.
- Medication that is prescribed to reduce aggressive behaviour can cause some degree of disinhibition and may result in an individual behaving in ways that normally they would have control of.

11.24. Confusion that may be of an organic or functional cause.

- Staff must be aware that the condition can at times be exacerbated by medication, be that prescribed or non-prescribed.
- Alcohol and drugs are often reported by staff working in health and social care settings as having an association with aggressive behaviour and psychological changes.
- Boredom and frustration that can be brought about by lack of structure in an individual's care plan that can be an antecedent to aggressive behaviour.
- Overcrowded environments.
- Emotional disturbance: The physical impact of violence seems secondary to its emotional impact, especially while the adrenalin is still increased in the body following an attack.

11.25. Warning indicators that staff should consider as an indication of imminent arouse/aggressive/violent behaviour include:

- Tense and angry facial expression.
- Increased or prolonged restlessness, tension and pacing.
- General over-arousal of breathing, heart rate, muscle twitching, dilating pupil.
- Increase in tone, volume and rate of speech, leading in some cases to reduction of tone, volume and rate of speech.
- Prolonged eye contact/loss of eye contact.
- Non-communication and withdrawal.
- Sideways stance within arm's length.
- Verbal threats and gestures

Care planning

11.26. A robust individualised careplan will be developed for each individual. Where there is a risk of aroused, violent, aggressive behaviour the care plan interventions are to incorporate the individual's gender, cultural, spiritual needs.

11.27. The results of risk assessments are to be included into the individual's care plan. This is also to include information regarding the individuals warning indicators and triggers. The individual's personal preferences regarding the management of violence and aggression are also to be included in the careplan to provide an individualised management approach. This si to include any advance directives made by the individual.

11.28. Via the care planning process staff will proactively manage potential sources of aroused/aggressive behaviour that may arise from inadequate planning around an individual's safety needs, privacy and dignity needs, their gender and cultural concerns, perceptions around physical over-crowding and their social and spiritual expression.

11.29. Cambian recognises that individuals have an important role to play in the management of violence and aggression. Strategies to reduce violence and aggression create a system and culture of safety that extends to staff, individuals and all who engage with services. Being informed and consulted with are important means through which staff can demonstrate to individuals that they are being treated with dignity and respect. This should take place regardless of race, culture, gender, diagnosis, sexual orientation, disability, ethnicity or religious/spiritual beliefs. The provision of information to individuals in a suitable format is an important way in which staff can proactively reduce the risk of

aroused/violent behaviour. Individuals with a history of violence and aggression are to have this discussed in their first ward round as per the ward round policy HCLD5.

Search

11.30. Policy guidance on personal and room searching can be found in the Cambian search policy HCLD 27. In the context of contributing to effective management of disturbed and violent behaviour, staff will be aware of the value of undertaking, where necessary, lawful searches of individuals.

De-escalation

11.31. Following a comprehensive risk assessment and where aroused/aggressive/violent behaviour is identified as a potential risk, staff should develop de-escalation strategies for individual. These are to be clearly documented in their care plan.

11.32. Staff should consider using the following de-escalation strategies:

- Proxemics - stance, posture and space.
- Eye contact.
- Facial expression.
- Environment.
- Influence of your appearance.
- Hand gestures/movements.
- Verbal/non-verbal communication.
- Check feelings and acknowledge.
- Start negotiations.
- Seek agreement.
- Distraction.
- Ascertain their needs and where conflict exists.
- Collaboration and encouragement for the patient to recognise their own trigger factors.

11.33. When in a situation where an individual is displaying aroused behaviour, one staff member should assume control and attempt to establish rapport with the individual. Solutions should focus on co-operation, realistic options and threat avoidance. In doing this, the staff member should seek to utilise an appropriate balance of question styles, (open, closed, probing, reflective etc.) and enquire about the individual's concerns, grievances and frustrations.

Observation and engagement

11.34. Effective observation and engagement are the key techniques in reducing levels of aroused and aggressive behaviour. Staff should use observation strategies in incident prevention and post incident management to reduce the risk of further episodes of arousal and to facilitate early use of de-escalation techniques. Please refer to SSCM 10.

Use of alternative, lower stimulus area

11.35. In extreme cases it may be necessary to ask the individual to move from an area to assist in them having space to calm down. This should be an area agreeable to the individual, included in their care plan and the individual goes there of

their own accord. The modulation room is an option to assist in the de-escalation of individuals. Its use is to be included into the individuals care plan.

Seclusion

11.36. Cambian does not use seclusion in CAMHS locations. Please refer to HCLD 26.

Physical Intervention

11.37. As a general rule, physical intervention should only take place once non-physical, de-escalation techniques have been tried and have failed.

11.38. If an aggressor is suspected of having a weapon, do not engage, isolate them and call the police.

11.39. If the person indicates that they wish to surrender the weapon, they should be requested to leave it in a neutral place where it can be collected after the person has left the area.

11.40. Staff should also be aware and take active steps to risk assess all individuals with respect to physical interventions being used.

11.41. It is the responsibility of the care team and staff involved to ensure that medical considerations and physical assessment takes place prior, during and post-physical intervention.

11.42. This applies to all patients regardless of health and/or disability status but special consideration needs to be demonstrated in the following circumstances:

- Physical disability.
- Pregnancy.
- Sensory disability.
- Obesity.
- Presence of drug and alcohol use.
- History of sexual abuse/assault.
- Where the patient has been behaviourally aroused over a prolonged period of time, (physical exhaustion.
- Where fluid and food intake is not known or known to be minimal.
- Where the patient has a cardiac, thoracic or respiratory condition.
- Where the patient has been recently started on a new therapeutic drug regime.

11.43. When a person observes a situation which is not usual and which has the potential to develop into a physical confrontation, assistance is requested immediately.

11.44. Staff must be aware that:

- On no account should a situation be addressed by one person.
- Staff should summon assistance by activating their personal alarm.
- Nominated members will respond to these situations.
- Every effort will be made to deal with the situation in a non-confrontational manner.
- The response team will be available to respond after evaluation and under direction.
- The member of staff directly involved will attempt to de-escalate the incident.
- If a situation is occurring in an area where other people are present, the area should be cleared.
- Staff involved directly will remove either the individual from the stimuli or the stimuli from the immediate environment.
- If the situation remains unresolved, the police should be alerted of a potentially difficult / dangerous situation being present or for emergency assistance.

- Once the situation is under control, reassurance must be given to other individuals who may have witnessed or been directly involved.
- The individual's consultant psychiatrist is informed.
- The level of observation and care plans to be reviewed for the management of the individual.
- Disclosure may be a difficult area for some individuals to agree to and the individual has a right to confidentiality. However, staff have a duty to balance consent with disclosure when reporting aggression and violence, for example: accurate reporting of violence and aggression in Tribunal reports. Where staff have discussed the incident with the individual or relatives/carers, then they should document it in the individual 's healthcare record contained in the "Active Care" files.

Rapid tranquilisation

11.45. 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. For guidance on rapid tranquilisation please refer to HCLD 29.

11.46. If rapid tranquilisation is used then monitor form SSCM 12.01 to be completed.

Physical Intervention Procedures

11.47. The procedure outlined below should only be followed when:

- A person observes a situation, which has the potential to develop into a physical confrontation.

Or

- De-escalation and diffusion have not had the desired effect and the situation develops into a potentially violent confrontation and there is a significant risk of injury to staff or the individual.

AND

- Three members of staff responding to the situation have undergone MVA training.

11.48. Staff will ensure that the following best practice guidance is adhered to throughout physical intervention procedures:

- Physical intervention should be avoided if at all possible and should not be used for prolonged periods.
- Staff should consider the use of rapid tranquilisation to bring a physical intervention to an end at the earliest opportunity.
- Any position during physical intervention carries potentially serious risks, therefore avoidance of prolonged restraint and monitoring of the individual 's health state are priorities for staff involved.
- During physical intervention, one team member should be responsible for protecting and supporting the head and neck where required. This staff member will be responsible for leading the team through the physical

intervention process, and for ensuring that the individual's airway and breathing are not compromised and that vital signs are monitored.

- During physical intervention, under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. The overall physical and psychological well-being of the individual should be continuously monitored throughout the process.
- The planned use of the prone position is not to be used in any of its CAMHS locations.
- Only techniques taught on a Cambian training course are permissible.

11.49. Wherever possible, individual members of staff should not be involved in physical interventions for longer than a period of 20-minutes without a break, but must only be relieved by someone else who has been fully trained in the use of physical interventions.

11.50. When the situation is under control and the risk has reduced, allow the person to regain their autonomy as soon as is practicable.

Monitor

11.51. The member of staff leading the intervention will allocate team members and a non-physically involved staff member to undertake and record observations respectively. However, it is the responsibility of the lead team member (allocated to care for the head) to monitor and observe respirations, and to note and respond to any distress in this area. This team member must maintain a supportive dialogue throughout the intervention. This can also be used as a means of monitoring the status of the individual.

11.52. Observations of the individual's vital signs will be every 15 minutes for 1st hour then hourly until 1 hour post restraint. Form SSCM 12.01 is to be used to record monitoring restraint.

Post Incident Observation Levels

11.53. Observation levels are to be discussed, agreed and implemented as outlined in the observation and engagement policy SSCM 10.

Post Incident Review And Documentation

11.54. The Cambian doctor will be contacted following any incident of restraint to examine the individual.

11.55. This examination will be fully documented in the medical notes and the date of examination entered onto form SSCM 12.01.

11.56. The Multi-Disciplinary Team will discuss the future management of the individual, which will be fully documented in the care plan, ward round records and regularly reviewed. Staff/Multi-Disciplinary Teams and Managers should ensure that lessons and information learnt from physical interventions are used to review the individual 's care plan. They should ensure that all aspects of the management of violence are reviewed to maintain best practice and assist in demonstrating modifications to plans when dealing with a known/consistently presenting risk of violence

11.57. The person taking charge of the physical intervention will instigate de-briefing as soon as is practicable following any incident using form GInd 33.1. Post-incident review should be a process and address what happened during the incident, trigger factors around the incident, each involved person's role, perceptions, feelings and concerns. As these are

dynamic factors, it is not appropriate to confine it to a one-off session and use of other formats such as supervision may be used to pick up on recommendations arising from the incident review.

11.58. The review process has the following aims:

- To produce and accurate description of the incident and the events leading up to the incident.
- To ensure all necessary action has been taken after the incident to ensure individual and staff safety.
- (This may include referral for medical examination, documentation and notification of others: relatives, Police etc).
- To identify information that can be used to modify the individual s risk assessment and care management plan.
- To ensure that documentation and statements made about the incident clearly identify the impact factors, level of aroused behaviour and level of force utilised by the team.
- To ensure that the individual has been given the opportunity to record their opinions, views and comments about the physical intervention procedure – in accordance with NICE Guidance.
- The post-incident review should take place as soon after the incident as possible, but in any event within 72-hours of the incident ending.

11.59. Once the situation is under control, the incident will be fully documented using the Cambian incident reporting system:

- Incident is recorded in START incident log with corresponding IR1 number entered.
- Aggressive behaviours and triggers record completed if agreed as an intervention.
- Monitor form SSCM 12.01 to be completed.
- Record in individual s daily records.
- Daily risk assessment should identify this incident
- If risk level and management changes, this needs to be reflected in care plan.
- Complete notification if applicable.
- Consider safeguarding if applicable.

11.60. Following a physical intervention, staff (who ideally were not involved in the process) should make attempts to ensure the individual understands why it happened, when and if the individual 's arousal and cognitive state permits

11.61. Individual's views regarding the physical intervention should be recorded as part of the post-incident aftercare. The individual should be given the opportunity to record their views in the "Active Care" files.

11.62. This may be by means of their own written submission, recorded by the Nurse, Advocate or other such record of their views. Where an individual declines to give their comments, a record should also be made to this effect.

11.63. The Registered Manager is to maintain an incident spreadsheet which will record incidences of restraint.

11.64. Incidences of violence and aggression are to be recorded in the weekly incident spreadsheet and submitted to the operations administrator.

11.65. All incidences are to be discussed in the clinical governance forum.

Equipment

11.66. In line with national guidance each location will house a defibrillator and a crash bag. These are to be located in a location which can be accessed within 3 minutes. Please refer to policy SSCM 13 for further guidance.

Training

11.67. It is necessary that all Cambian staff receive regular training on all aspects of the management of disturbed/violent behaviour.

11.68. Cambian provides a range of training options to ensure that staff has the appropriate skills to manage disturbed/violent behaviour. (see chart below)

11.69. The Management of Violence and Aggression Training Levels chart identifies who should receive what level of training, refresher periods and outlines the techniques each level will focus on.

11.70. Cambian MVA trainers work to a nationally agreed syllabus, and will be affiliated with the National Federation of Personal Safety.

11.71. All MVA training levels will have a values training session incorporated to foster acceptable and responsible attitudes to the use of physical interventions for each participant undertaking the associated competencies.

11.72. The values base will be a working document, displayed and revisited throughout each training course. The training includes an awareness of racial, cultural, social and religious/spiritual needs, and gender differences along with other special concerns which need to be taken into account when managing violent/ aggressive behaviour.

11.73. Registered Managers are responsible for ensuring that staff has the capability to undertake physical intervention and physical intervention training courses. Where staff are employed in a clinical area, it is assumed that the ability to undertake the appropriate level of physical intervention forms part of the essential criteria for employment in that area.

11.74. Where staff cannot meet the capability requirement, advice from Occupational Health about the person's suitability to undertake training will need to be sought with the member of staff's involvement.

11.75. If on training courses the trainer identifies a member of staff that demonstrates inappropriate attitudes this will be flagged with their line manager to ensure this is dealt with.

Training Level	Aims & Control	Course Length	Refresher Course Length	Target
Breakaway	Personal Safety De-escalation Legal Brief Basic Defence Low and high level Disengagement	½ Day	½ Day	Staff with non-direct clinical contact.
MVA	**Module 1. Theory** Causes of Aggression (Trigger factors) Debriefing The Assault Cycle Personal Safety De-escalation/Conflict Resolution Dangers of Restraint Legal & Ethical Issues **Module 2. Team Work** Introduction to Holds Working in 2&3 person teams Team work variation including sitting and kneeling positions and assisting from the floor if necessary Incident management-First on scene **Module 3. Breakaway** Basic Defence Low & High level disengagement	3 Days		All clinical staff
MVA Refresher	As MVA, but condensed	1 Day (Providing staff are within a 12 month period of training)		

11.76. Staff are to have their MVA training scheduled in order that they receive their training as required.

11.77. To supplement staff skills and knowledge staff will also be trained in the following:

- Equality and diversity.
- Risk assessment.
- Observation and engagement.
- Basic life support.
- Intermediate life support (see resuscitation policy).
- Incident recording.
- Rapid tranquilisation.

11.78. The training manager will be responsible for the audit/ review of training provided to staff.

Audit

11.79. The use of restraint including recording will be audited as per the company audit schedule.

12. Standard Forms, Letters and Relevant Documents

Documents relating to this policy

12.1. Restraint and Rapid Tranquilisation Monitoring Form

12.2. IR1

12.3. START incident log

12.4. Debrief Form

12.5. HCLD 7.2 - AMEWS

Associated Cambian Policy

12.6. Observation and engagement

12.7. Ward round

12.8. Search