NICE National Institute for Health and Care Excellence

NICE quality standard

Violent and aggressive behaviours in people with mental health problems

Quality standard

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This standard is based on NG10.

This standard should be read in conjunction with QS101, QS88, QS59, QS163 and QS194.

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NICE has developed guidance and quality standards on patient experience in adult NHS services and service user experience in adult mental health services (see the NICE Pathways 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 disability: behaviour that challenges. NICE quality standard 101
- Personality disorders: borderline and antisocial. NICE quality standard 88
- Antisocial behaviour and conduct disorders in children and young people. NICE quality standard 59

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

Quality statement 1: Identifying triggers and warning signs

Quality statement

People in contact with mental health services who have been violent or aggressive are supported to identify triggers and early warning signs for these behaviours.

Rationale

Personal, social, institutional or environmental factors can trigger violent or aggressive behaviours in people with mental health problems who receive support in mental health, health or community settings. Identifying these triggers can help people using mental health services, care staff and carers to understand what prompts violent or aggressive behaviour when people are using these services. This knowledge can prevent violent or aggressive behaviours from escalating by alerting people to early warning signs of distress and enabling them to start immediate de-escalation or remove the triggers causing the violent or aggressive behaviour. Identifying triggers and early warning signs can also help services to improve organisational practice.

Quality measures

Structure

Evidence of local arrangements to ensure that people in contact with mental health services who have been violent or aggressive while receiving support in mental health, health or community settings have identified triggers and early warning signs for these behaviours included in their care plan.

Data source: Local data collection, for example, service protocols on managing violent or aggressive behaviours.

Process

Proportion of people in contact with mental health services who have been violent or aggressive while receiving support in mental health, health or community settings whose care plan includes identified triggers and early warning signs for these behaviours.

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 while receiving support in mental health, health or community settings.

Data source: Local data collection.

Outcome

a) Service user experience of involvement in managing violent and aggressive behaviours.

Data source: Local data collection, for example, surveys capturing service user experience.

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

Data source: Local data collection and restrictive interventions recorded in the NHS Digital Mental health services 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 identify the factors that prompt violent or aggressive behaviours in people with mental health problems. Service providers also ensure that people are supported to identify their own triggers and early warning signs and that these are recorded in the person's care plan. Service providers share this information to inform care, organisational learning and practice.

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 while receiving support to identify triggers and early warning signs. They record identified triggers and early warning signs in the person's care plan, and share this information to inform care, organisational learning and practice.

Commissioners (clinical commissioning groups, local authorities and NHS England) ensure that they commission services that identify the factors that prompt violent or aggressive behaviours in

people with mental health problems. They also ensure that people with mental health problems who have been violent or aggressive while receiving support in mental health, health or community settings are supported to identify their own triggers and early warning signs and that these are recorded in the person's care plan.

People in contact with mental health services who have been violent or aggressive when they were using mental health, health or community services are encouraged to think about 'triggers' that might have caused the violent or aggressive behaviour (for example, something that happened to them, something they saw, or a feeling such as disappointment or anger). They are also encouraged to think about the early warning signs that they are about to feel violent or aggressive. They discuss their thoughts with their care team and any 'triggers' or possible warning signs they identify are recorded in their care plan.

Source guidance

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

Definitions of terms used in this quality statement

Violent or aggressive behaviours

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]

Triggers

Factors that may instigate violent and aggressive behaviours. They may be:

- personal
- constitutional
- mental
- physical
- environmental

- social
- communicational
- functional
- behavioural.

Triggers may be internal to the service user, based on their perception of the environment potentially shaped by delusions, hallucinations, confusion, disorientation and misperception, or they may be responding to the behaviour or actions of others.

Common triggers in inpatient psychiatric wards include the denial of a request, or a demand to either do something or cease an activity. The symptomatic behaviours of other service users can also trigger violence as they may be intrusive or hard to tolerate. A service user's ability to handle frustration may be severely weakened by their mental health problem, making an aggressive response more likely than if they were well. [NICE's full guideline on violence and aggression]

Quality statement 2: Preventing and managing violent or aggressive behaviour

Quality statement

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

Rationale

Identifying de-escalation techniques that have worked in the past increases the likelihood that de-escalation will be effective and restraint won't be necessary. De-escalation should start when the first signs of agitation, irritation, anger or aggression are recognised. Should a situation escalate to a point at which restrictive intervention is needed, de-escalation should still be attempted. Making advance statements for circumstances when restrictive interventions need to be used allows the person to express their wishes about the most acceptable types of restrictive intervention and can minimise potential harm or discomfort.

Quality measures

Structure

Evidence of local arrangements to ensure that people in contact with mental health services who have been violent or aggressive while receiving support in mental health, health or community settings 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, for example, service protocols on managing violent or aggressive behaviours.

Process

a) Proportion of people in contact with mental health services who have been violent or aggressive while receiving support in mental health, health or community settings 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 while receiving support in mental health, health or community settings.

Data source: Local data collection, for example care plan reviews.

b) Proportion of people in contact with mental health services who have been violent or aggressive while receiving support in mental health, health or community settings 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 while receiving support in mental health, health or community settings.

Data source: Local data collection, for example care plan reviews.

Outcome

a) Service user experience of managing violent and aggressive behaviours.

Data source: Local data collection, for example surveys capturing service user experience.

b) Number of incidents requiring 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 NHS Digital Mental health services 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 while using the services in identifying de-escalation

techniques that have been successful, and 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 while using the services to identify de-escalation techniques that have been successful and to make advance statements about the use of restrictive interventions, and record this information 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 while using the services are involved in identifying de-escalation techniques that have been successful and make advance statements about the use of restrictive interventions, and that this information is recorded in care plans.

People in contact with mental health services who have been violent or aggressive while using the services are encouraged to think about what made them feel calmer (such as talking with someone or taking a medication). They discuss this with their care team and explain what they would like their care team to do in the future if they become distressed. They may also make a written statement (called an advance statement) about their preferences if a 'restrictive intervention', such as physically holding them, or giving them an injection of medication, is needed. All of this information is recorded in their care plan.

Source guidance

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

Definitions of terms used in this quality statement

Violent or aggressive behaviours

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]

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 are most likely to be used in inpatient psychiatric settings and should only be used if other preventive strategies have failed. They should be used for no longer than necessary and de-escalation should continuously be attempted. 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, for example, service protocol on physical restraint.

Process

a) Proportion of incidents involving manual restraint of a person with a mental health problem in which physical health was monitored during the restraint.

Numerator – the number in the denominator in which physical health was monitored during the restraint.

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

problem.

Data source: Local data collection, for example, patient safety incident reports.

b) Proportion of incidents involving manual restraint of a person with a mental health problem in which physical health was monitored after manual restraint.

Numerator – the number in the denominator in which physical health was 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, such as patient safety incident reports.

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 mental 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. They should also ensure that the healthcare practitioners who may be required to physically restrain service users are trained in the safe application of physical interventions and monitoring the physical health of people during and after restraint.

Healthcare practitioners (such as mental health nurses and staff working in forensic mental healthcare 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. Healthcare practitioners who may be required to physically restrain service users are trained in the safe application of physical interventions and monitoring of the physical health of people during and after restraint. If they do manually restrain a person, they monitor the person's physical health during and after

restraint until there are no further concerns.

Commissioners (clinical commissioning groups and NHS England) 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. They also 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.

People withamental health problem who are being violent or aggressive are only manually restrained (physically held so that they can't hurt themselves or others) if all other attempts to stop the violence or aggression 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. NICE guideline NG10 (2015), 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 immobilise the service user. [NICE's guideline on violence and aggression]

Physical health monitored during manual restraint

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

Physical health monitored after manual restraint

Monitoring physiological parameters could, as a minimum, be in line with the Royal College of Physicians' National Early Warning Score (NEWS), which measures:

- respiratory rate

- oxygen saturations
- temperature
- systolic blood pressure
- pulse rate
- level of consciousness.

[Expert consensus]

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 the intervention.

Rationale

Restrictive interventions are most likely to be used in inpatient psychiatric settings and 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 a potentially high-risk intervention that can result in a range of side effects linked to the medication and dose. People given rapid tranquillisation need to be monitored at least every hour until there are no further concerns about their physical status. If rapid tranquilisation is used while the person is in seclusion, additional measures may be needed to ensure safety. 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, for example, service protocol on physical restraint.

Process

Proportion of incidents involving rapid tranquillisation of people with a mental health problem in which side effects, vital signs, hydration level and consciousness were monitored after the intervention.

Numerator – the number in the denominator in which side effects, vital signs, hydration level and

consciousness were monitored after the intervention.

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

Data source: Local data collection, for example, patient safety incident reports.

Outcome

Proportion of incidents involving rapid tranquillisation 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 mental healthcare 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.

Healthcare practitioners (such as mental health nurses and staff working in forensic mental healthcare services) who 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, they monitor the side effects, vital signs, hydration level and consciousness at least every hour until there are no further concerns about the person's physical health.

Commissioners (clinical commissioning groups and NHS England) ensure that the services they commission keep people safe after rapid tranquillisation by monitoring side effects, vital signs, hydration level and consciousness until there are no further concerns about the person's physical health. They also 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.

People witha mental health problem who are being violent or aggressive and are given rapid tranquillisation by an injection of medicine have frequent checks after the injection for any side effects and to make sure that they stay safe and well. Rapid tranquillisation is given to calm people

down quickly if all other attempts to stop violence or aggression haven't worked.

Source guidance

Violence and aggression: short-term management in mental health, health and community settings. NICE guideline NG10 (2015), 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 are involved in an immediate post-incident debrief.

Rationale

Restrictive interventions are most likely to be used in inpatient psychiatric settings. Conducting a post-incident debrief helps the organisation to identify and address any physical harm to service users or staff, ongoing risks, and the emotional impact on service users and staff. The person with a mental health problem who was involved in the incident should be offered the opportunity to contribute to the immediate debrief and discuss the incident with a member or staff, an advocate or a carer. This debrief should take place as soon as possible after the person has recovered their composure. This gives them the opportunity to give their perspective of the event and understand what happened.

Quality measures

Structure

a) Evidence of local arrangements to ensure that the service carries out an immediate post-incident debrief after each incident when restraint, rapid tranquillisation or seclusion was used.

Data source: Local data collection, for example, service protocol on physical restraint.

b) Evidence of local arrangements to ensure that people with a mental health problem who experience restraint, rapid tranquillisation or seclusion are involved in an immediate post-incident debrief.

Data source: Local data collection, for example, service protocol on physical restraint.

Process

Proportion of incidents involving a person with a mental health problem where the person was involved in the immediate post-incident debrief.

Numerator – the number in the denominator where the person was involved in the immediate post-incident debrief.

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

Data source: Local data collection, for example, patient safety incident reports.

Outcome

a) Service user experience of post-incident debriefs.

Data source: Local data collection, for example, local surveys capturing service user experience.

b) Reduced number of incidents.

Data source: Local data collection and restrictive interventions recorded in the NHS Digital Mental health services data set.

What the quality statement means for different audiences

Service providers (such as providers of mental health services and secondary care services) ensure that they conduct an immediate post-incident debrief after the use of restraint, rapid tranquillisation or seclusion to address physical harm, ongoing risks and the emotional impact of the incident. They should ensure that they provide an opportunity for people with a mental health problem involved in the incident to be involved in the debrief as soon as they feel ready.

Healthcare practitioners (such as mental health nurses and staff working in forensic mental healthcare services) use restraint, rapid tranquillisation or seclusion only when de-escalation techniques have not worked. Immediately after an incident, they conduct a post-incident debrief that includes addressing physical harm, ongoing risks and the emotional impact of the incident. They provide an opportunity for people with a mental health problem involved in the incident to be involved in the debrief as soon as they feel ready.

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

People with a mental health problem who become violent or aggressive and have manual restraint, rapid tranquillisation or seclusion are given a chance to talk about what happened, why the restraint was used and how they feel about it. This should happen only after they have recovered their composure. Manual restraint, rapid tranquillisation (giving an injection of medication) and seclusion (taking the person to a room away from everyone else) are used to stop violent or aggressive behaviour when all other methods of stopping it haven't worked.

Source guidance

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

Immediate post incident debrief

The debrief should include a nurse and a doctor and identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses. The incident should only be discussed with service users, witnesses and staff involved after they have recovered their composure.

The debrief should use a framework for anticipating and reducing violence and aggression to determine the factors that contributed to an incident that led to a restrictive intervention, identify any factors that can be addressed quickly to reduce the likelihood of a further incident and amend risk and care plans accordingly. [Adapted from 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.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

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

See our webpage on quality standard advisory committees 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 from the webpage for this quality standard.

This quality standard has been included in the NICE Pathway on violence and aggression, which brings together everything we have said on a topic in an interactive flowchart.

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
- NHS outcomes framework
- Public health outcomes framework for England
- Quality framework for public health.

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 for this quality standard 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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Endorsing organisations

This quality standard has been endorsed by the following organisations, as required by the Health and Social Care Act (2012):

- NHS England
- Department of Health and Social Care

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Royal College of Nursing (RCN)
- NAPICU
- Royal College of General Practitioners (RCGP)
- Royal College of Paediatrics and Child Health