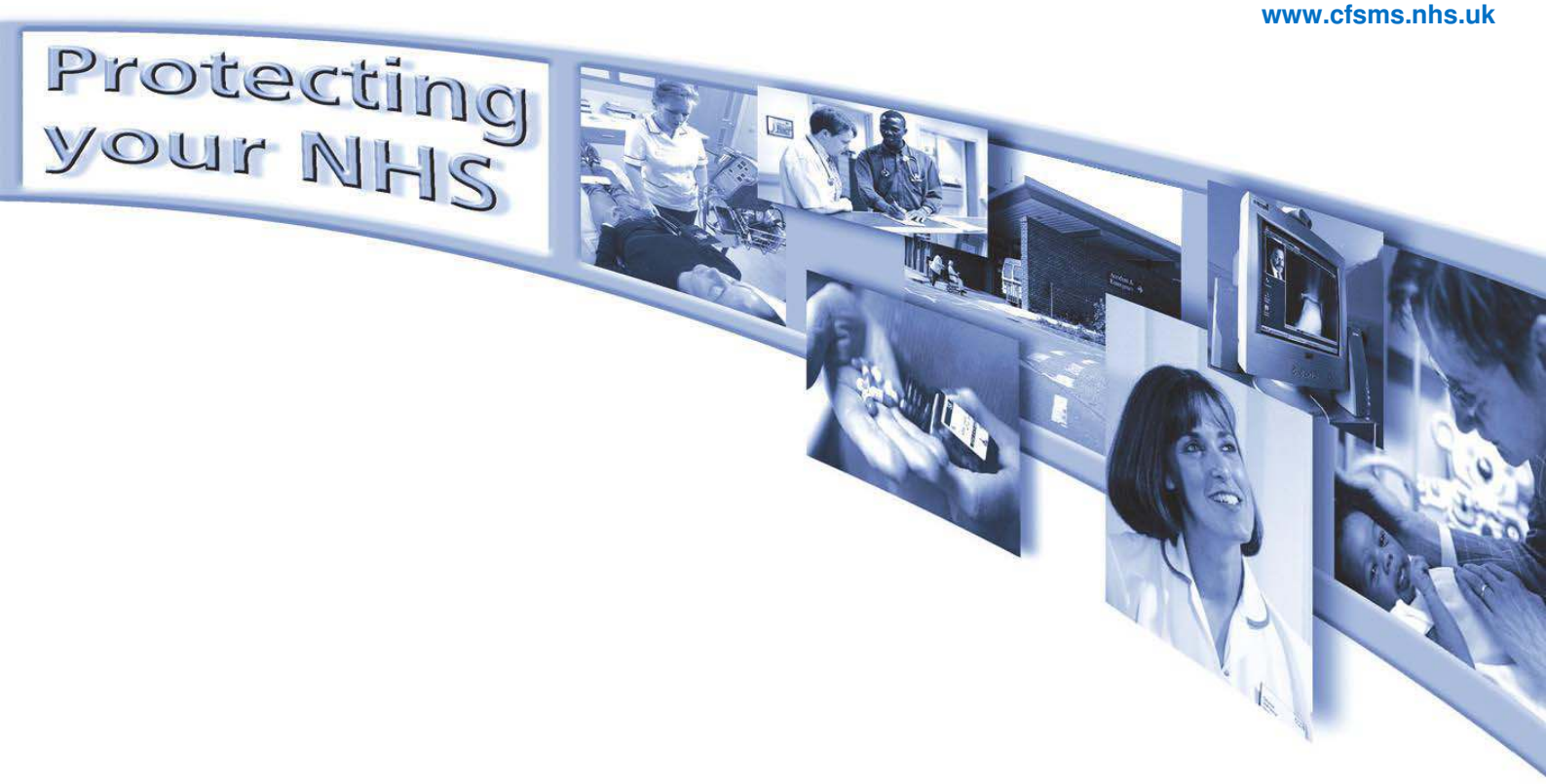

Implementing learning outcomes in conflict resolution for NHS ambulance services

NHS
Business Services Authority
Security Management Service

City & Guilds

ASA THE AMBULANCE SERVICE ASSOCIATION

maybo® THE CONFLICT SPECIALIST

South Central Ambulance Service NHS NHS Trust

UNISON Health Care

London Ambulance Service NHS NHS Trust

NHS Business Services Authority Security Management Service

This guidance has been developed by the NHS Ambulance Services Conflict Resolution Training Project Group:

Richard Absalom, London Ambulance Service

Tom Benson, City & Guilds

Bill Fox, MAYBO

Richard Parker, UNISON

Hilary Pillin, Ambulance Service Association

Ian Teague, Hampshire NHS Ambulance Trust

Andrew Masterman, Jayne Saunders, Rick Tucker, NHS Security Management Service

Further thanks to: Gail Miller, formerly NHS Security Management Service, Josephine Gravell, Health and Safety Executive and Antonio Zarola, University of Nottingham.

Author: NHS Security Management Service, 2006.

Contents

1 Foreword

All staff working in the NHS, including ambulance staff, have the right to work in an environment that is properly safe and secure, so that the highest possible standard of clinical care can be made available to patients.

Unfortunately, ambulance workers face the very real risk of violence and abuse whilst carrying out their everyday duties of caring for those who are often the most vulnerable in society.

The NHS Security Management Service (NHS SMS) has the remit to protect staff and property in the NHS, with a particular focus on tackling violence. The NHS SMS takes violence against staff working in the NHS very seriously and believes it is wholly unacceptable that those providing care to the most vulnerable in our community should be subjected to abuse and physical assault.

As part of our comprehensive security management strategy, we are committed to ensuring that key preventative measures are introduced to tackle violence against staff and professionals, to complement a range of reactive measures which have already been put in place.

As a result of this, in collaboration with the Ambulance Service Association (ASA) and other key stakeholders, the NHS SMS has developed these learning outcomes in conflict resolution which will form the minimum standard for NHS ambulance services.

The learning outcomes relate to non-physical intervention techniques, with the aim of equipping staff with the necessary skills to identify and de-escalate potentially violent situations. We recognise the unique context in which ambulance services are delivered and the outcomes have been tailored to reflect these specific needs.

The learning outcomes are also consistent with conflict resolution training (CRT) which has been introduced in other health sectors where the feedback from staff has so far been very positive, indicating increased levels of confidence in dealing with violent situations. This is especially the case when combined with the necessary organisational arrangements to manage incidents of violence and aggression and the availability of support mechanisms in the aftermath of such events.

We know that you will want to join us and our key NHS stakeholders in supporting this and other important initiatives, to ensure that the NHS can continue to be a safe and secure place to work.

Richard Hampton
Head of Security Management
NHS Security Management Service

Richard Diment
Chief Executive
Ambulance Service Association

2 Introduction

2.1 The NHS SMS – part of the NHS Counter Fraud and Security Management Service (NHS CFSMS), which is an independent division of the NHS Business Services Authority (NHSBSA) – was established in April 2003 with the policy and operational responsibility for the management of security within the NHS (Statutory Instrument 3039/2002).

2.2 The NHS SMS strategy document *A Professional Approach to Managing Security in the NHS* was launched in December 2003 and outlines the new professional approach to security management in the NHS. The aim of the strategy is to deliver an environment that is safe and secure so the highest possible standard of clinical care can be made available to patients.

2.3 The remit is broad and includes the protection of people, property and assets. An essential part of this work is tackling violence against staff and professionals working in the NHS. This NHS SMS comprehensive strategy goes beyond the scope of the 'zero tolerance' approach, which it replaces, and places a particular emphasis on the introduction of preventative measures to stop violent incidents from occurring in the first place. The NHS SMS works in partnership with key stakeholders within and outside the NHS to develop and implement this strategy to ensure that the NHS is properly protected. This inclusive approach includes working with representatives of staff, professionals and other organisations, including regulatory bodies such as the Health and Safety Executive (HSE).

2.4 The HSE enforces health and safety legislation, which requires employers to ensure, as far as is reasonably practicable, the health, safety and welfare of employees at work. The Management of Health and Safety at Work Regulations 1999 also require employers to consider the risks from reasonably foreseeable violence to employees and others who may be affected by work activities. This, for example, requires a risk assessment to be undertaken and appropriate control measures to be implemented and reviewed regularly. The HSE and the NHS SMS have agreed a concordat[1] which puts in place working arrangements to ensure that both organisations work together to deliver the shared aim of reducing incidents and ill health as a result of violence and aggression.

2.5 It is essential to note that the approach to security management is founded on the principle that one size *does not* fit all. A comprehensive programme of work that puts in place a legal framework and a national structure to tackle the problems faced are needed if lasting measures that make a real difference are to be achieved. It is also important to recognise that training is only one element of this strategy and in order to tackle a multi-faceted phenomenon such as violence, changes at both an organisational and a national level are needed.

2.6 The NHS SMS is issuing these learning outcomes to inform training providers of the **minimum standard** necessary for the delivery of non-physical interventions training in order to prevent and manage violence and aggression in the ambulance service. This training is designed to give staff the skills, confidence and capability to recognise potentially violent situations and to deal with them. The objective is to provide staff with an appropriate hierarchy of skills which allow interventions to be made before situations escalate, to minimise the risk of injury to staff, patients or others.

[1] *Concordat between the Health and Safety Executive and the NHS Counter Fraud and Security Management Service*, March 2005, at: http://www.cfsms.nhs.uk/doc/sms.agreements/concordat.sms.hse.pdf

2.7 The training standard within this guidance has been developed in consultation with key stakeholders and is intended to assist ambulance trusts in ensuring that staff receive CRT which is based on best practice and reflects the latest available evidence. Ambulance trusts should use this guidance when providing or procuring CRT to ensure that staff receive a suitable level of training appropriate to this working environment.

2.8 The standard described in this guidance covers non-physical intervention skills and is appropriate for emergency and non-emergency ambulance personnel. It is, however, recognised that some staff groups working in this environment will need appropriate skills in disengagement should they find themselves or a colleague unexpectedly under attack, perhaps in a confined space, and need to remove themselves to safety. Staff needing such skills should be identified through a trust's risk assessment and training needs analysis processes. General observations on training in disengagement skills are offered in Appendix A.

(Detailed guidance based on best practice covering physical interventions within healthcare settings is currently being developed by the National Patient Safety Agency (NPSA) and National Institute of Mental Health in England (NIMHE)).

3 Background

3.1 The NHS SMS, as part of its work to tackle violence, has put in place some important measures to deal with incidents of physical and non-physical assaults on NHS staff and professionals. On 20 November 2003 and 24 March 2004, Secretary of State Directions on measures to deal with violence and relating to security management were issued to all NHS bodies. These introduced:

- the requirement for all health bodies to nominate a Security Management Director (SMD) – a member of the Executive Board – to take overall responsibility for security management work, with particular responsibilities for tackling violence at the highest level
- the nomination of a Local Security Management Specialist (LSMS) for each health body, to investigate cases of physical assault not investigated or pursued by the police and to implement a local strategy to reduce violence, aggression and security incidents
- new concise, legally-based definitions for staff to report physical and non-physical assaults
- a new, streamlined national system for the reporting and recording of physical assaults, which has the capacity to track cases from report to conclusion, allowing for intervention where necessary (the reporting system is designed to achieve consistency across the NHS and to give hard and accurate information on the nature and scale of incidents of physical assault, as well as assuring staff that tough and consistent action will be taken against assailants)
- the creation of the NHS SMS Legal Protection Unit (LPU) to provide health bodies with cost-effective advice on a wide range of sanctions that can be pursued and to work with the police and the Crown Prosecution Service to increase the rate of prosecutions and other action taken against those who perpetrate such acts.

3.2 As part of the strategy to tackle violence against staff and professionals and in the NHS, the NHS SMS has just carried out the second national survey to provide an accurate picture of the nature and scale of incidents of physical assault across the NHS, including the ambulance service. Details can be obtained from the NHS SMS section of the NHS CFSMS website[2].

3.3 It is not, however, sufficient to react to incidents after they occur; ways of preventing them from happening in the first place must also be addressed. Therefore, in April 2004, the NHS SMS introduced a CRT programme for staff and professionals working in the acute sector of the NHS. The aim of this programme is to ensure that all frontline staff receive a minimum national standard of training in order to achieve consistency.

3.4 The minimum training standard identifies the learning outcomes necessary to equip staff with the skills to identify and de-escalate potentially violent situations. Returns made by health bodies by 31 March 2006 in relation to the 2005–06 financial year showed that 250,000 frontline staff had received this training.

[2] http://www.cfsms.nhs.uk/doc/sms.general/2005-06_violence_against_NHS_staff_per1000.pdf

3.5 Recognising that one size ***does not*** fit all, the NHS SMS has sought to develop sector-specific standards for CRT. An NHS SMS-led expert group has recently developed modules for prevention and management of violence training for staff in mental health and learning disability settings. This training was launched in October 2005 and includes theoretical aspects for the prevention and management of violence, de-escalation and physical intervention as well as related legal and ethical issues, for those who are working in this particular healthcare setting.

3.6 To ensure that a consistent approach to training is maintained in the ambulance environment, the NHS SMS is now issuing this national standard for CRT to ambulance trusts. This takes the form of a set of learning outcomes which have been developed by an NHS SMS-led stakeholder and expert group including the ASA, ambulance trusts, staff-side representatives and training providers with expertise in conflict management and personal safety in the ambulance sector. These learning outcomes have been designed, in consultation with all ambulance trusts, to ensure they meet the needs of ambulance personnel who have direct contact with patients and the public within their working environment.

3.7 These outcomes have also been mapped to a Qualifications and Curriculum Authority (QCA)-approved award in Conflict Management at Level 2 on the National Qualifications Framework (NQF). This will provide any individual who successfully completes this training with a head start should they wish to work towards a formal qualification with awarding bodies such as City & Guilds or Edexcel. Trusts may choose to support candidates in pursuing this.

3.8 Finally, in recognition of the fact that some ambulance personnel face the risk of physical assault, this guidance includes observations on the teaching of disengagement skills that will enable staff to remove themselves to safety. This is to provide a focus for trainers to structure additional disengagement training as necessary. See Appendix A, ‘Observations concerning the teaching of disengagement skills’, for further details.

4 Implementation

4.1 This guidance is being issued to all ambulance trusts which are covered by Secretary of State Directions on measures to deal with violence against staff, issued to health bodies in November 2003. Paragraph 3(b) of these Directions states that health bodies must 'take into account any other guidance or advice on measures to deal with violence against NHS staff which may be issued by CFSMS'.

4.2 Ambulance trusts must therefore take this guidance into account when organising or procuring CRT for staff. Further advice on the guidance contained in this document can be obtained from the NHS SMS by emailing **crtguidance@cfsms.nhs.uk**.

4.3 Ambulance trusts must ensure that these learning outcomes are met when providing CRT to staff. Trusts that have existing training, either in-house or through an external training provider, should ensure that this training meets these learning outcomes. The purpose of setting the learning outcomes is not to replace existing training which meets the standards; it is to ensure that all ambulance trusts are brought up to a consistently high national standard.

4.4 SMDs in ambulance trusts should, if they have not done so already, nominate a suitable person to act as a Training Liaison Officer, to oversee and take responsibility for the provision of training according to this guidance. Details of that person should be sent to the NHS SMS as soon as possible using the CRT training plan template document previously issued. The details required are: name of Training Liaison Officer, name of trust, address, telephone number, email and job title. This can be emailed to **crtguidance@cfsms.nhs.uk** or faxed to **0207 895 4360**.

4.5 To help monitor the implementation of these standards and their effectiveness, ambulance trusts should submit a return to the NHS SMS on the numbers and categories of staff they intend to train each year, based on a training needs analysis (TNA), along with the chosen methods of delivery which meet the outcomes in this guidance as a minimum.

4.6 For the financial year 2007–8, this information should be with the NHS SMS by 31 January 2007 and for future years by 1 December preceding the next financial year. This information should be sent to the NHS SMS by using one of the points of contact listed in paragraph 4.4 above.

5 Monitoring and review

5.1 The Management of Health and Safety at Work Regulations 1999 (Reg. 5) requires employers to have arrangements in place for the effective planning, organisation, control, monitoring and reviewing of preventative and protective control measures. Employers therefore need to ensure that suitable arrangements are made to monitor and review the identified training plans to assess how effective they are in controlling the risks. This is particularly important to ensure that the content, delivery and timing of CRT for nominated staff remains suitable. For example, if additional training – including refresher training – is needed, it should be provided.

5.2 The effective implementation of CRT is also a key performance indicator of security management. Ambulance trusts should co-operate with the NHS SMS to enable this provision to be monitored. The NHS SMS is feeding into the Healthcare Commission's annual health check to assess whether health bodies are meeting the Government's Standards for Better Health. Core standard C20a requires that health services are provided in 'a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation'. The required information outlined in paragraph 4.5 above will be summarised by the NHS SMS – a full member of the Healthcare Commission-led concordat[3] – and shared with the Healthcare Commission, and will contribute to its assessment of whether ambulance trusts are meeting standard C20a.

5.3 Once trusts have successfully implemented CRT, they will be in a position to assure the NHS SMS that these standards have been implemented and are being delivered. Further details will follow the publication of this guidance.

5.4 All training should be delivered in response to a TNA that reflects best practice. Evidence and tools for undertaking effective TNAs are provided in the recent HSE research report RR440 2006. This guidance provides the sample TNA checklist designed by Zarola and Leather[4] in 2005 at Appendix B to assist trusts and/or training providers with the process of planning a TNA.

5.5 Although each member of operational ambulance staff who has face-to-face contact with patients and the public should eventually receive training to this standard, initial focus should be on those who are most at risk. These staff will have been identified through the risk assessment process, TNA and personal development plans.

5.6 The training should be provided to both full- and part-time staff. Trusts may also need to assess the training needs of any temporary staff not directly employed by the trust.

5.7 Each ambulance trust should maintain a record of staff who have received this training, their staff category and the training provider. This record should be kept for regular review and quality assurance purposes. This will also highlight when refresher courses should be undertaken.

---

[3] *Concordat between bodies inspecting, regulating and auditing healthcare,* May 2006, at*:* http://www.concordat.org.uk

[4] *Violence and aggression management training for trainers and managers – A national evaluation of the training provision in healthcare settings, HSE RR440, March 2006, at:* http://www.hse.gov.uk/research/rrhtm/rr440.htm

6 Design and delivery

6.1 There are three means of delivery (a combination of these may be used). These are as follows:

- in-house trainers – employed directly by the trust
- the NHS SMS training service
- private third party training providers.

6.2 Trusts should ensure that they provide a suitable learning environment in which CRT can be effectively delivered and which will also facilitate effective learning. This includes conducting a proper risk assessment of accommodation to enable training to take place safely and securely.

6.3 When commissioning or procuring CRT, care must be taken as regards the trust's rules on procurement and tendering, contained in its standing orders and standing financial instructions. Trusts should ensure that any training they procure is of good quality, provides value for money and delivers the learning outcomes within these standards. Potential bidders must be able to demonstrate that their training matches the learning outcomes within this standard.

6.4 To assist with the design of a training programme, the 'Training design and delivery checklist' developed by Zarola and Leather[5] is provided in Appendix C, to help trusts and training providers assess the quality and potential effectiveness of their training packages.

6.5 During the design and delivery process, it is important that trusts, in consultation with trainers, ensure that the CRT course is of a sufficient duration to meet all the learning objectives and also matches the trainees' needs to fulfil the specific duties required of their jobs. This may involve considering different delivery methods, such as e-learning or pre-learning, for the knowledge-based elements, prior to any face-to-face training sessions. However, trusts must make sure that there is a clear practical element to the training; e-learning alone will not be sufficient.

6.6 Ambulance trusts should also ensure that the training is evaluated on a regular basis, with regard to the recommendations in HSE RR440 2006. This research indicates that optimal effectiveness from a CRT programme requires delegates to have a clear understanding of how this training fits into the organisation's overall strategy for tackling violence in the workplace.

6.7 Training providers will need to be able to demonstrate a good appreciation of the organisational context in which they are delivering this training, or to identify the mechanisms by which they would develop this understanding prior to delivery.

6.8 Each member of staff who attends CRT which meets these standards should receive a certificate of attendance from the training provider. Following the launch of these standards, employees should be asked whether they have undergone such training in the past and will be required to verify attendance by producing a certificate.

6.9 Staff who can demonstrate that they have previously undertaken CRT which is either specific to the ambulance service or applicable to a different healthcare sector should be assessed to establish whether there are any shortfalls in previous training, with new or revised training that is based on these minimum standards. If

[5] *Violence and aggression management training for trainers and managers – A national evaluation of the training provision in healthcare settings, HSE RR440, March 2006, at:* http://www.hse.gov.uk/research/rrhtm/rr440.htm

staff are still considered to be at high risk, the trust will need to decide whether they might need to undertake the new or revised training or be put forward for further refresher training. Ultimately, trusts should ensure that *all* staff identified through a TNA have received training which meets these standards by the target date in paragraph 8.1 below.

6.10 Following a period of delivery and evaluation, guidance on refresher training at appropriate intervals will be issued separately by the NHS SMS.

7 Familiarisation

7.1 The NHS SMS will offer familiarisation events for all identified training leads responsible for the delivery of the training within trusts, as well as existing in-house and private third party trainers. Both in-house and third party trainers will be expected to attend a familiarisation event before delivering this training.

7.2 The aim is to provide trainers with background information and context that is important for the delivery of this training, as well as details of these training objectives, which will enable an assessment to be made as to whether any existing CRT needs to be amended and brought into line with these standards. This will ensure that the delivery of CRT is consistent across trusts. These events will also provide trainers with the opportunity to share best practice with their colleagues.

7.3 Following the launch of this guidance, the NHS SMS will contact training leads and in-house and third party trainers to invite them to attend an event in preparation for these standards becoming operative; see Section 8, ‘Timescales’.

7.4 **Please note:** Familiarisation events do not form part of a process of accreditation. Furthermore, the NHS SMS does not endorse or approve trainers or training providers for CRT delivery.

7.5 Further details of these familiarisation events can be obtained by emailing **conflictresolution@cfsms.nhs.uk**

8 Timescales

8.1 These standards become operative on **1 April 2007**. All ambulance trusts need to develop a training plan based on a robust risk assessment and TNA to ensure that all staff who are at high risk are prioritised for training. NHS ambulance trusts should ensure that training which meets these learning outcomes has been delivered to all frontline staff as identified through the training plan by **31 March 2010**, with the capacity to deal with new staff joining within that timeframe and thereafter.

8.2 The three-year target date has been agreed by the representative organisations involved in developing this guidance as a realistic deadline, given the large-scale reconfiguration of ambulance trusts throughout England in 2006 and the internal reorganisation which this requires. Furthermore, it balances the needs of trusts to be able to provide an essential service against the requirements to release staff for this training.

8.3 This target date does not remove legal obligations on ambulance trusts to provide training for those most at risk following a robust TNA within a shorter timescale, where the need has been identified under the Management of Health and Safety at Work Regulations 1999.

9 Qualifications

9.1 The training set out in this national standard can provide a substantial part of the knowledge and training requirement for nationally recognised qualifications in conflict management, such as the vocationally related NQF Level 2 Certificate in Conflict Management, through a recognised awarding body – for example, City & Guilds or Edexcel. Participants therefore have the opportunity to gain recognition for learning and should be made aware by their trust of any arrangements made with awarding body centres to facilitate and support access to qualifications.

10 Useful references

1. NHS Counter Fraud and Security Management Service (December 2003). *A Professional Approach to Managing Security in the NHS*.

   http://www.cfsms.nhs.uk/pubs/sms.gen.pubs.html

2. Department of Health (November 2003). *Secretary of State Directions to NHS bodies on measures to deal with violence against NHS staff and professionals who work in or provide services to the NHS.* Also see amended Directions (2006).

   http://www.cfsms.nhs.uk/pubs/sms.gen.pubs.html

3. Department of Health (April 2004). *Secretary of State Directions to NHS bodies on security management measures.* Also see amended Directions (2006).

   http://www.cfsms.nhs.uk/pubs/sms.gen.pubs.html

4. NHS Counter Fraud and Security Management Service (November 2004). *Non-Physical Assault Explanatory Notes.*

   http://www.cfsms.nhs.uk/pubs/sms.gen.pubs.html

5. NHS Counter Fraud and Security Management Service (March 2005). *Not Alone – A Guide for the Better Protection of Lone Workers in the NHS*.

   http://www.cfsms.nhs.uk/pubs/sms.gen.pubs.html

6. NHS Counter Fraud and Security Management Service (January 2007). *Tackling Violence Against Staff. Explanatory notes for reporting procedures introduced by Secretary of State Directions in November 2003.*

   http://www.cfsms.nhs.uk/pubs/sms.gen.pubs.html

7. Ambulance Service Association (December 2003). *National Policy and Strategy Framework for the management of violence and aggression against ambulance staff*.

   http://www.asa.uk.net/editorial.asp?page_id=66&keywords=management|||violence|||aggression

8. The Management of Health and Safety at Work Regulations 1999. ISBN 0 11 085625 2.

   http://www.opsi.gov.uk/SI/si1999/19993242.htm

9. Antonio Zarola and Dr Phil Leather (2006). *Violence and aggression management training for trainers and managers – A national evaluation of the training provision in healthcare settings* RR440. Prepared by the University of Nottingham for the Health and Safety Executive.

   http://www.hse.gov.uk/research/rrhtm/rr440.htm

10. Antonio Zarola and Dr Phil Leather (2006). *Violence management training – The development of effective trainers in the delivery of violence management training in healthcare settings* RR495. Prepared by Zeal Solutions for the Health and Safety Executive.

    http://www.hse.gov.uk/research/rrhtm/rr495.htm

11 Learning outcomes for operational ambulance personnel

11.1 These learning outcomes constitute the set national minimum standard. The onus is on ambulance trusts to ensure that the training provided complies and is consistent with these outcomes.

The aim of this training is to:

- equip frontline ambulance personnel, who face the very real risk of violence and aggression in their workplace, with the skills, knowledge and confidence to recognise and manage such situations safely and effectively
- raise awareness of the organisational arrangements in place to manage violent and aggressive incidents and related issues and the support mechanisms available in the aftermath of such an event
- demonstrate the importance of reporting incidents of violence, whether they have resulted in harm or not, to assist personal and organisational learning and to inform the NHS SMS so that it can develop appropriate guidance and policy
- ensure understanding of the NHS SMS's overall strategy for addressing issues around violence in the workplace as this is critical to the long-term effectiveness of this training.

The learning outcomes are presented in the following format:

Outcome – The underpinning knowledge that the learner is expected to acquire during the learning/training programme and which can be tested. Also, what the learner is expected to demonstrate practically during the learning/training programme.

Training context – Ambulance-specific issues/scenarios to be addressed during training.

11.2 At the end of their training, participants will achieve the following outcomes:

ASSESS AND REDUCE THE RISK OF VIOLENCE IN THE WORK ENVIRONMENT

OUTCOME 1: THE LEARNER CAN:

- identify the hazards and risks of violence that exist in the working environment
- discuss ways in which the hazards and risks of violence associated with key tasks and activities can be reduced
- assess a scenario situation as it is developing, to identify risks of violence and discuss options available, including withdrawal
- describe the responsibilities of employers and employees outlined in the *Health and Safety at Work Act 1974* and the *Management of Health and Safety at Work Regulations 1999*
- explain the organisational arrangements in place and the guidance provided by their employer in relation to the risks of work-related violence
- describe risk reduction measures which eliminate or reduce risks
- identify the key risks of violence faced by ambulance personnel in their specific role
- describe precautions to be taken when lone working
- describe how staff can assess threat levels in a dynamic and developing situation
- recognise the importance of providing positive and proactive services to service users *
- respond calmly and politely to complaints of poor service and resolve issues promptly and fairly
- explain ways of dealing professionally with complaints and dissatisfaction.

** The term 'service user' can include any person with whom the learner may come into contact whilst performing their role, e.g. patients, friends, relatives, passengers, detainees, the public, minors, parents, carers.*

Training context: within ambulance context, consider:

- exploration of different perceptions of violent behaviour and an explanation of HSE and NHS SMS definitions of workplace violence
- participation in a 'first contact' practical scenario: discuss how risk can be assessed by staff in a live situation and safety considerations when approaching an incident involving a patient and relatives/bystanders
- participation in practically-based training incorporating problem-solving scenarios in a realistic context, e.g. using an ambulance, core equipment (trolley bed/carry chair) and confined spaces, including:
    - safer assessment, approach and positioning skills to reduce potential for assault
    - keeping a safe distance from those individuals who present an imminent and deliberate threat of assault
    - non-physical intervention strategies which will assist in the assessment and management of a situation involving potential violence

  - stance and movement skills which can be used to reduce risk of injury and facilitate disengagement
  - safe practice for guiding/escorting unpredictable patients (e.g. elderly, confused)
  - demonstrating methods for reducing vulnerability to assault when guiding and escorting an unpredictable patient in a non-restrictive way

- organisational arrangements: details of the systems and procedures in place to prevent and manage violence and aggression, policies in place, reporting arrangements, the hierarchy of control measures, roles and responsibilities of the LSMS, SMD etc
- risk reduction:
  - how duty of care considerations would influence how staff dealt with a risk situation
  - safety considerations and good practice with regard to handover of patients with acute mental health problems from other agencies including approved social workers and clinicians
  - guidance covering higher-risk activities and locations, arrangements with other agencies, rendezvous and 'safe' areas
  - awareness of physical and non-physical risk reduction measures, such as risk register and flagging systems, personal communications and safety equipment, CCTV and means of summoning help
  - accounting for one's actions, including standing off, withdrawal and refusal to convey
  - key risks of violence faced by emergency ambulance personnel
  - additional precautions to be taken when lone working
  - continuously assessing the level of threat faced in a developing situation, evaluating the options and responding appropriately – see above concerning withdrawing from a situation
  - the importance of being proactive in providing good service to patients and their friends and relatives, carers and the general public
  - how stereotypes and preconceptions about people and situations can increase the likelihood of conflict and be self-fulfilling
  - why it is important to respect cultural differences and respond to the individual needs of patients
  - how one's attitude and behaviour can impact on other people and influence the outcome of a situation and the importance of giving positive first impressions
- complaints of poor service:
  - identify any event which the service user perceives to have been dealt with below the expected standards, e.g. late arrival, long waiting times, unhelpful service, incompetence, rudeness
  - include ways of dealing professionally with complaints and dissatisfaction.

Additional areas of knowledge for *emergency ambulance* personnel relating to the risks of physical assault and physical intervention:

- risks of clinical violence (where there is no intent to inflict harm; largely unreported but relatively common)
- common risks of assault resulting from a patient's clinical condition or response to treatment
- risks associated with holding and restraint of an individual; for example, by police officers or security staff and:
  - identify factors that can increase risks of positional asphyxia and sudden death
- vulnerable groups and the individual needs and fears of patients and:
  - identify vulnerable groups, including children, older people, victims of previous abuse and those with mental health problems and learning disabilities

- identify medical conditions, pre-dispositions and treatments that increase risk of injury/harm
- identify particularly vulnerable areas of the body and the harm that can be caused by strikes and blows, secondary injury, i.e. falls, and holds across joints.

OUTCOME 2

IDENTIFY BEHAVIOUR THAT INDICATES AN ESCALATION TOWARDS VIOLENCE AND TAKE APPROPRIATE MEASURES TO AVOID OR CALM AND DEFUSE THE SITUATION

OUTCOME 2: THE LEARNER CAN:

- demonstrate skills and behaviours which will help calm and defuse
- take appropriate action in a high-risk conflict to minimise the risk of injury to themselves and other people
- demonstrate the skills to signal non-aggression through stance and positioning, space and non-verbal communication
- describe natural human responses to threatening situations
- identify the most common triggers and situations where there is a risk of escalation into violence in ambulance work
- identify the signs of an escalation in a situation
- choose responses which will de-escalate a potentially aggressive situation
- describe action and exit strategies if a situation is escalating to a high-risk conflict – see Appendix A: Observations concerning the teaching of disengagement skills
- identify specific communication considerations relating to acutely unwell individuals, in terms of their mental health, and individuals with learning difficulties
- describe how to defuse and calm a person who is behaving in an angry and aggressive way
- choose appropriate assertive behaviour for confronting examples of obstructive and unacceptable behaviour
- identify methods for diverting attention
- explain the law relating to self-defence and use of force
- identify the ethical implications surrounding the use of 'force' on patients and the issue of consent.

Training context: within ambulance context, consider:

- participation in a 'calming' scenario: apply and discuss verbal and non-verbal skills to calm a situation involving emotional and frustrated bystanders/relatives
- participation in a 'confronting' scenario: apply and discuss appropriate assertive skills for dealing with aggressive patients and/or bystanders who may be obstructing staff in the course of their duties

- recognition:
    - human responses such as ‘fight or flight’, emotional versus rational responses, stimulus and response
    - general triggers and inhibitors, including embarrassment, loss of face, insults, not being taken seriously, fear
    - common triggers of an escalation in ambulance work
    - signs of an escalation in a situation and indications of imminent risk of assault
    - awareness of the importance of proximity, positioning and preparation of exit strategies, i.e. valid reasons for leaving the scene

- communication and de-escalation skills and strategies:
    - preventing and de-escalating conflict through active listening, helpful attitude, empathy, positive body language
    - models of communication
    - recognising and overcoming potential barriers to effective communication, including the physical environment, emotions and feelings, attitudes, prejudices, cultural differences, alcohol and drugs, acute mental health problems, people with learning disabilities
    - calming through signalling non-aggression, showing empathy, active listening, building trust
    - positive assertive language and techniques for diverting attention

- legal and ethical issues relating to use of force:
    - explain common law relating to the use of reasonable force in defence of oneself or another
    - explain common law relating to ‘necessity’ in protecting life
    - explain the concept of proportionality within the Human Rights Act
    - identify the ethical implications surrounding the use of ‘force’ on patients and the issue of consent
    - identify steps that should be taken if witness to physical or psychological abuse of a service user.

IDENTIFY POST-INCIDENT SUPPORT AND UNDERSTAND THE NEED FOR REPORTING

OUTCOME 3: THE LEARNER CAN:

- explain the reporting arrangements that are in place to record and review incidents and demonstrate an awareness of how to report incidents
- report and record an incident of workplace violence to provide information to further the prevention and reduction of risk across the organisation
- review the incident, including the sequence of events leading up to it, to provide personal learning and the sharing of good practice with work colleagues
- develop key learning points to ensure that he/she will deal more effectively with a similar incident in the future
- describe the reactions which may be experienced by a victim of workplace violence and the support mechanisms available for that person
- identify potential sources of advice and legal support following an incident (employer and independent sources) and compensation opportunities.

Training context: within ambulance context, consider:

- employer and employee responsibilities in relation to reporting and recording set by their trust, including internal and national reporting procedures – NHS SMS (PARS), HSE (RIDDOR), NPSA – and reporting incidents to the police
- reviewing what happened, why it happened and what can be learned for next time if a similar incident occurs, identify key learning points and implement actions. Emphasis should be on the employer's responsibility to review such incidents and the need for the employee to participate in that process
- immediate post-incident reactions, medium-term reactions and long-term reactions
- potential sources of advice and support roles: line manager, team, other colleagues including the SMD and LSMS, occupational health, employee assistance programme, staff support networks, counselling, psychological and psychiatric referral
- legal support following an incident (employer and independent sources) and compensation/injury benefit opportunities
- liaison with the NHS SMS LPU.

Observations concerning the teaching of disengagement skills

It is widely recognised that emergency ambulance personnel in particular face a significant risk of physical assault – both intentional and clinically-related – in their duties.

The trust will identify whether staff need additional training in disengagement through its risk assessment and training needs analysis (TNA) process. This process will also indicate the most likely types of assault and ensure training focuses only on the skills needed i.e. not spending time on techniques addressing a type of assault that is unlikely to be experienced. During this process trusts can consider some of the more typical risk areas highlighted in the example learning outcomes below.

The focus of disengagement training is on how to avoid and protect oneself or another (i.e. a colleague) from assault and to disengage to safety. There is a potential for injury during practically based training and the risks need to be assessed and addressed. Any training in physical skills must include awareness of medical implications as previously set out in Section 11, Outcome 1.

When selecting skill sets, trusts should ensure that these are:

Simple

Focus on a minimum of techniques and principles that are simple to learn and apply, based on natural, instinctive responses and movements. Techniques requiring complex motor skills should be avoided.

Effective

Directly relevant to the job and activities performed and effective in the confined spaces in which ambulance personnel often work. They should develop confidence in staff, irrespective of sex, age or size and should not require strength, speed or aggression to be effective.

Safe and Ethical

Risk-assessed and focus on less aversive and intrusive responses to reduce risk to staff and patients.

Example Disengagement Learning Outcomes

The following is offered simply as an ***example*** of outcomes addressing different types of assault. The aim is to provide trainers with a focus to enable them to structure additional disengagement training, based on a clearly identified need. It is unlikely that all of these examples will be required and they are not intended to form a minimum standard. The key is that trainers should be able to provide training which demonstrates to staff how to protect themselves and others and disengage to safety **using *instinctive* rather than a series of complex moves or techniques.**

- Practise skills to evade and protect against blows and kicks (intentional or not) and:
  - demonstrate how to protect the head and upper body from blows
  - demonstrate how to evade and disengage from blows to the head and upper body

  - demonstrate how to evade and protect against kicks

- Practise disengagement skills (including releases) to allow safe exit and:
  - demonstrate how to avoid grips and grabs
  - demonstrate release from grips and grabs to a single wrist
  - demonstrate release from grips and grabs to both wrists
  - demonstrate release from grips and grabs to the neck
  - demonstrate release from grips and grabs to clothing
  - demonstrate release from grips and grabs to hair
  - demonstrate release from bites

- Practise skills for guiding/escorting unpredictable patients (e.g. elderly, confused):
  - demonstrate skills for reducing vulnerability to assault when guiding and escorting an unpredictable patient

- Practise skills to come in support of a colleague under attack and disengage:
  - demonstrate skills for releasing another person from a grip or grab to the wrist/s and arms
  - demonstrate skills for releasing another person from a grip or grab to the neck
  - demonstrate skills for supporting another person grabbed by the hair
  - demonstrate skills for releasing another person from a grip or grab to clothing
  - demonstrate skills for supporting another person being bitten
  - demonstrate skills for assisting another person receiving blows

- Practise skills for reducing the risk of non-intentional assault (where there is no intent to inflict harm; largely unreported but relatively common)
- Recognise potential safety and medical implication of techniques:
  - State the safety points and potential medical implications relating to techniques taught in each of the above areas

Training should include participation in practical problem-solving scenarios that utilise: an ambulance, equipment and realistic environments to explore safe practice and allow application of assault avoidance and disengagement skills in confined spaces.

Appendix B

Training needs analysis tool: TNA checklist [6]

This checklist should be consulted when conducting a training needs analysis. The checklist can be used to complement techniques such as questionnaires, interviews or focus groups. Together the information gathered throughout the needs assessment process should be used to feed into the design and selection of training, the delivery of training as well as the evaluation of training.

1. Who is training for?

a. Is the training for all staff?
b. Is the training for a specific group (i.e. *team/department*) of staff?
c. Is the training for a specific role (i.e. *nurse*/*manager*) within the organisation?

2. At what level are needs being assessed?

a. Have the needs of the organisation been considered?
b. Have the needs of particular departments or teams been considered?

3. How will the needs of staff be identified?

a. Has a risk assessment been conducted that can support the identification of training needs?
b. Are you able to gather information about training needs using other qualitative and quantitative methods of data gathering such as focus groups with key personnel, interviews or surveys?

4. Are you able to make use of other forms of knowledge and information to support the needs identification process?

a. Can information be obtained from incident report forms?
b. Can information be obtained about when, where and how staff members are exposed to incidents of violence?
c. Is information regarding the job role (i.e. job descriptions) readily available?

5. Are you able to make a case for why a particular method or content of training is needed?

a. Is there a specific knowledge requirement?
b. Is there a skill requirement?
c. Is there an ability requirement?

6. Are you able to prioritise the needs of the individuals concerned?

a. Is there a requirement for specific knowledge or skills?
b. Is training required for all staff?
c. Are some groups in greater need of training than others?

[6]Tool re-printed with the kind permission of Zarola and Leather (2005), from *Violence and aggression management training for trainers and managers – A national evaluation of the training provision in healthcare settings,* prepared by the University of Nottingham for the Health and Safety Executive, RR440, 2006.

Training design and delivery tool: design and delivery checklist [7]

This tool comes in the form of a list of questions. These questions can be adapted and asked of those who are providing (selecting, delivering or selling) training or can be considered by those (e.g. teams or individual persons) who have a specific role to design a programme of training.

Objectives of training

- Does the training have clear and specific objectives (i.e. is the relationship between the training objectives and the application of those objectives made clear and explicit)?
- Do the training goals and objectives clearly relate the training to the desired performance back on the job?
- Are the objectives realistic?
- Are the objectives in line with standards set out by other authorities and agencies (e.g. Health and Safety Executive (HSE) and NHS Security Management Service (NHS SMS))?
- Are the objectives in line with guidance set out by other relevant bodies or groups (e.g. National Institute of Clinical Excellence (NICE), National Institute for Mental Health in England (NIMHE), Welsh Assembly, Scottish Executive, etc.)?

Key topics of training

- How does all of the content support the objectives?
- How accurate and up-to-date is the content of the training?
- Is the level of content appropriate for the learners?
- How does the content of the training programme align itself with standards and guidance published by agencies and bodies such as the HSE and NHS SMS?
- How does the content of the training programme align itself with standards and guidance published by other relevant bodies or groups such as NICE, NIMHE, etc.?
- Does the training provide an appropriate balance between the topics emphasised and the perceived needs of staff?
- Does the training emphasise and demonstrate the organisational context, by including content on, for example:
    - reporting procedures
    - how reporting information is used, in terms of taking action
    - organisational, team and individual support practices and procedures; and
    - how the organisation is progressing and learning?

Training flow

- Is there sufficient variety in learning activities and training methods?
- Do methods included in the design support the training goals and objectives?
- Does the sequencing of material and topics seem reasonable (i.e. with most elements leading clearly to the ones that follow)?

[7] Tool re-printed with the kind permission of Zarola and Leather (2005), from *Violence and aggression management training for trainers and managers – A national evaluation of the training provision in healthcare settings,* prepared by the University of Nottingham for the Health and Safety Executive, RR440, 2006.

- Are a variety of learning styles engaged and satisfied by combining methods?
- Are the time estimates reasonable (i.e. will the time allocated for the training allow for the topics to be covered in enough breadth and/or depth to meet the learning needs of the delegate)?
- How is the training sensitive to the training characteristics of the adult learner in general (i.e. are learning styles and preferences taken into consideration through the use of various instructional strategies)?
- How will the training focus on application (i.e. are there clear links and strategies to support the end goal (transfer) of training)?
- Has the training considered the diverse needs of the learners (i.e. has the design of the training taken into account differences in personal experience related to factors such as gender, race, ethnicity, religious background, age, physical and mental abilities, etc.)?

Materials

- How do utilised materials support the objectives?
- Are the materials supplied appropriate for the intended learners and easy to use?
- Is there a stated purpose for each learning activity?
- Do any audiovisual materials fit the objectives and the learners?
- Are the audiovisual materials realistic for the conditions under which the training will be delivered?

Evaluation

- Is there a plan for the evaluation of training?
- What are the questions the evaluation is trying to answer?
- Will the evaluation enable the objectives and outcomes of the training to be assessed?
- What methods are being used to collect evaluation data?
- Are there opportunities during the training for participants and instructors to assess progress towards objectives?
- Are there tools that measure the behavioural outcomes of the training?