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## **Recognition, Prevention and Therapeutic Management of Violence and Self Harm Procedure**

<b>INITIATED BY:</b>	Child & Adolescent Mental Health Directorate (CAMHS)
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### ***Definition of a Procedure***

A procedure is a set of detailed step-by-step instructions that describe the appropriate method for carrying out tasks or activities to achieve a stated outcome to the highest standards possible and to ensure efficiency, consistency and safety.

### ***Minor Amendments***

If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

Type of change	Why change made	Page number	Date of change	Version 1 to 1.1	Name of responsible person

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## 1. Purpose

The procedure aims to provide a systematic approach to caring for young people (YP) that have the potential to become violent or pose a degree of risk to self that could indicate requirement to intervene.

## 2. Principles

- The primary emphasis is on recognition, prevention and de escalation strategies as first line Interventions for violence.
- Restrictive Physical Interventions (RPI) must only be used as a last resort when all other interventions have failed and must be within the best interests of the YP. Everything possible must be done to prevent injury and maintain the YP's personal dignity.
- It is of paramount importance to differentiate between restrictive physical intervention and therapeutic holding.
- Restrictive physical intervention is described as direct physical contact between persons where reasonable force is positively applied against resistance to either restrict movement or mobility or to disengage from harmful behaviour displayed by an individual (Welsh Assembly Government, 2005). It should only be used to prevent serious harm.
- Therapeutic Holding means immobilisation, which may be by splinting, or by using limited force. It may be a method of helping YP with their permission (RCN 2010) and or a method that is deemed to be in the best interest of the YP. This could include aspects in line with safeguarding; examples include therapeutic holding to place an NG tube, to prevent a YP from self-harm, absconsion, to escort a YP without use of force to an area that could assist de-escalation, to administer medication and support YP co-operation with treatment plan.
- ***Therapeutic holding is distinguished from restrictive physical intervention by the degree of force required and the intention (RCN 2010).***
- ***Refer to Appendix 1:- Please ensure that a hard copy of this flowchart is kept visible and displayed in the nursing office at all times.***
- All YP admitted to Ty-Llidiard will undergo a thorough WARRN risk assessment.
- In conjunction with the YP the multi-disciplinary team will develop an inpatient care and treatment plan, containing planned interventions for YP who have the potential to present with violent or challenging behaviour.

- Physical interventions will always be viewed as the final option in a hierarchy of therapeutic interventions.
- The physical intervention selected must be justifiable, appropriate, reasonable and proportionate to the specific situation and applied for the minimum possible time necessary.
- All staff implementing RPI will have an awareness of the physiological and psychological effects on the YP being restrained.
- Staff will also have an awareness of the psychological effects such interventions have on themselves and other YP and will have the ability to respond appropriately.
- All incidents of RPI must be reported in accordance with the Cwm Taf UHB incident reporting policy.
- A debrief involving staff and where possible the YP will be considered following all situations involving violent and aggressive behaviour.
- The specific strategies in management of challenging and violent behaviour will require professional judgement in making necessary and appropriate management decisions.

### **3. Responsibilities**

The Clinical Team at Ty Llidiard are responsible for ensuring that the core principles are adhered to when caring for YP with challenging and violent behaviour.

### **4. Recognition**

It is important that staff recognise the early stages of behaviour that are likely to develop into violence, aggression and self-harm. Recognising early warning signs and taking appropriate action to de-escalate the situation, can often prevent the need for RPI.

Certain behaviours can serve as warning signs to indicate that the YP may be escalating towards physically violent or challenging behaviour.

This list is not exhaustive but indicators may include:-

- Increased and prolonged restlessness or pacing
- Increased volume and pitch of speech, use of swearing
- Abrupt replies to questions, very often with gestures
- Rapid breathing, muscle tensing in the face or limbs, dilated pupils
- Clenching of hands to make a fist
- Prolonged eye contact
- Delusions or hallucinations with violent content
- Reporting anger or violent feelings

- Threats
- Wanting to leave hospital.

All YP will receive a thorough assessment which will include their potential for challenging behaviour.

Challenging or violent behaviour can never be predicted 100% although certain factors can indicate an increased risk and must be considered when completing the WARRN risk assessment:

- History of disturbed/ violent behaviour
- History of substance or alcohol misuse
- Carers reporting previous anger or violent behaviour
- Previous dangerous impulsive acts
- Evidence of recent severe stress
- Known trigger factors
- Previous use of weapons
- Verbal threat of violence

Where practically possible the risk assessment process will include a structured and sensitive interview with the YP, and appropriate carers or family. When assessing for the risk of challenging or violent behaviour, care needs to be taken not to make negative assumptions based on previous history / gender and ethnicity.

The components of risk assessment are dynamic and may change according to circumstance, the risk assessment must be reviewed after each episode of violent or challenging behaviour.

Following completion of the risk assessment, if it is foreseeable that the YP presents a risk of violence and aggression, consideration needs to be given to their physical health as this may be critical to any physical intervention. Any physical condition that may increase the risk of collapse or injury must be clearly documented and communicated; this may include:

- Problems with cardio pulmonary function
- Muscle and joint impairment, i.e. Arthritis
- Asthma
- Heart Disease
- Obesity
- Pregnancy
- Substance misuse
- Frailty particularly in eating disorders
- Exposure to CS spray /Gas

If it is foreseeable that the YP may need a physical intervention the clinical judgement must show that the risk of employing the intervention is lower than the risk of not doing so. This must be clearly documented in individual case-notes. Consideration must also be given to whether there are sufficient resources to manage the RPI and its consequences.

## **5. Prevention**

All YP must be given the opportunity to be fully involved in their care. Listening to the YP's views and where appropriate the views of carers and taking them seriously is regarded as an important factor in managing aggressive and violent behaviour.

An essential first step in care planning is to understand the reason behind the YP's behaviour, and what sort of therapeutic behaviour management might help them. Where it is anticipated that a YP may be aggressive it is considered good practice to discuss the issue of staff needing to intervene in some circumstances with both the YP and their carers if deemed appropriate.

Inpatient care and treatment plans will describe all the identified risks and the approaches and interventions that have been agreed by the YP, carer and multidisciplinary team. The care plans should include:

- Strategies that prevent behaviours that precipitate violence and aggression
- Strategies for de-escalation
- Explicit details of in what circumstances physical intervention may be used; and what actions may be taken following aggressive behaviour?

Any physical health condition must be taken into account when formulating the management strategies that are to be utilised on the individual.

A copy of the inpatient care and treatment plan is signed with the YP where possible and made available to the YP so that they are aware of all the agreed actions.

All Inpatient care and treatment plans relating to the management of violence and aggression will be reviewed by the multidisciplinary team in ward round as per the Care Programme Approach. This review must be evidenced in the case-notes.

## **6. De-escalation**

De-escalation are techniques to reduce the level and intensity of a difficult situation. De-escalation means making a risk assessment of the situation and using both verbal and non-verbal communication skills in combination to reduce problems (RCN 2010). Such skills can assist in redirecting the YP to a calmer personal space (Stevenson 1991). The goal of such is to reduce anxiety, maintain control and avoid acts of violence.

De-escalation skills should be implemented at the first sign of hostile or aggressive behaviour. Where appropriate use of medication should also be considered.

Tactics for de-escalation and managing an imminent threat of violence include:

- Maintaining an adequate distance
- Moving towards a safe area, avoiding backing into corners and maintaining a path to retreat and identifying any escape routes
- Moving to a position where there is a barrier between to prevent the YP getting too close i.e. behind a table or chair
- Present in a calm, self controlled and confident manner
- Ensure own non verbal communication is non threatening
- Requesting the person stops the behaviour if the person can understand this
- Engage the YP in conversation, acknowledge their concerns and feelings, ask for facts of the problem, encourage reasoning
- Encourage the YP to move to quiet area and / or ask other YP to move away
- Avoiding sudden movements
- Consideration of offering oral medication
- Consideration of activating the alarms

Every attempt should be made to verbally and non verbally de-escalate any potentially aggressive situation. This may require a significant degree of negotiation.

In situations of immediate threat of violence where a person has made physical contact with a member of staff, where necessary the member of staff must use recognised Breakaway techniques as a first line measure as taught within module C. The use of physical force can be used as a last resort measure.



It needs to be recognised that at times touch is an integral component of skilled nursing care. When a YP is agitated, and there is a risk of the situation escalating, the use of therapeutic touch may be appropriate to calm the situation.

In assessing whether or not to use therapeutic touch in such situations staff must consider the following:

- Their relationship with the YP
- The YP's previous response to therapeutic touch
- Gender issues
- Proximity of other staff and YP

Here appropriate therapeutic touch could be used to assist a YP into a quieter area or move them away from potential triggers which might escalate their behaviour.

Many of the strategies identified above are recognised in the training and theory of the management of aggressive and violent behaviour. However, it is recognised that skills associated with experience are also an important factor in identifying triggers and de-escalating situations.

## **7. Therapeutic Holding**

Therapeutic holding for a particular clinical procedure requires nurses to:-

- Give careful consideration of whether the procedure is really necessary
- Work to anticipate and prevent the need for holding, by giving the YP information, encouragement, distraction techniques or calm down methods and, if necessary, using medication management
- Efforts should be made to obtain consent from the YP and or NoK where deemed appropriate
- Advanced directives or statements regarding the above point can be included in the inpatient care and treatment plans or the WARRN risk assessment if more appropriate
- Consideration must be made as to whether the YP's NoK is informed of the incident. Confidentiality versus the need to share for safeguarding purposes must form part of this decision making and be clearly documented within the case-notes
- Where it hasn't been possible to obtain consent post incident support must include a full explanation of why therapeutic holding was necessary (RCN 2010)

The rationale around decision making for therapeutic holding must be clearly documented within individual case-notes and form an integral part of inpatient care and treatment plans, WARRN risk assessments and MDT clinical discussions, such discussions must be reflected in the clinical case notes.

## **8. Restrictive Physical Intervention**

As a consequence of their illness, individuals in need of care and treatment for mental health problems can at times exhibit behaviour that presents risks to themselves or others. Such behaviour can be particularly challenging for healthcare staff, sometimes to the extent that the use of RPI is necessary to minimise the risk of harm to the YP or others, or to ensure compliance with lawful treatment.

The Wales Assembly Government defines RPI as, ***Direct physical contact between persons where reasonable force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behaviour displayed by an individual.***

RPI should be done with the principle of “least restriction” in mind at all times, and only as a last resort option and never as a matter of course. When managing aggressive behaviour, staff should aim to support those under their care in a therapeutic not punitive manner, and in such a way that optimises the YP’s safety, privacy and dignity. RPI should be used when there seems to be a real possibility that significant harm would occur if no intervention is taken.

There may be times when YP are physically held or restrained for the safety of themselves or others.

Physical intervention/restraint should be avoided if at all possible.

All physical interventions should be brought to an end as soon as practically possible.

All physical interventions/restraint must be used/taught or referenced as a last resort and only when all other non physical options have been considered/attempted or deemed inappropriate.

Physical intervention/restraint must always be a reasonable, necessary and proportionate response to the immediate threat posed.

It should be noted that all restraint positions pose a degree of risk as breathing could be compromised. A YP must be continuously monitored during any period of physical restraint and this is emphasized within all RPI training.

There may be times when a YP is restrained on the floor whether in prone or supine position and this must be considered as an **extreme last resort**.

If the YP is required to be restrained on the floor, supine take down techniques should be the first option.

Should the YP be restrained in the prone position they should be turned into the supine position whenever practically possible in accordance with UHB RPI training techniques. Alternatively attempts must be made to mobilise into a kneeling or standing position.

All physical interventions should be for the shortest possible period of time using the lowest level of intervention with the least number of staff.

Nice (2015) recommend that restraint should not be continually used for more than 10 minutes.

Staff must assess each individual YP and each individual situation and use the most appropriate form of intervention in each case.

Any decision to physically intervene or restrain should always be based on a sound rationale and judgement and on a staff members own professional and clinically based knowledge and experience, all aspects of decision making must be clearly recorded in case notes.

All physical interventions must be in the best interests of the YP and staff must continue to employ de-escalation techniques and continually explain the reasons for the action to the YP.

A single individual should be responsible for co-ordinating the whole RPI.

Whenever possible there must be a minimum of 3 RPI trained staff within the team.

A suitable team should be identified to undertake the RPI. Each member of the team should have a clear role and should be comfortable fulfilling this role.

Pre-determined methods of communication should be established between each member of the team.

The purpose of the intervention should be discussed, and if the YP is to be moved to a different area this needs to be clear to everyone.

Where possible staff must remove items of jewellery, name badges, pens and ties prior to any RPI as this will help to reduce the risk of damage and injury occurring.

Any relatives present should be asked to vacate the ward or move to a safe area.

Those staff that are present and not part of the RPI team should ensure that the immediate area is made safe and clear of obstructions and that other YP's anxieties / concerns are addressed.

The YP should be approached in an appropriate area of the ward.

Consideration should be given to privacy of the area, space available, ease of access and exit routes if needed.

If a prolonged RPI is anticipated or required the Nurse in Charge should ensure sufficient staff resources are assembled to rotate the team and that there is adequate ventilation of the area to prevent overheat and exhaustion.

Under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvis such manoeuvres may restrict breathing or cause internal injuries.

## **9. Post Incident**

Any situation that requires the use of RPI must be carefully assessed, this must consider, the mental, emotional and physical state of the YP, the inpatient care and treatment plan and the WARRN risk assessment. **The CTP risk assessment log must be updated** following any situation that has required RPI.

Vital signs must be recorded post incident and a medical opinion must be sought. The outcome of the medical opinion must be clearly documented in the case notes, this assessment will either be based on a direct medical review or information sharing between the Nurse and Doctor that formulates a plan in line with the individual needs of the young person. This must

consider historical factors (including physical health) and all present assessments of the YP, including physical health and risk assessment and present plans of care, level of nursing observation and further risk management. This procedure must be used in line with procedure number 3 (Levels of Observation). Documentation in the case-notes must provide the rationale for decision making.

If the young person or staff have physical injuries and/ or there is concern regarding the health/ welfare of the YP they should receive immediate and appropriate care, this will either be in the form of a direct medical review or A&E assessment.

All YP subject to RPI must be monitored every 2 hours post restraint for up to 24 hours or as directed by the doctor, this should include:

- Blood pressure
- Pulse
- Temperature
- Respirations
- Fluid and food input and output

The Paediatric Mews score will be used to record the above and entries also made in the main body of the case-notes. Fluid and food input and output must be clearly recorded in the case-notes.

It is paramount to note the importance of vital signs monitoring. Whilst the risk of death from positional asphyxia during restraint has been increasingly recognised, harm can also occur in the period following restraint from the effect of illicit substances, alcohol, prescribed medications (including rapid tranquilisation) and co-existing medical conditions, or from direct effects of muscle damage as which can lead to renal failure or seizures. The risk of death following restraint may be increased if the YP is also in seclusion or staff are avoiding close observation for fear of distressing the YP (NICE 2016).

If the YP has required Rapid Tranquilisation vital signs must be monitored in line with procedure number 22 (Use of Rapid Tranquilisation). Blood pressure, pulse, temperature, respiratory rate, blood oxygen saturation and level of consciousness should be monitored every 15 minutes for one hour, and then hourly for 4 hours or until the YP becomes active again. This must be recorded on the Paediatric Mews score and entries also made in the main body of the case-notes.

The mandatory RPI training will teach staff management strategies for when attempts to record vital signs may lead to further violence and aggression and this must also be embedded in daily clinical discussions with the MDT and in line with this in the individual WARRN and inpatient Care and Treatment plan.

If the YP refuses to co-operate with vital signs monitoring this must be clearly documented in the YP's case notes and communicated to the unit Dr/ On-call Dr, please refer to page 10 of this procedure for requirements of information sharing with doctors.

All staff must receive mandatory training in CPR and be familiar with the emergency equipment including defibrillator. All emergency equipment is stored in the Enfy's ward treatment room. **The reasons for omissions of vital signs monitoring must be clearly documented in the case-notes and communicated to the unit Dr/ On-call Dr.**

## **10. Emotional Support and Learning**

All YP must be given the opportunity to discuss the way in which staff responded to the incident, express concerns and preferences for future management.

Both YP and staff will be given opportunities to talk about what happened in a calm and safe environment. As soon as practicably possible there should be a team review to discuss:-

- What happened
- Any triggers
- How everyone felt at the time of the incident
- Which interventions were successful
- Future management of the YP
- Advice on further support

***The B6 Senior Staff Nurse will be responsible for the initial team review and will escalate the need for formal team de-briefs.***

All RPI incidents will be reported via Datix with the attached RPI audit form (See Appendix 2).

## **11. Staff Training**

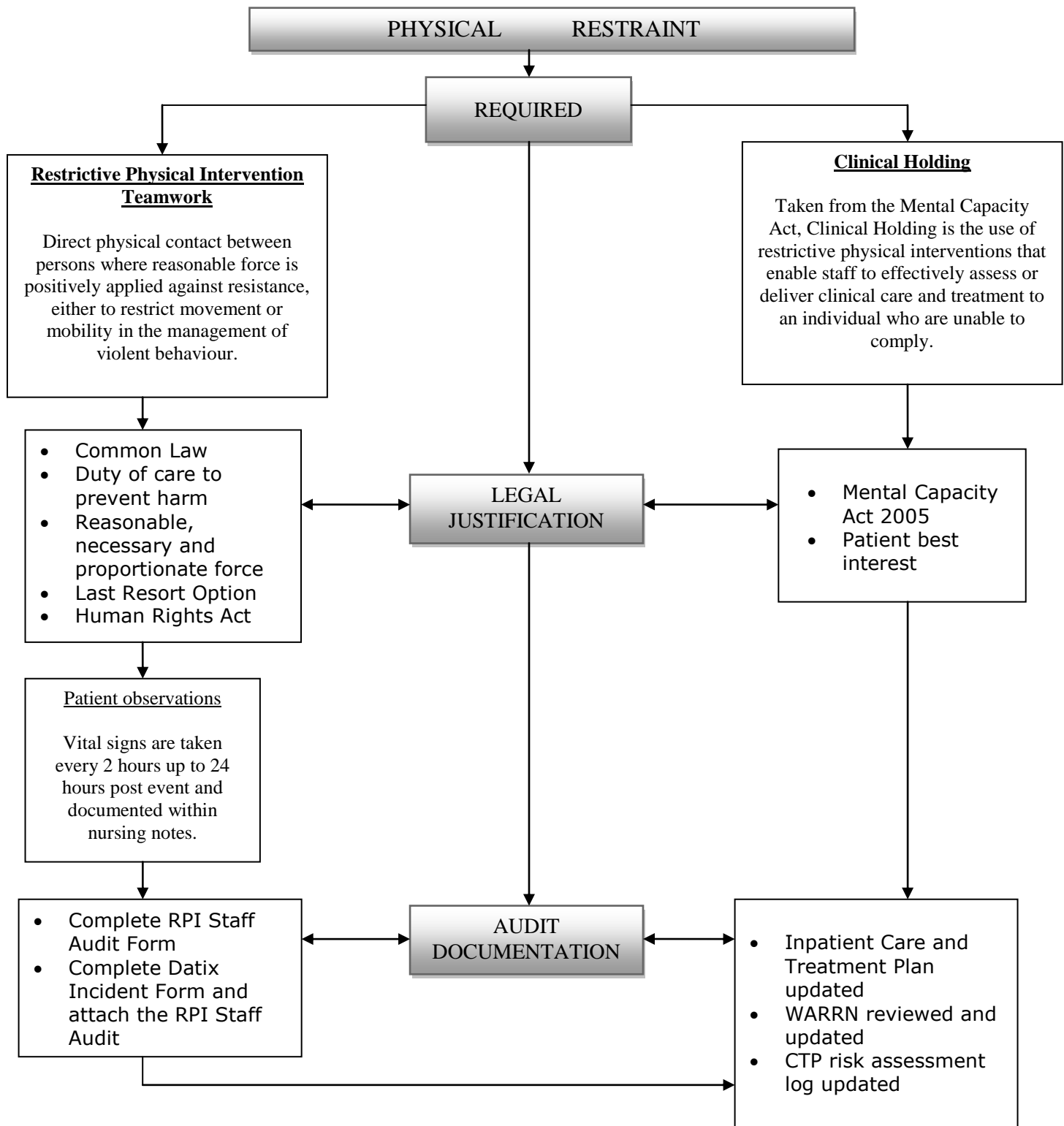
In Line with Nice Guidelines (2015) all staff receives the required RPI training which is mandatory to the post. This includes an awareness of legal aspects that underpin all aspects of decision making for young person care and interventions. Staff are trained to understand and appropriately apply the Human Rights Act 1998, the Mental Capacity Act (2005) and the Mental Health Act 1983. Such legislation must be at the forefront of clinical decision making and clearly recorded in the case-notes.

Safeguarding will at all times remain the paramount consideration, decision making around the protection of welfare will be clearly recorded in case notes.

## **12. Non Conformance**

This procedure will be monitored on a regular basis. Non conformance may be subject to investigation.

APPENDIX 1





## CAMHS MENTAL HEALTH RESTRICTIVE PHYSICAL INTERVENTION AUDIT FORM



The purpose of this audit form is to ensure all restraint incidents are reviewed in order to identify lessons learnt and to determine basic outcome measures, on which to develop and improve upon restraint practice and training. The form is to be completed by the nurse in charge at the time of the incident.

The form must be completed following all incidents where a 2/3 person team have been used, where no other option exists, in response to a violent incident. **Staff will not be expected to complete this form when mild holding techniques are used in managing patients who are resistive to activities of daily living.**

**An incident form (Datix) MUST be completed following restraint incidents. This audit form should be attached to the incident form within the documents field.**

All information will be treated in the strictest confidence.

<b>Directorate:</b>	
<b>Ward:</b>	
<b>Exact location:</b>	
<b>Time and date:</b>	
<b>Patients name:</b>	
<b>Datix reference number:</b>	W

<b>1. What was the rationale for the physical intervention?</b> <ul style="list-style-type: none"> <li>• Patient presented a danger to themselves</li> <li>• Patient presented a danger to others</li> <li>• Patient was non compliant with prescribed medication</li> <li>• Other please specify:</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>2. Was the intervention planned or unplanned due to an emergency situation?</b>	Planned <input type="checkbox"/> Unplanned <input type="checkbox"/>
<b>3. How many staff were involved in the physical intervention?</b>	
<b>4. Identify the staff responsible for securing and holding the following:</b> <ul style="list-style-type: none"> <li>• Left arm / wrist</li> <li>• Right arm / wrist</li> <li>• Head</li> <li>• Legs</li> <li>• Any other staff involved?</li> </ul>	
<b>5. a. Were all staff trained in restraint techniques?</b> <b>b. If no, how many staff were not trained?</b>	Yes <input type="checkbox"/> / No <input type="checkbox"/>

<b>6. Details of aggressor:</b> Male <input type="checkbox"/> Female <input type="checkbox"/> Age: _____ If Applicable - MHA Sec: Informal Patient: <input type="checkbox"/> Other: _____	
<b>7. a.</b> Were any other persons involved: i.e. client/friend/relative? <b>b.</b> If Yes who?	Yes <input type="checkbox"/> / No <input type="checkbox"/>
<b>8. a.</b> Was there a risk assessment form completed prior to the incident? <b>b.</b> Has this been updated following the incident?	Yes <input type="checkbox"/> / No <input type="checkbox"/> Yes <input type="checkbox"/> / No <input type="checkbox"/>
<b>9.</b> Does the person have a history of violence?	Yes <input type="checkbox"/> / No <input type="checkbox"/> / Don't Know <input type="checkbox"/>
<b>10. a.</b> Identify duration of verbal intervention: <b>b.</b> Briefly describe why the de-escalation strategy was ineffective:	<b>a:</b> _____
<b>11. a.</b> Were Breakaway techniques used? <b>b. If Yes</b> were they effective?	Yes <input type="checkbox"/> / No <input type="checkbox"/> Yes <input type="checkbox"/> / No <input type="checkbox"/>
<b>12. a.</b> Was medication offered prior to intervention? <b>b.</b> Was medication given during intervention?	Yes - Oral / IM <input type="checkbox"/> No <input type="checkbox"/> Yes - Oral / IM <input type="checkbox"/> No <input type="checkbox"/>
<b>13.</b> Did you require emergency help from outside the Unit i.e. Police?	Yes <input type="checkbox"/> / No <input type="checkbox"/>
<b>14. a.</b> Was any person injured during physical intervention? <b>b.</b> If <b>Yes</b> who?	Yes <input type="checkbox"/> / No <input type="checkbox"/>
<b>15.</b> Please give brief description of injury:	
<b>16.</b> Was post incident support offered to staff?	Yes <input type="checkbox"/> / No <input type="checkbox"/>
<b>17.</b> Was post incident support offered to the client?	Yes <input type="checkbox"/> / No <input type="checkbox"/>
<b>17 a.</b> Were the patients vital signs which include pulse , blood pressure, respirations, temperature, fluid and food input/ output undertaken every 2 hours post restraint event and documented within nursing notes	Yes <input type="checkbox"/> / No <input type="checkbox"/>
<b>17b</b> If no please explain the reasons	

APPENDIX 2

18. Was the presence of a doctor requested?		Yes <input type="checkbox"/> / No <input type="checkbox"/>
19. Did a doctor attend?		Yes <input type="checkbox"/> / No <input type="checkbox"/>
20. Has a team de-brief aimed at preventing the incident from occurring again taken place?		Yes <input type="checkbox"/> /No <input type="checkbox"/>
21. Was prone restraint used ? If prone restraint was not used please disregard 21b below		Yes <input type="checkbox"/> /No <input type="checkbox"/>
21b. If prone restraint was used what was the reason?		
Clinical holding used for the administration of intramuscular medication		Yes <input type="checkbox"/> / No <input type="checkbox"/>
Was the prone restraint unplanned due to the patient's presentation		Yes <input type="checkbox"/> / No <input type="checkbox"/>
Other reason please specify :		
22. Identify the number of restraint positions used:		
Standing	Seated on chairs	
On floor (seated)	On floor (on back lying flat)	
On floor (on front kneeling)	On floor (on front lying flat)	
On bed (on back lying flat)	On bed (on front lying flat)	
Other (specify):		
23. Identify the duration of each restraint position:		
Standing	Seated on chairs	mins
mins		
On floor (seated)	On floor (on back lying flat)	mins
mins		
On floor (on front kneeling)	On floor (on front lying flat)	mins
mins		
On bed (on back lying flat)	On bed (on front lying flat)	mins
mins		
Other (specify):		
24. What was the total duration of physical intervention?		Hours
		Minutes
25 Did the duration of the restraint exceeded the 10 minute recommendation as stipulated by the NICE Guidance 2015 ?		
If so please provide details why this occurred		

**All parts of this form must be completed to ensure accurate information is recorded.**

**Completed By:**

<b>Name:</b>	
<b>Position:</b>	
<b>Date:</b>	

Following completion

- Forward to your Ward Manager
- Attach to the documents field within the incident form
- Alternatively you can email the audit to Emyr Jones, Personal Safety Advisor