

Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings



We would like to thank all colleagues and organisations that have assisted in the development of this guidance, in particular thanks to NHS England and the Royal College of Nursing for ongoing help and support.

Endorsements



About the guidance

The purpose of this guidance is to provide practical strategies to help identify, assess, understand, prevent and manage clinically related challenging behaviour, by preventing or minimising a person's distress, meeting their needs, and ensuring that high quality care is delivered within a safe environment.

A unique feature of the guidance is that the principles and approaches outlined in it are exactly the same for any adult patient and service user in any NHS healthcare setting.

Although specific techniques and interventions may differ, the strategies for delivering high quality personalised care that meets the patient and service user's needs remain the same. The importance of positive engagement and communication cannot be over-emphasised.

How should the guidance be used?

- Clinical staff should apply the approaches outlined here to their practice, in conjunction with their professional judgement in specific situations
- Support staff and carers should apply the approaches when assisting in the delivery of care
- Organisational managers should implement the guidance when meeting their legal responsibilities to ensure the health, safety and wellbeing of staff, patients and service users.

The guidance can be read as a whole; however each section stands alone and will be of particular interest to specific audiences, depending on their role, setting and client group.

The following table identifies those accountable for preventing and managing challenging behaviour, and signposts the relevant section(s)

Roles	Responsibilities	✓	Sections
Chief executive, board members, directors of care, senior managers	<ul style="list-style-type: none">○ Ratify and monitor the effectiveness of policies, systems and procedures to prevent challenging behaviour○ Ensure the safety of staff, patients and service users in compliance with legal and regulatory requirements○ Ensure the delivery of high quality, compassionate, personalised care○ Demonstrate a commitment to the reduction of restrictive interventions○ Take swift, decisive action if suboptimal care is being delivered○ Make available resources, including training for a highly skilled workforce○ Demonstrate strong organisational and clinical leadership○ Develop a positive culture where high quality care can flourish, and encourage staff to report concerns about poor practice○ Seek assurance that these priorities are being met through regular feedback, outcomes and incident analysis.		Intro, 1, 2, 5, 6, 7

Roles	Responsibilities	✓	Sections
Doctors, nurses, allied healthcare professionals with a supervisory role	<ul style="list-style-type: none"> ○ Provide leadership and foster a culture in which compassionate, personalised care is delivered and where physical interventions are only ever used as a last resort ○ Help formulate policies, systems and procedures to ensure an awareness and understanding of challenging behaviour to help prevent it ○ Support, instruct and advise on long term strategies to deliver personalised care consistently to prevent challenging behaviour ○ Provide good role modelling and clinical supervision for positive engagement and communication ○ Support, instruct and advise on escalating and emergency situations ○ Encourage reporting of all incidents of challenging behaviour through the incident reporting system ○ Manage post incident reviews, debriefs and the implementation of lessons learnt ○ Release staff for targeted training commensurate to the risks faced ○ Ensure information sharing with clinical colleagues, security staff, training staff, the police and appropriate external agencies. 		Intro, 1, 2, 3, 4, 5, 6, 7
Doctors, nurses, allied healthcare professionals	<ul style="list-style-type: none"> ○ Follow all policies, systems, procedures, guidance and updates to keep safe ○ Understand challenging behaviour, how to recognise it, how it relates to clinical conditions, how to prevent and manage it ○ Apply effective personalised care strategies to prevent challenging behaviours ○ Maintain compassion, empathy and positive attitudes when delivering care ○ Apply effective strategies for the clinical assessment, diagnosis and management of challenging behaviour ○ Apply effective strategies to manage escalating and emergency situations ○ Report all incidents of challenging behaviour to the line manager and through the incident reporting system ○ Understand and reduce risks and implement preventative strategies as is reasonably practicable ○ Undertake all necessary training, education and updates to keep safe and to provide the highest quality care. 		Intro, 1, 2, 3, 4, 5, 6
Security and emergency response teams	<ul style="list-style-type: none"> ○ Identify and understand challenging behaviour, common triggers and simple prevention strategies ○ Understand own role in preventing challenging behaviour in longer term care, including legal requirements around physical interventions ○ Undertake all necessary training, education and updates in relation to the safe and appropriate application of physical interventions. 		Intro, 1, 2, 3, 5, 6

Contents

Foreword

page 2

ALL

Introduction to challenging behaviour

page 3

ALL

Section 1 Understanding challenging behaviour

page 9

ALL

Section 2 Managing risk and assessing behaviours

page 15

ALL

Section 3 Care strategies

page 25

S D N A R C

Section 4 Medical assessment and management

page 35

S D N A

Section 5 Training

page 39

S M N A R D

Section 6 Communication and information sharing

page 45

S M N A R D

Section 7 Organisational responsibilities

page 49

M S

Appendices Website Case studies Learning outcomes Glossary Expert group

page 57

KEY

Applies to all ALL

Senior managers M

Supervisors S

Doctors D

Nursing staff N

Allied healthcare staff A

Response teams R

Carers C

Foreword

The challenge of keeping patients safe at times when they may be especially vulnerable and are outwardly exhibiting challenging behaviour has been increasingly recognised over the last few years. This guidance, *Meeting needs and reducing distress*, is aimed at improving the safety and wellbeing of patients whose challenging behaviour arises from their clinical condition. It provides a welcome focus on an extremely important issue, particularly for the acute and primary care settings.

Meeting needs and reducing distress is part of a wide and far-reaching programme of work on the avoidance and safe management of restraint that is being developed by a range of agencies, both within and beyond healthcare settings.

There are three particular aspects of the publication I would like to highlight:

First and foremost, the need for assessment to uncover any acute physical or neurological cause to the challenging behaviour. A recent review of the National Reporting and Learning System uncovered a small but significant number of incidents where challenging behaviour was not recognised as a sign that the patient had a life-threatening illness and needed emergency intervention.

Secondly, the fact that any episode of challenging behaviour is a demonstration of distress from the patient and a source of worry and concern to their family, friends, and to healthcare staff as they strive to provide the very best safe and compassionate care. To reduce distress there is a strong requirement to maintain a safe, supportive and clinically led service with active patient participation, that is reliant on forward planning, training and teamwork to ensure both patients and staff feel fully supported and valued. It is recommended you read this publication alongside *Compassion in Practice*, so the required steps can be taken at a local level to create a positive and proactive environment where alternatives to restraint have been established.

Finally, the need to recognise any physical intervention or restraint used in response to challenging behaviour as a patient safety incident that must be reported through local systems and shared with the National Reporting and Learning System. An open and transparent structure for

learning from incidents and working in partnership with patients and the public will ensure 'the power of pervasive and constant learning', as recommended in Professor Don Berwick's report into NHS patient safety.

Our vision for patient safety in the NHS is to ensure that every time any person needs to access our services, they can be confident they will be treated in an environment where safety is paramount and every step will be taken to keep risk to a minimum. The ultimate aim is to make the NHS the safest healthcare system in the world, and now, more than ever, we are committed to establishing a culture that is rooted in continual improvement.

Dr Mike Durkin

**National Director of Patient Safety
NHS England**



Introduction to challenging behaviour

Meeting needs and reducing distress

Guidance on the prevention and management of clinically related
challenging behaviour in NHS settings

Introduction to challenging behaviour

Clinically related challenging behaviour is often a manifestation of a patient's distress and an attempt by the person to communicate their unmet needs.¹ It may result from an individual feeling threatened, fearful or anxious, suffering delusions or hallucinations, or it may be in response to a difficult situation, or a misinterpretation of the actions of other people. It may simply be a result of an individual trying to express that they are hungry, thirsty or in pain.

Preventing challenging behaviour is concerned with understanding the reasons for a person's distress by recognising their vulnerability, anticipating needs and designing care accordingly.

It challenges perceptions, motivating professionals and organisations to ask:

'What are we doing to make things worse?'

and

'How can we change what we are doing to make things better?'

This is a collective endeavour which involves everyone and may require a review of existing care models, following an approach which relies on engaging, occupying and talking to the person through the delivery of high quality personalised care.

It may require time and sustained effort to change existing cultures. There may need to be a change in perceptions about certain conditions and types of patients and service users. For example, an older person showing challenging behaviour needs to be treated with the same concern and expedience as any other individual.

Negative staff attitudes can be a factor in causing or provoking challenging behaviour and an effective approach relies on compassion, empathy and respect for the person.

Previous government strategies have pursued a 'zero tolerance' approach to tackling violence and aggression in the NHS. While this has been a helpful starting point, it is problematic in the context of this work. This guidance adopts a person-centred approach that relies on greater tolerance and understanding.

Background

Clinically related challenging behaviour, although underreported, is a significant problem in the NHS.² This includes behaviour arising from dementia, delirium, injury to the head and brain, cancer, substance and alcohol abuse and withdrawal, mental health conditions and learning disabilities. It may also result from other factors, such as bereavement, anxiety and fear, adverse reactions to medication and treatment, or a feeling that staff are not paying attention.

This type of behaviour has been well publicised particularly in connection with older people with dementia, however it could instead be found in a young person who is otherwise physically fit and is recovering from a head injury. Statistically, however, the former outweighs the latter.

Behaviours such as grabbing, biting, scratching, pinching, poking, hair pulling, punching, kicking and slapping, along with self-injurious behaviours can, if left unchecked, pose a significant safety risk to staff or result in the person bringing harm to themselves, as well as causing alarm and distress to other patients and visitors.

Challenging behaviour can take place in any healthcare environment; however the picture in terms of prevalence is complex. In the acute sector, most incidents necessitating restraint did not take place in A&E, as is often thought, but occurred on acute medical wards.³

Individuals who present with challenging behaviours and who may be vulnerable should not be labelled or stigmatised as being violent and aggressive. Often, challenging behaviour is a function of a patient's inability to communicate their needs. It does not form a necessary 'part of their condition'.

1 Stokes, G. (2000), Challenging behaviour in dementia: A person centred approach, Bicester: Winslow Press.

2 NHS Protect (2013), 79% of reported physical assaults against NHS staff in England in 2012-13 were due to medical factors (medical illness, mental ill health, severe learning disability or treatment administered).

3 National Patient Safety Agency (2012), National Reporting and Learning System (NRLS) data.

Consequences of not addressing challenging behaviour

The consequences of challenging behaviour can be severe, especially over the long term. Some of these include:

- Ineffective delivery of healthcare
- An overreliance on anti-psychotic medication, seclusion and physical interventions
- An increase in physical injuries and psychological ill health among patients, service users and staff
- Reductions in staffing due to sickness and absence, low morale and confidence
- Higher staff turnover, reductions in permanent staff and a greater need for temporary staff
- Difficult management decisions around staffing, resources and training
- Inability of an organisation to meet its legal duties to protect staff and vulnerable individuals
- Inability to deliver important national agendas for improving patient care
- Diminished organisational reputation and negative publicity
- An increased number of complaints.

When things go wrong

The poor care at Mid Staffordshire NHS Foundation Trust and the abuses at Winterbourne View Hospital illustrate only too clearly what can go wrong when there are poor standards of care and a culture which allows it to happen. These events had serious repercussions on the safety, wellbeing and dignity of patients and service users; staff failed in their duty of care to patients and service users and put themselves at risk; and organisations tolerated poor practice and failed to be accountable for delivering high quality care.^{4,5}

A key lesson is that when the delivery of care is sub-standard, this often exacerbates and perpetuates a person's distress, leaving staff increasingly unable to cope, and abusive practices can soon become the norm.

Purpose and scope of this guidance

The purpose of this guidance is to provide practical strategies to help identify, assess, understand, prevent and manage challenging behaviour, and to improve the quality of care given to individuals by **preventing or minimising distress and meeting needs**, and ensuring that care is delivered within a safe environment. This will complement the forthcoming Department of Health guidance on the minimisation of restrictive practices across health and adult social care.

The scope of the guidance includes strategies to improve the experience of:

- All individuals, many of whom may be vulnerable, who cause harm to themselves and/or to others
- Staff who deliver essential treatment and care, aftercare and rehabilitation
- Other individuals who may also be vulnerable and disturbed
- Relatives, carers and visitors involved in caring for someone who is in distress.

This will be achieved by:

- Improving the assessment, diagnosis and management of those individuals who are at risk of challenging behaviour, so that such behaviour might be prevented
- Improving the understanding of how challenging behaviour relates to specific clinical conditions and unmet needs
- Improving the approach, skills and attitudes that minimise distress and meet needs
- Providing practical strategies to risk assess and manage challenging behaviour
- Providing managers with guidance enabling them to give staff appropriate training, and make resources available to prevent and manage challenging behaviour.

⁴ Robert Francis QC (2013), Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, <http://www.midstaffspublicinquiry.com/report>

⁵ Department of Health Review: Final report (2012), Transforming care: A national response to Winterbourne View Hospital, <https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response>

Guiding principles

The approach followed by this guidance is in accordance with the values in the NHS Constitution⁶:

- Working together for patients – we put the patient first in everything we do
- Respect and dignity – we value every person: patients, families, carers and staff
- Commitment to quality of care – we insist on quality of care: safety, effectiveness and patient experience every time
- Compassion – we respond with humanity and kindness to each person's pain, distress, anxiety or need
- Improving lives – we strive to improve health and wellbeing and peoples' experience of the NHS
- Everyone counts – we make sure nobody is excluded, discriminated against or left behind.

Legal framework

The following laws apply when preventing and managing clinically related challenging behaviour:

Common law

Health professionals have a duty of care to their patients and must take reasonable steps to avoid acts or omissions that are likely to cause foreseeable harm to the individual by employing a suitable standard of care.

Equality Act 2010

NHS organisations have a responsibility for tackling health inequalities and promoting equality of access to healthcare for all people. This includes avoiding direct or indirect discrimination on the basis of age or disability, and making reasonable adjustments to ensure that services are appropriate and accessible for people with disabilities.

Human Rights Act 1998 and the European Convention on Human Rights

All public authorities, including the NHS, have a statutory duty to act in accordance with the Human Rights Act 1998. The act translates the protections of the European Convention on

Human Rights into UK law, including the following articles:

Article 2 – Right to life

Article 3 – Prohibition of torture, inhuman or degrading treatment

Article 5 – Right to liberty and security of person

Article 8 – Right to respect for private and family life

Article 10 – Freedom of expression

Article 14 – Prohibition of discrimination.

The Mental Health Act 1983 (as amended by the Mental Health Act 2007)

The Mental Health Act 1983 Code of Practice provides guidance to health professionals on how they should proceed when undertaking duties under the Act. The Code and guiding principles under the Code, published in 2008, are currently being reviewed by the Department of Health for publication in 2014. This will include a revision to the section on 'Safe and therapeutic responses to disturbed behaviour'.

The current guiding principles which should be considered when making decisions about a course of action under the Act are set out in Chapter 1 of the Code. These are:

- Purpose - decisions must be taken with a view to maximising the safety and wellbeing of patients, promoting their recovery and protecting other people from harm
- Least restriction - keep to a minimum the restrictions imposed on the patient's liberty
- Respect - for the person's past and present wishes and feelings, and for diversity including religion, culture and sexual orientation
- Participation - involvement of the person in planning, developing and delivering care and treatment
- Effectiveness, efficiency and equity - in the use of resources.

The Mental Capacity Act 2005

The Mental Capacity Act 2005 provides a statutory framework for people who lack capacity to make decisions for themselves and where this is not possible, for decisions to be made in their

⁶ Department of Health (2013), The NHS Constitution - The NHS belongs to all of us, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

best interests. This framework is underpinned by five principles:

1. A person must be assumed to have capacity unless it is established that he lacks capacity
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests
5. The least restrictive option should be considered before any decision is made on behalf of the incapacitated individual.

Deprivation of Liberty Safeguards (under the Mental Capacity Act 2005)

Deprivations of Liberty Safeguards (DoLS) exist for individuals who lack the mental capacity to consent to their treatment or care. The safeguards are designed to:

- Prevent arbitrary decisions to deprive a person of liberty
- Provide the person with a representative
- Allow a right of challenge against the unlawful deprivation of liberty
- Provide a right for deprivation of liberty to be reviewed and monitored regularly.

When making arrangements for the care of someone who lacks capacity, healthcare providers must apply for authorisation for deprivation of liberty, based on the answers to the following questions:

- Is deprivation of liberty in the person's best interests?
- Has the least restrictive option been considered?
- Is it needed to keep the person safe from harm?
- Is it a reasonable response to the likelihood of the person suffering harm?

Health and Safety at Work Act 1974 etc, and Management of Health and Safety at Work Regulations 1999

NHS organisations have responsibilities under the Health and Safety at Work Act 1974 to ensure, as far as is reasonably practicable, the health, safety and welfare of employees, patients, service users, visitors and members of the general public. The associated regulations require employers to assess, manage, monitor and review the health and safety risks to employees.

Other legal considerations

Challenging behaviour may be a result of clinical factors, or it may take place as a result of someone's intentional or reckless actions (e.g. drunkenness). The approach for de-escalating and pacifying a situation applies in both scenarios.

Where someone is being challenging as a result of clinical factors that seriously impair their mental capacity, whether temporarily or permanently, at the time that the incident takes place, their behaviour would generally not constitute a malicious act that carries criminal culpability.

Each incident should be assessed on a case by case basis, as clinical factors and impaired capacity may be transitory in nature and have to be present at the time that the incident took place for there to be no criminal culpability.

Where an incident is caused by either intentional or reckless behaviour, this may constitute a criminal offence and should be managed in line with tackling violence guidance produced by NHS Protect.

Finally, it is important to ensure that for all incidents the victim is given the necessary care, support and assistance and that all incidents are reported through established incident reporting systems.⁷

The NHS organisation's Local Security Management Specialist (LSMS) will be able to provide further advice and assistance.

⁷ NHS Protect (2009), Tackling violence against staff, www.nhs.uk/SecurityManagement/Documents/SecurityManagement/Tackling_violence_against_staff_2009.pdf



Section 1

Understanding clinically related challenging behaviour

Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

Understanding clinically related challenging behaviour

Introduction

Our definition of clinically related challenging behaviour is:

Any non-verbal, verbal or physical behaviour exhibited by a person which makes it difficult to deliver good care safely.

Other definitions are widely available.⁸

Common characteristics

Individuals who manifest challenging behaviour often have some degree of cognitive impairment, either chronic (e.g. dementia or a learning disability) or acute (e.g. delirium, head or brain injury, drug or alcohol intoxication). It may also be seen in other mental health conditions such as psychosis or personality disorder.

Care is needed that the behaviour is not as a result of an underlying illness or injury which needs urgent attention.

Types of behaviour

Challenging behaviour may describe many kinds of deliberate or non-deliberate non-verbal, verbal or physical behaviour. Some of these behaviours (e.g. staring, crying and shouting) may represent legitimate expressions of distress.

It can include behaviours which may be less risky, such as apathy, lethargy, fatigue, hyperactivity, hypoactivity, being non-compliant or withdrawn, **if staff need to intervene** because the behaviour poses a safety risk to staff, patients and service users or others, e.g. an individual trying to get out of bed when they cannot stand and may fall.

There is no continuum of behaviour and where someone is sufficiently distressed or alarmed, their behaviour may instantly result in a physical action.

Patterns of challenging behaviour

Identifying patterns to predict when challenging behaviour is more likely to occur can assist when planning, preventing and preparing for it. Challenging behaviour tends to occur in

response to:

- Unmet care needs (e.g. toilet, pain, thirst, hunger)
- Care tasks, including intimate procedures
- Administering medication (especially where the patient has to wait for pain relief)
- Pre-operative period (waiting, nil-by-mouth, clinical interventions and procedures)
- Post-operative period
- Gender issues (preferences for male or female carer)
- Pressure on staff time (i.e. staff not being on the 'shop floor')
- Lack of engagement by staff
- Times when staff are otherwise engaged (mealtimes, medication, handovers etc)
- Areas where there are less experienced staff (e.g. less aware of psychological issues)
- 'Sundowning' (i.e. behaviours are more prevalent during afternoon and evenings, due to factors such as tiredness and changes in levels of light, or sensory deprivation)
- Night time disturbance
- Over-stimulating or under-stimulating environments
- Heightened activity (e.g. mealtimes)
- Lack of meaningful activity
- Relatives leaving
- Cultural, religious or spiritual needs
- Individuals feeling that staff are not hearing or listening to what they are saying
- Staff hostility
- Inconsistent rule setting
- Provocation by other individuals, distress in other individuals.

⁸ 'Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion,' Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, in Challenging Behaviour – A Unified Approach (2007).

Table 1 - Types of behaviour

Non-verbal	Verbal	Physical
<ul style="list-style-type: none"> ○ Agitation ○ Wandering, pacing, following ○ Intimidating facial expressions, staring ○ Intimidating body posture ○ Cornering, invading personal space ○ Interference with equipment or property ○ Being withdrawn, extreme passivity, refusal to move 	<ul style="list-style-type: none"> ○ Shouting ○ Swearing ○ Crying ○ Screaming ○ Repetitive statements or questions ○ Personal comments or questions ○ Racist, sexist, offensive speech ○ Bizarre, psychotic content, not based on known reality 	<ul style="list-style-type: none"> ○ Scratching ○ Grabbing, hair pulling ○ Biting ○ Hitting, slapping, punching ○ Pinching ○ Spitting ○ Kicking ○ Pushing, shoving, knocking into someone ○ Striking or throwing furniture or objects ○ Inappropriate touching (self or others) ○ Urinating, smearing ○ Undressing ○ Self harm ○ Absconding ○ Removal of lines, masks, catheters, dressings, incontinence pads ○ Non-compliance, resistive behaviour (e.g. refusing medication, blood tests)

Triggers and antecedents

Triggers and antecedents are factors which occur prior to an individual's challenging behaviour. These factors may include the care environment or setting, individuals or interventions, activities or objects, thoughts or feelings, pain or discomfort.

For example a person may become overwhelmed, when a high number of healthcare professionals undertake a care intervention in close proximity to them.

Observing, identifying and documenting triggers and antecedents is the first part of a proactive strategy for minimising an individual's stress or distress. This is because, once identified, many of these situations can be avoided or changed.

Precursors

Challenging behaviours can occur without warning and staff need to be aware of, recognise

and identify precursors. Precursors are behaviours and are different to triggers, which are factors that can lead to challenging behaviour.

Precursors can often be very subtle and leave staff feeling 'uncomfortable', or they may signpost the onset of challenging behaviour.

Common recognisable cues include:

- Tense and angry facial expressions
- Increased and prolonged restlessness, pacing, body tension
- Increased breathing, muscle twitching and dilated pupils
- Increased volume of speech and swearing
- Refusal to communicate, withdrawal, irritability
- Prolonged eye contact
- Confusion of thought processes, poor concentration

- Delusions or hallucinations
- Verbal threats or gestures
- Verbalising an intention that suggests distress, e.g. 'I want to go...'
- Replicating behaviour which preceded earlier disturbed or challenging episodes
- Reporting anger or violent feelings
- Generally, anything that seems out of character, e.g. excessive crying or laughing hysterically.

Reasons for challenging behaviour

There is **always** a cause of clinically related challenging behaviour, even if it is not evident at the time. An overall approach that looks to prevent distress by identifying, categorising and understanding its reasons should reduce the likelihood of these potentially 'unforeseen' events occurring. The main categories are:

- 1) Physical factors
- 2) Cognitive factors
- 3) Psychological and emotional factors
- 4) Environmental or social factors

Communication problems, which have been included as cognitive factors here, are extremely important and may warrant a separate category.

Understanding the reasons for challenging behaviour

Staff need to translate the reasons for challenging behaviour into unmet needs before identifying strategies to meet these needs.

Physical factors

The physical causes which may lead to challenging behaviour include features of an individual's condition that pre-dispose him or her to distress (such as sensory impairments e.g. a loss of sight, hearing) unpleasant symptoms, pain and discomfort. They can all cause irritability and agitation or trigger distress.

Patho-physiological changes that cause delirium can be a significant factor and it is worth mentioning them specifically. Delirium is a short term confusional state, or worsening of pre-existing confusion, due to a physical cause. It comes on suddenly (days to hours), fluctuates with time and is characterised by cognitive

impairment and inattentiveness (distractibility) or drowsiness. Delusions, hallucinations and emotional changes (fear, anger) are common and symptoms are often worse at night. Delirium usually resolves with treatment of the underlying cause, but it may persist and does not always recover. Suspicion of delirium requires assessment by a suitably skilled doctor.

Poor sleep is common in illness and in hospital, and leaves people fatigued and irritable. Hunger, thirst and urinary symptoms are associated with strong urges in an individual and may manifest as challenging behaviours if they cannot be communicated.

Cognitive factors

Cognitive factors include the inability to remember new information, explanations or instructions, the loss of inhibitions, poor judgment and planning and importantly communication problems. They often result in an inability to articulate needs, or a difficulty in understanding and interpreting the communication of those around them (both verbal and non-verbal) and can all lead to distress or difficult behaviours.

Staff and carers can sometimes lack an understanding of communication impairment and overestimate a person's ability to understand information and make choices.

Psychological or emotional factors

Individuals suffering from delusions, especially paranoid, can feel they are being threatened and this can lead to defensive and challenging responses on their part. People with personality disorders may have difficulty foreseeing the consequences on others of their actions and may become acutely distressed. Fear is powerful in provoking difficult or aggressive behaviours. Anger can arise at a time of threat, as part of bereavement, or if needs are not being met.

Environmental or social factors

Factors relating to an individual's surroundings (e.g. excessive noise) can be provocative particularly if they are prolonged or persistent and may also interfere with the individual's rest and sleep. People with cognitive impairment often find care surroundings overwhelming and over-stimulating and may not keep up with the speed or volume of information or activity they are exposed to.

A lack of stimulation and activity, engaging in meaningless activity or over-activity can lead to frustration in individuals. This may be exacerbated by a lack of communication and dialogue between staff and patients or service users, poor care planning and a lack of coordination of activities between multi-disciplinary teams (MDTs).

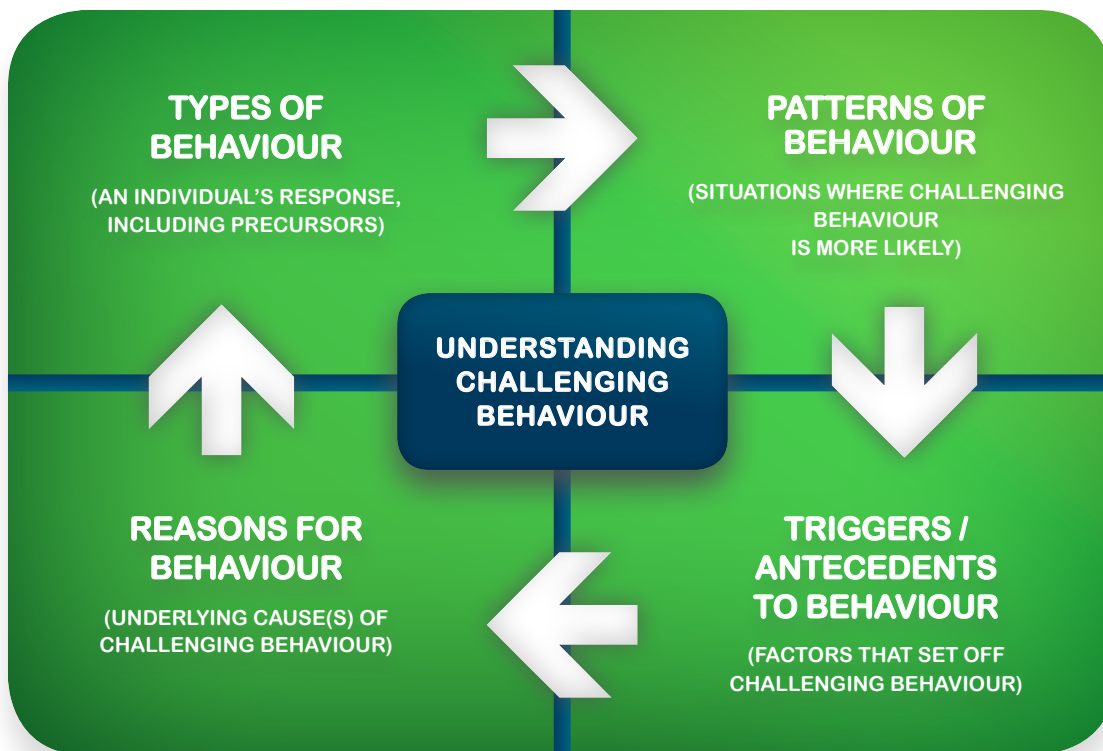
Finally, a lack of understanding of an individual's culture and related behaviour can lead to frustration and agitation on their part. This can lead to a lack of trust, misinterpretation of their

behaviour and miscommunication. Cultural sensitivity is important in dealing with this kind of challenging behaviour.

Table 2 - Reasons for challenging behaviour

Physical	Cognitive	Psychological/ emotional	Environmental/social
<ul style="list-style-type: none"> ○ Hypoxia ○ Hyperglycaemia ○ Hypoglycaemia ○ Electrolyte abnormality ○ Dehydration ○ Constipation ○ Infection ○ Pain ○ Visual or hearing impairment ○ Sleep deprivation ○ Medication (effects) ○ Illicit drugs or alcohol ○ Drug or alcohol withdrawal ○ Pre or post-operative ○ Hunger, thirst ○ Incontinence, urgent toilet needs ○ Earache ○ Epilepsy 	<ul style="list-style-type: none"> ○ Communication problems (expression and understanding) ○ Memory loss ○ Difficulty with language or dialect ○ Reduced spatial awareness ○ Learning disabilities ○ Disorientation ○ Poor executive function (reasoning, planning, foresight) ○ Loss of insight ○ Autism 	<ul style="list-style-type: none"> ○ Fear ○ Anxiety ○ Anger ○ Depression ○ Social isolation ○ Mania ○ Fixed beliefs or current thinking ○ Separation anxiety ○ Loss of self worth 	<ul style="list-style-type: none"> ○ Noise ○ Lights ○ Temperature ○ Overcrowding, or busy environment ○ Inappropriate signage ○ Lack of information ○ Long waiting times ○ Cultural factors ○ Lack of continuity of staffing, or care ○ Loss of routine ○ Unfamiliar surroundings ○ Pace of surroundings ○ Lack of meaningful activity ○ Over-stimulation ○ Under-stimulation ○ Imposed boundaries or routine ○ Stopping a habit/ behaviour (e.g. smoking)

Figure 1 – Understanding challenging behaviour





Section 2

Managing risk and assessing behaviours

Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

Managing risk and assessing behaviours

PART ONE – Understanding risk

Introduction

In high-risk, potentially dangerous situations, prevention, avoidance and de-escalation are always the preferred approaches. Physical interventions, rapid tranquillisation, seclusion and heightened levels of observation should only be used as a last resort in conjunction with continuous de-escalation, where these other approaches prove insufficient.

Assessing risk

Risk assessment is concerned with assessing the likelihood and consequences of challenging behaviour and implementing appropriate measures to avoid, mitigate or control the risks. Protective factors, such as greater collaboration with other colleagues and services, and family involvement should also be emphasised.

A formal risk assessment for individual patients will not always be possible in fast paced emergency departments, admissions units and intensive care, as in these settings: there is little or no lead up to situations; there is limited or no observation time; the person does not necessarily have a history of challenging behaviour (or at least one that is readily accessible by staff); lengths of stays may be short, or the individual may already be in crisis and require immediate stabilisation.

Similarly, acute medical wards are usually busy and detailed risk assessment for all patients may not always be feasible. Nonetheless, risk assessment should be used selectively for those patients with a propensity for serious challenging behaviours and it is important for such areas to have policies and procedures in place to minimise the risks.

In emergency and acute clinical settings it is important that staff can quickly identify the triggers of challenging behaviour, recognise the precursors, dynamically assess the risks and implement timely de-escalation strategies to reduce the dangers. Staff should still try to ascertain as much background information as possible from the patient and carers and from notes, to enable positive engagement to take

place. Assessments and adjustments to the patient's care plan should be shared with all who need to know.

Risk factors

Risk factors increase the likelihood of challenging behaviour and require quick management decisions. Risk factors may include a person's previous history and current clinical presentations. Historical and current factors may operate independently or interact together, and they may combine with environmental and situational triggers to heighten the risk of challenging behaviour (see Figure 2).

The following factors point to an increased risk of challenging behaviour:

Person

Historical factors

- History of aggressive/violent behaviour
- History of intent to harm others
- History of mental condition(s)/self harm/ suicide attempts
- Cognitive impairment
- Previously detained under a section of the Mental Health Act
- Forensic, criminal related history, e.g. prisoners in hospital etc
- History of abuse or trauma
- History of substance and alcohol abuse or withdrawal
- History of disruption to service delivery and resources, e.g. damage to property, equipment, disruption to staffing levels etc.

Current presentation

- Specific diagnoses, physical, cognitive, (especially communication) and psychological/emotional factors.

Environment

- Environmental factors, e.g. new environments, busy, active, crowded treatment areas
- Other agitated or distressed patients or service users
- Lack of meaningful activities.

Situational

- Activities being undertaken, e.g. washing, dressing, giving medications etc
- Services being provided and the client group
- Staff member, e.g. inconsistent staff attitudes, awareness and approach
- Staffing, e.g. staffing levels, skill levels and training
- Certain times of day
- Patient, e.g. mix/tensions, patient-on-patient incidents
- Restrictions, denial or confrontation, e.g. a person wanting to leave, cigarette requests.

Preventing the risk of challenging behaviour

- Preventing the risk of challenging behaviour relies on meeting personalised care needs:

‘Care where the patient is an equal partner with the healthcare professional and where both parties work together to make an assessment, identify options for the delivery of the most appropriate care. The care provided is holistic and the ‘whole person’ sits at the centre of the care package, which may be delivered by a range of health and social care professionals.’ (NHS Education for Scotland, 2010)⁹

- This approach is based on positive staff attitudes, high levels of tolerance, compassion and empathy. Dignity is important and requires

that the individual is kept comfortable, valued, respected, is in control, and that they have choices in their treatment and care. Empathic understanding means seeing problems from the perspective of the patient or service user.

- It requires strong leadership, skilled staff confident in their own abilities and adequate resources. It requires training, practice and often role-modelling by people who know how to do it and can share their expertise.
- In acute health settings, staff are often instilled with the belief that they need to work quickly in order to be effective. However, the approach presented here relies on staff being able to talk to the patient or service user and understand their psychological, emotional and physical care needs.
- Personalised care means staff building positive relationships with the person being cared for, their family and carers. The rewards equally apply to those delivering the care as well as the person being cared for, as staff tend to feel empowered and supported by this approach.
- Staff should understand that the way they interact is vital in helping the patient communicate the reasons for their distress and their unmet needs. They also need to be aware (and this should be reiterated through training) of how their interaction with the patient can positively or negatively reinforce challenging behaviours and of the need to communicate with them in a sensitive way.
- A collaborative approach is the most effective way of preventing a person’s challenging behaviour, which involves all staff having a unified understanding of an individual’s behaviours, antecedents, triggers, reinforcers and consequences and what everyone needs to do to prevent the behaviours. This understanding requires developing a personal profile and wherever possible observing and analysing what is happening and designing effective interventions – a functional assessment can assist where possible (see Section 2, Part 3).

⁹ See also Professor Peter McGill, Positive Behaviour Support (PBS), The Tizard Centre, University of Kent.

Managing the risk of challenging behaviour

Care planning

Risk assessment and management should inform the care plan as to whether specific interventions are required to manage challenging behaviour. The risk assessment documentation should sit alongside the care plan and should be cross-referenced and updated accordingly if new risks emerge.

De-escalation

If prevention has failed, is failing or has never had a chance to work, staff need to be skilled in de-escalation. This is based around highly developed communication skills, fostering good relationships, empathy, calming, non-confrontation, minimising threat, negotiation, compromise, agreeing to any reasonable requests, distraction, activities and changes of staffing which are all key here.

‘Art of doing nothing’

The ‘art of doing nothing’ and ‘watch and wait’ are important strategies in high risk situations where it is safe to apply them, although they require staff confidence as they may seem counter-intuitive. Challenging behaviour around the time of transition (e.g. hospital or care home admission, or ward or bed moves) often settles down within 2 or 3 days without intervention other than trying to keep the individual, staff and other people safe and offering comfort and reassurance. The latter meets psychological and emotional needs and improves the individual’s experience of care.

Leave and return

‘Leave and return’ is a strategy when someone is resisting care. Staff need to employ good judgment here. If a patient or service user absolutely needs medical intervention or another essential intervention (e.g. a soiled incontinence pad needs changing), brief physical interventions may be necessary. But in the majority of cases things can wait (washing or shaving, for example). Constant informal risk assessment is needed, along with adequate supervision, opportunities to discuss and debrief dilemmas and staff being trusted to use their judgment.

Better understanding and tolerance

Some challenging behaviours may be difficult to stop (e.g. wandering or persistent ‘vocalisation’). It is important for staff to be able to understand these behaviours, tolerate them (where they are not offensive), accommodate them within the confines of the care environment, keep the patient or service user and others safe and sometimes mitigate effects. For example, someone who is persistently shouting may have to be isolated to reduce stimulation and keep the environment tolerable for others, as well as to avoid provoking others or ‘setting them off’.

Observation

Observation¹⁰ that goes beyond normal therapeutic engagement and assists in building relationships with patients or service users should be considered for the immediate and long term prevention and management of challenging behaviour. It must not be intrusive, should respect dignity and privacy and must be conducted safely. Organisations should have an action plan for checking availability of internal staff for observation (e.g. staff bank, temporary staff, central response team, movement of staff from other areas). An observation policy should clarify observation levels according to risk and what is expected of staff (a prior knowledge of the person’s history is desirable) and how to initiate or discontinue higher level support.

Physical intervention and rapid tranquillisation

It is important for staff to be able to recognise situations where physical intervention and/or rapid tranquillisation are required. Clinical staff need to be confident about when these short term intervention strategies are required, e.g. immediate control of a dangerous situation (see Part 2 below), and when they are not required, i.e. where de-escalation, non-pharmacological means, or use of more routine medication (e.g. pain relief) should be attempted first.

During care planning, ‘advance directives’¹¹ (decisions) may be considered by asking a person to indicate what forms of treatment they would or would not prefer, should they lack capacity to refuse or consent in the future. This includes any treatment preferences that they may

10 See definition in NICE clinical guideline 25 (2005), The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.

11 See the MHA Code of Practice, 2007.

have in the event that they become challenging. Where a person has memory/understanding issues, relatives and carers should assist.

Post-incident reviews

Post-incident reviews and/or reviews of near misses are invaluable in identifying lessons to be learnt. It is good practice to include staff involved in the incident or situation, witnesses, other colleagues, the patient or service user and carer to ascertain the reasons for their behaviour. The person's perspective can help identify triggers relating to staff communication, actions or behaviours. A post incident review will only be effective if it is documented and shared with everyone involved in delivering care for that individual (see Section 6).

PART TWO – Emergency situations: Principles around physical intervention

The purpose of physical intervention

Physical intervention may be required to:

Take immediate control of a dangerous situation; to end or reduce significantly the danger to the patient or others around them; and contain or limit the patient's freedom for no longer than is necessary (Mental Health Act 1983 Code of Practice (2008)).

It requires some form of physical contact and application of force to guide, restrict or prevent movement such as touching, guiding, escorting, holding, chemical and mechanical restraint and seclusion.

When applied inappropriately

There are inherent dangers to patients and staff in the inappropriate use or poor application of physical intervention in challenging situations. Between 2009 and 2012, 126 out of 823 physical intervention incidents caused moderate or severe harm and even led to death of two patients in the acute healthcare setting. Clinical staff involved in incidents ranged from nursing to support

staff. A significant proportion of these involved security staff and police, either in isolation or in combination.¹²

Even where physical intervention only involves what is perceived as minimum force (e.g. something as innocuous as holding a wrist), when used against the vulnerable, for example an older person, it has the potential to lead to injuries such as bruising, skin tears and fractures.

When physical intervention must be considered

Physical interventions should be used to manage an emergency situation: ***one of immediately apparent risk to the health, safety and wellbeing of the patient or service user, staff or third parties.***

Based on a rapid risk assessment, an immediate judgment is needed as to whether the patient or service user showing challenging behaviour has an acute illness which could be potentially life threatening and must receive urgent attention. In this situation, emergency physical intervention and rapid tranquillisation may be essential in order for a clinical procedure to take place.

In these circumstances, staff may need to take immediate action to prevent harm. Not to act in these circumstances could constitute a breach of their duty of care under common law.¹³

Any form of physical interventions must always be in line with NICE clinical guideline CG25 and should be:

- Necessary, justifiable and proportionate
- Conducted by appropriately trained and competent staff
- Combined with strategies to continuously de-escalate
- Carried out using the least restrictive interventions
- Used for the minimum amount of time
- Done so as to enable staff to continually monitor the patient for signs of medical or physical distress
- Formally recorded as soon as possible after the event.

¹² National Patient Safety Agency, NRLS data (2012).

¹³ See RCN guidance (2008), "Let's talk about restraint" rights, risks and responsibilities, www.rcn.org.uk/development/communities/rcn_forum_communities/mental_health/resources/a-z_of_resources/restraint

Rapid risk assessment

A rapid risk assessment must be carried out before any decision is made for physical intervention. The rationale for any action must be recorded and justified. However, in an emergency situation a formal risk assessment may not always be possible and the decision must be documented retrospectively. There is a judgement here, in which the need to use reasonable force to protect someone must be balanced against the risks of potentially behaving negligently by not acting.

Assessing capacity

Staff must presume that the individual has capacity unless there is a good reason to suspect it is lacking. If someone is behaving 'oddly', or dangerously, there may be *prima facie* evidence to suspect capacity is lacking and a need to assess it under the Mental Capacity Act 2005 (MCA).

Under the MCA, physical intervention is acceptable if the person lacks capacity and the decision is the least restrictive option and is made in their best interests. There is judgment involved, but as long as it can be shown that there were grounds to doubt capacity, and the action taken was necessary to preserve health or life and proportionate to the gravity of the risk, then it is appropriate and legal.

However in a dangerous situation, a full mental capacity assessment may be impractical and practitioners should not delay immediate action necessary to preserve life or health. An assessment should be completed following the intervention to regain control of the situation.

Use of reasonable force

All staff must understand the law concerning the use of reasonable force during a physical intervention and how such action can be justified in light of the desired outcome. The main principles are **proportionality, necessity and reasonableness**: Are there any viable alternatives to using force? Is it proportionate and necessary in the situation that presents itself? Does it use the least amount of force for the shortest time? Finally, can the use of force be justified in a court of law, if necessary?

Roles and responsibilities

An organisation's physical intervention policy should identify a clear decision making process for the acceptable use of physical interventions. This should include a division of responsibilities, who is permitted and not permitted to do what and who should take the lead. It should outline a process for planning and undertaking physical interventions, highlight the continuing risks of harm (particularly positional asphyxia), and explain the need for constant physical monitoring, post incident support and debriefing. Safety considerations include the designation of appropriate areas or rooms to enable safe de-escalation, observation and physical interventions.

Organisations must hold up-to-date records and specify a minimum number of trained and competent staff that are available (e.g. a rapid response team) to manage an emergency situation safely.

Staff involved in physical interventions should be appropriately and specifically trained. However, there must always be a pragmatic approach to safely managing a situation, for example some escorting or guiding by staff who are not specifically trained may be permitted in some circumstances (e.g. where an older person with dementia is wandering away from a controlled area).

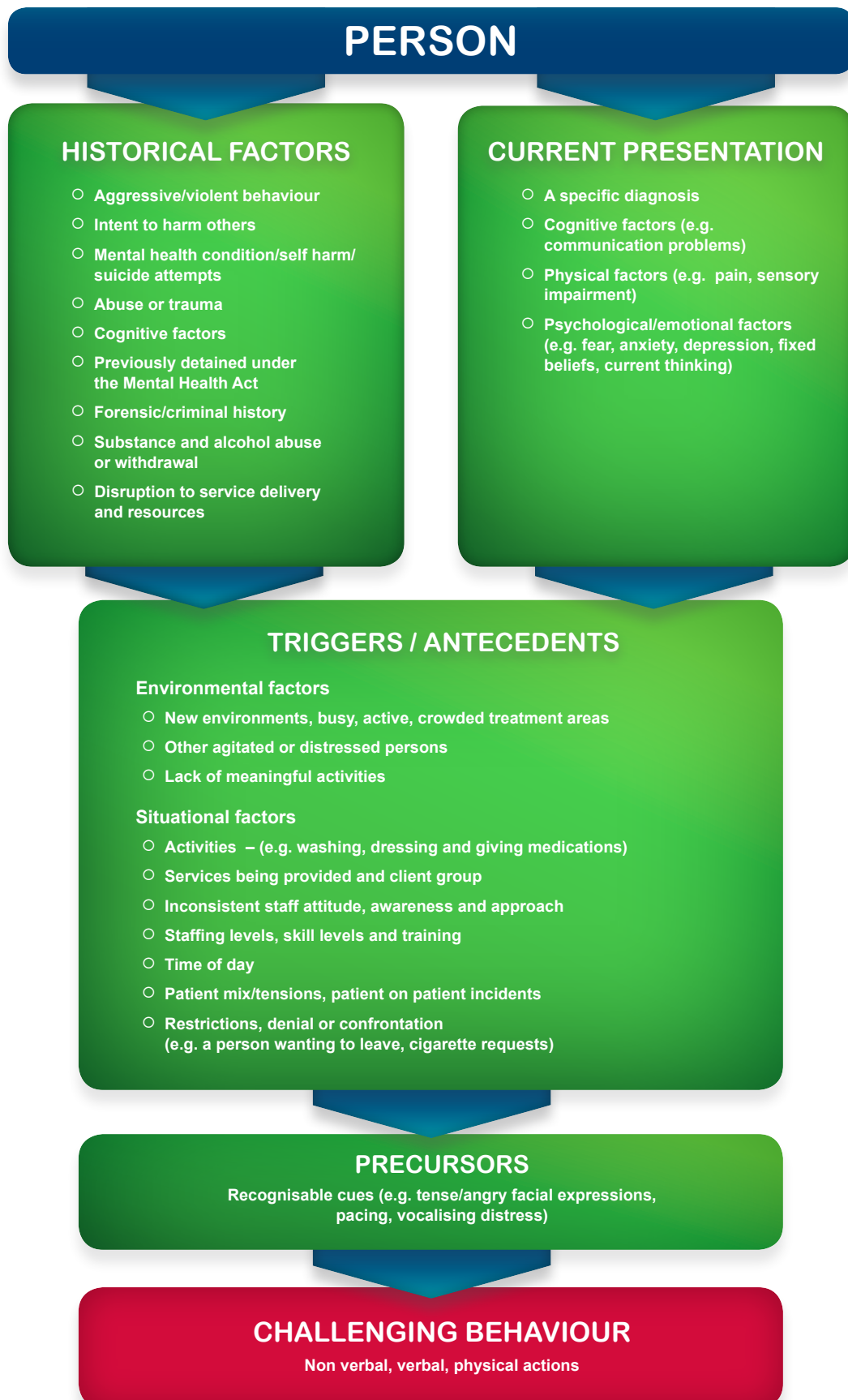
Finally, organisations need to centrally record and analyse restraint incidents, to avoid the inappropriate use of restraint, reduce levels of restraint and develop new safe techniques.

When to call the police

This should be determined by local arrangements with the police, however they should generally be called:

- Where a crime has possibly been committed
- Where the victim requests it
- Where all possible avenues to safely de-escalate and manage a situation have been exhausted and have failed
- Where staff, patients and the public remain in imminent and grave danger.

Figure 2 – A framework for explaining challenging behaviour



PART THREE – Understanding behaviours

Staff exposed to challenging behaviour on a routine basis can over time become ‘conditioned’ to the behaviour. By this we mean that staff may become unable to acknowledge, recognise or describe these behaviours, or may perceive them as being a normal part of their duties, leading to the widely used expression ‘it’s part of the job’. This is particularly true for low level behaviours, which are historically underreported.

Staff need to be ‘reflective practitioners’ who can observe, analyse and understand the reasons for challenging behaviours and implement simple, immediate or longer term prevention strategies. This approach has a vital learning and education element.

Prevention through better understanding is about identifying how to avoid challenging behaviour in the first place by asking:

‘What is causing the distress?’

‘What are we doing that is leading to the individual’s distress?’

‘What can I or we as an organisation do differently?’

Culture and habit in dealing with individuals and their carers, for example by being more collaborative or less confrontational and by tolerating behaviours, may be more important than specific actions. For example, individuals who are ‘uncontrollable’ in one area often inexplicably settle down when on a specialist unit or a mental health ward.

Functional assessment and formulations

The successful prevention of challenging behaviour is underpinned by a good formulation (explanation) of the behaviour and the identification of appropriate interventions, which can be used by all staff interacting with the patient.

The explanation is derived through functional assessment. Functional assessment is particularly suitable for assessing individuals who are unable to communicate their needs verbally in any setting. This approach relies upon identifying the typical context in which the

individual’s challenging behaviour occurs and factors which may well perpetuate the behaviour. It also requires identifying relevant characteristics of the individual as well as less immediate environmental and situational influences.

Typically these observations are recorded and organised on Antecedent Behaviour Consequences (ABC) charts, or similar specialist screening tools, whereby staff record events that occurred immediately before, during and after the behaviour, along with any observations or ideas on why the incident occurred. An ABC chart is a post incident chart which can be used for as long as is needed to identify behaviour triggers and patterns, in order to identify appropriate and effective care strategies.

The chart should be completed by the member of staff who witnessed the behaviour as soon as possible after the incident happened, ideally during, or possibly at the end of their shift when the incident is still fresh in the mind.

Antecedents and triggers of the behaviour

These may originate from a single factor or a combination of factors relating to the person, other persons, staff delivering the care or the environment immediately before the incident occurred.

Behaviours at the time of the incident

How did the individual react during the incident, what was their appearance like and their actions? A detailed description is important to understanding the behaviour. Generalisations should be avoided, e.g. describing the individual as ‘verbally abusive’ or ‘physically aggressive’ will not provide the detail needed to understand behaviours.

Consequences of the incident

Does the analysis indicate that staff behaviours, reactions, or interventions negatively or positively reinforce the individual’s behaviour? Does the individual want something that is not available (a person, object or activity)? Are they trying to

remove something that is aversive to them, or are they simply engaging in a behaviour that is stimulating and feels good? Can any simple practical prevention strategies be identified? Often minor modifications to care can have dramatic effects: for example, modifying someone's bathing or washing routines may stop agitation or aggression.

Training should be provided to staff, where appropriate, on accurate assessment (using ABC charts), see Section 5.

Delivering care

Understanding the reasons for challenging behaviour, including identifying what needs to be done to minimise an individual's distress, will help MDTs understand the appropriate role and limitations of drug treatments. A thorough understanding of non-pharmacological interventions is needed, for the following reasons:

- It is often an individual's distress and the context in which care is delivered that can lead to challenging behaviour
- It is not an inevitable consequence of conditions such as dementia or delirium
- Staff attitudes and skills may need to change, e.g. not blaming the individual
- It requires staff to honestly appraise their performance and clinical leaders (ward managers, consultants) to develop a culture which promotes personalised care
- It may require models of care and ways of working to be modified (e.g. making adjustments to care pathways to minimise distress).

Challenging behaviour also requires designing on-going and follow-up care on discharge for people with mental health or other needs. This includes:

- Community provision of counselling, rehabilitation and care services
- Up-skilling family carers
- Community mental health teams
- Care homes and dementia outreach services
- Community Learning Disability Teams (CLDTs)
- Primary care social care access services

- Debriefing (e.g. after recovery from an episode of delirium)
- Support for carers, in particular family support networks.



Section 3

Care strategies

Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

Care strategies

Introduction

This section provides prevention care strategies to meet the immediate and longer term needs of patients and service users. While particularly applicable to nurses, it will be relevant to all healthcare professionals who interact with patients, service users and their families and contribute to decision making and care planning to minimise challenging behaviour, including doctors, allied health professionals, ancillary and non-clinical staff.

This section should be read in conjunction with Section 4 - Medical assessment.

Escalating and emergency situations

- Be compassionate, empathise, reassure and understand distressing situations from an individual's perspective throughout:
 - What do they perceive is happening?
 - Does the individual understand what is going on, even if they have been told?
 - May they perceive something or someone as a threat?
 - Is their understanding limited by cognitive problems?
- If in doubt, do what is safe. Staff should never put themselves, patients, service users or visitors in danger. Staff need to be able to respond to an escalating situation, seek assistance and know when to withdraw to a place of safety.
- On presentation, the patient should be rapidly assessed as to whether their behaviour may be as a result of acute illness (e.g. meningitis) or injury (e.g. head/brain injury) which requires immediate lifesaving treatment and care.
- In a dangerous or emergency situation, individuals displaying challenging behaviour require the same level of care and attention, irrespective of their clinical presentation and where the behaviour takes place.
- Good communication should be the overarching strategy to de-escalate, calm and reduce distress, stress or anxiety, and will help move through the rest of the strategies.
- Be aware of non-verbal cues and body language which may be interpreted as aggressive or confrontational by someone in distress.
- Move away from speed, efficiency and being task focused, and attempt to initiate a conversation to gain the individual's cooperation.
- Avoid trying to 'control the situation', focus on finding out what the problem is that is causing the person's distress.

A practical approach for managing escalating and emergency situations

Planning

1. Orientate staff to the care environment (including safe places and exits), safety procedures, security arrangements and points of contact for help.
2. All staff (including agency staff) should be familiar with the local security provisions, have the relevant numbers to call, call points and procedures.
3. Make sure that staff are issued with all safety equipment and alarms (including lone worker devices) as appropriate. For example, in emergency departments there are usually emergency buzzers in every room and some staff carry personal alarms.

Escalating situations

4. Use effective verbal and non-verbal communication skills as the first strategy for de-escalation (see communication techniques on p. 32-33).
5. Approach the individual in a calm and non-confrontational way. If necessary stand back to give them personal space. Ask: "You seem upset. Can I help you?"
6. Allow time to talk to the person, family and carers. Listen to their concerns and offer lots of reassurance. Can reasonable requests be incorporated within the delivery of care?
7. Give clear and consistent information. Repeat it, especially if the individual has a learning disability, head injury, short-term memory loss or is intoxicated.
8. Ensure that the person understands why you are doing certain things (e.g. carrying out examinations).
9. Explain what is going to happen and why and reach agreement, e.g. "Here is your medication, how would you like to take it?". Is a degree of compromise needed?

Consider:

10. Any immediate causes of distress and find solutions. Is the person deaf, do they understand English, or are they unable to express themselves? Do they require immediate pain relief?
11. Removing monitoring equipment, venous and arterial lines, or catheter if they are the source of discomfort or distress and it is safe to do so.
12. Using distraction techniques (e.g. chat about the weather, past life, hobbies and interests) to focus the person's attention away from the issue or situation causing agitation or distress.
13. Moving the individual to a quiet bay, separate waiting area or side ward or to a unit that is able to provide specialist care.
14. Removing yourself and change staff members if you are unable to defuse a situation.
15. Using 'watch and wait' or 'leave and return' strategies if safe and appropriate to do so, and if it is judged that the individual's behaviour may settle as a result.
16. Continually evaluating the situation and making a judgment about whether it is getting better or worse and needs escalation. If necessary, seek support or help from:
 - A mental health or learning disability liaison team or contact point
 - An emergency response team (where applicable)
 - A doctor, if the individual is acutely unwell or may need rapid tranquillisation

- A security manager/supervisor, to enable them to have their teams on stand by
 - Other senior doctor or manager as appropriate.
17. Special observation to prevent further escalation. Make an assessment first, decide on level of observation required and ensure the safety of staff, patients and service users during the observation period.

Emergency situations

18. The first priority is to ensure that staff, the patient or service user and others in the vicinity (including visitors) are cared for and safe.
19. A senior doctor or nurse should act as a single point of contact, coordinator and decision-maker during the incident, with an overall view of events.
20. Continue to make constant attempts to calm and de-escalate.
21. Consider physical intervention and/or pharmacological management within the overall context of behavioural and medical management.
22. If the situation becomes dangerous:
- Consider calling for help, activating an alarm, or leaving the area
 - Request assistance from security staff
 - Call the police.

Post incident support (serious or severe incidents)

23. Managers should ensure that, where proportionate, the staff member(s) involved is able to take a break, move to a quiet area or undertake different duties. If this is not possible, clinical supervision may be an alternative.
24. The staff member, the patient or service user should be given access to immediate medical attention if required. Reassurance should be provided to all.
25. Document the incident via the incident reporting system, incident forms and/or individual notes. Allow for personal notes from staff involved in the incident.
26. The staff member, in consultation with the ward or unit manager, may want to report the incident to the police (if they have not already been called). Seek advice from the Local Security Management Specialist (LSMS) or union representative if required.
27. The ward or unit manager should evaluate the event and offer staff the option to debrief if necessary, when they feel the time is right.
28. Conduct an incident review where appropriate, reviewing risk assessments and communicating lessons learned to the rest of the team.
29. Facilitate an in-depth clinical assessment of the patient by a MDT to respond to any physical or organic needs or causes of discomfort (e.g. dementia, delirium, depression, other mental disorders, acute precipitants or predisposing factors).
30. Plan ongoing care for the individual and record this in the care plan. Decide who the care plan needs to be shared with (e.g. security staff).

Sub-acute and longer term situations¹⁴

Appendix 2: case studies 1-6 demonstrate how these approaches apply in practice.

The following care strategies are designed to minimise and prevent challenging behaviours:

1 Involve family and carers

- Explain the service routine to the family.
- Ask for personal profile information on the individual for planning care.
- Encourage family contact as often as possible, in line with the patient's or service user's wishes and clinical need.
- Give family and visitors advice on how to interact with the individual and what to expect.
- The family should receive verbal and written information on the effects of the individual's condition and treatments, subject to patient confidentiality.
- Support the family in coming to terms with the events or illness.
- Be proactive and inclusive towards family, carers and other visitors. Can they help with activities, occupation or other care tasks if available and willing to do so?

2 Gather information

- Learn about medical history, liaise with family, carers, clinical staff and the ambulance crew; check records.
- Develop a personal profile: include important chronology and events, personality traits, previous occupations, interests, hobbies, likes and dislikes, preferences, normal routines, needs and aspirations, spiritual, cultural and religious needs and practices. For individuals unable to communicate their needs, family and carers will be able to give detailed information.
- Use something equivalent to the 'This is me' tool¹⁵, or the 'Hospital Passport'.

- Have they got any sensory impairments, physical health problems or any retained abilities? Physical health needs must be attended to.
- Learn about the individual's functional ability, what are they able to do for themselves, what provokes distress and what relieves and calms them; liaison with speech and language therapists and occupational therapists¹⁶ is important here.
- Observe and record any challenging behaviour, using an ABC analysis chart or similar where practical.

3 Group meeting to plan care

- Ensure that all relevant staff work collaboratively in planning care.
- Discuss all possible causes of behaviour (based on the indications under point 2 above). Make a written formulation (explanation). Involve the individual, family and carers (where possible).
- Discuss overall care aims and objectives, all possible care strategies and delivery aimed at minimising distress and meeting needs.
- Think about the effect of patient-staff interactions (including where appropriate gender preferences and cultural sensitivity), routines and environmental factors.
- Look to promote familiarity and routine for the patient or service user.
- Look to minimise lengths of stay, ensure appropriate discharge planning and follow up care, including the use of community mental health and intermediate care teams.

¹⁴ Amalgamated from Poole's Algorithm (2009), Nursing Management of Disturbed Behaviour in Aged Care Facilities NSW Health; includes elements of Brighton and Sussex Foundation Trust (2012), Guidelines for the management of behavioural disturbance and cognitive impairments following acute brain injury.

¹⁵ The Alzheimer's Society, http://alzheimers.org.uk/site/scripts/download_info.php?fileID=849

¹⁶ Occupational therapists specialising in working with people with learning disabilities may offer sensory integration therapy as a treatment approach for challenging behaviour.

4 Initiate care plan

- Make sure that all staff, the patient or service user, their family and carers are aware of the plan, its aims and objectives.
- Discuss the plan at all handover meetings.
- Monitor consistency of approach in applying the plan.
- Plan regular evaluations and modification of the care plan where necessary.

5 Plan communication strategies

- Use the communication techniques outlined on p. 32-33.
- Plan communication strategies to achieve treatment objectives and get agreement from the person if they have capacity, otherwise from their family, carer or advocate.
- Assess the person's communication abilities (both understanding and expression) and change the way you communicate accordingly. See a speech and language therapist report if available and consider referring to a therapist for advice and support.
- If the person has difficulties understanding spoken communication, agree and develop an approach for communicating with them, by discussing with others who have successful communication strategies in place and following recommendations from a speech and language therapist report if available.
- Use appropriate language and be aware of cultural practices; if the person does not understand English, seek an interpreter or family members who are bilingual.
- Make sure hearing aids and glasses are on and in working order where needed. Consider portable external hearing aids if necessary.
- Is the person in bed? Get low to the bed to aid effective eye-level communication.
- If there are barriers to communication, consider moving the individual to a quiet area, reducing background noise (TV, radio etc).
- Use visual methods to support speech

such as pictures and photos (e.g. angry/sad faces), body language and gestures.

- Consider substituting a staff member where the individual may be having difficulties with them, if this forms a barrier to effective communication.
- Always keep calm, even if the individual starts to become agitated or distressed, e.g. trying to get out of bed or pulling at their lines. Do not shout, argue, or become upset in front of the individual.

6 Adapt environment

- Adapt or modify the environment, e.g. make it 'home-like', calm and comfortable, less crowded, reduce noise, improve lighting and avoid temperature fluctuations.
- Allow personal objects, photographs and notes from family and friends and reminders of when visitors will return.
- Address any disorientation and way-finding problems (e.g. the way to the ward, bed and toilet); have reminders of the date, time, location, day and night, if appropriate.
- Reduce excessive noise; switch off radios and TVs if needed. Consider impact of electronic alarms (call buzzers, infusion pumps, mattress alarms, bed brake alarms and telephones) on distress levels.
- Consider moving the individual to an area of low stimulation. A single room is preferable (not appropriate if behaviour suggests a need for social contact, or if falls risk is unacceptably high). Avoid excessive bed moves.
- For individuals in need of stimulation, consider environmental adaptations and designated areas or spaces to engage them and reduce boredom.
- Nurse on low beds for individuals assessed at risk of falling or climbing out of bed.
- Encourage day and night routine. Keep the bed area well lit during the day and dark and quiet at night if safety of individuals allows.
- Allow the individual to move around the

ward or unit corridors with supervision if safe to do so. Consider security measures for staff (e.g. personal alarm, mobile phone).

7 Activity programme

- Involve occupational therapists to assess, intervene in and evaluate activities to promote an individual's health and wellbeing and build their skills and motivation.
- Develop meaningful and enjoyable activities.
- Match activities to a person's interests and current abilities.
- Avoid loneliness and boredom.
- Seek the assistance of volunteers, students, family members and other staff in the planning and delivery of the activity programmes.
- Plan appropriate activities on a daily, weekly (including weekends where practicable) and monthly basis as appropriate.
- Consider discussions, reminiscences, music, games, exercises and creative activities (getting dressed and social eating also constitute valuable activities).

8 Independence and mobility

- Maintain dignity and promote self confidence.
- Encourage the person to do as much as possible for themselves.
- Ensure that attempts to minimise falls do not have restrictive consequences.
- Encourage participation in an exercise programme.

9 Normalise sleep and rest periods

- Allow for a short rest period only in the afternoon.
- Provide exercise, stimulation and daylight during the day.
- Use the bed area for sleep only.

- Avoid caffeine in the evening.
- Provide help and reassurance with toileting and orientation at night.
- Accept that a person may be wakeful at night; provide reassurance and gentle activities.

10 Nutrition

- Make sure that the individual has an adequate diet and has sufficient fluid.
- Can the individual feed themselves or do they need assistance with eating and drinking? Do they eat slowly and need more time?
- Consider strategies for individuals who are at risk, e.g. use a 'red tray' system for those who require assistance during mealtimes from nurses, HCAs and volunteers.¹⁷

11 Document, monitor and evaluate

- Review care plan daily and modify when necessary.
- All changes to care strategy must be documented and communicated to all staff.

¹⁷ Age Concern, (2010), Still hungry to be heard, www.ageuk.org.uk/BrandPartnerGlobal/londonVPP/Documents/Still_Hungry_To_Be_Heard_Report.pdf

Communication techniques: an approach for talking AND listening to an individual when delivering care

Engage

Establish a personal connection, e.g. introduce yourself, make eye-contact, smile, ask how the individual wants to be addressed.

Conversation

Speak clearly and calmly and try to initiate a conversation. Do not be afraid to talk to the person. Talk to family members and carers.

Empathise

'Step into their world.' How would you feel in their situation? Acknowledge their concerns, validate feelings and show compassion.

Listen

Actively listen, accept and validate feelings and ideas expressed. Try to be open-minded and not judgemental.

Reassure

Acknowledge any concerns, anxieties and worries and explain that they will be addressed, wherever possible.

Understand

If there are difficulties with spoken communication, use the individual's first name to get attention, speak slowly, keep information simple, and allow time to process, understand and respond. Avoid sounding patronising.

Clarify

Check your understanding, repeat what you heard back, check it is accurate, ask them to repeat it if necessary.

Question

Consider alternatives to multiple questions, e.g. make statements ('you look unwell today'), use 'we' ('we must do something about that'), ask questions with yes/no answers, or offer a number of choices.

Transparent

Be open, honest and transparent and get your message across when communicating about what needs to be done.

Collaborate

Work out a compromise between what you need to do and what the individual wants or will accept; as a rule look to give choices. Tell the individual 'If you do x, we'll do y.' Tailor the approach if the person has limited reasoning skills.

'Talking through'

Provide a running commentary of what you are doing, e.g. 'now we are going to sit down here' etc. Explain procedures and interventions at each episode of care.

Avoid confrontation

Adopt a firm but gentle tone, if necessary. Avoid using a harsh or patronising tone of voice.

Defuse

Remove yourself from the situation: 'I'll just leave you for a short while'. Consider swapping staff if your communication fails.

Promises

Never make 'false' promises that you cannot keep, e.g. in a busy unit, 'I'll see you in a minute'.

Inquire

Ask about their behaviour: 'When you shout, what does it mean?' 'When you're angry, how would I know that you're angry?' 'What would you like me to do when you're angry?'

Reinforce

Encourage positive behaviours, avoid punitive measures such as embarrassment or humiliation, and allow face saving in front of peers.

Non-verbal communication (including voice tone)

Always consider:

- Giving personal space
- Approaching and communicating in view
- Non-threatening stance and posture (open posture)
- Body movement (avoiding sudden movements)
- Making eye contact
- Friendly and reassuring voice tone
- Facial expression (smile)
- Acknowledging (nodding)
- Appropriate use of touch (reassurance, affection).

Debriefs

Debriefs are distinct from post incident reviews (see Section 2, Part 1). Post incident reviews analyse the incident, to identify weaknesses and prevent it from reoccurring. Debriefs are part of the essential support offered to staff following an incident of challenging behaviour and sufficient time should be allocated for them to take place.

Debriefs should be conducted as a conversation among peers, allowing staff a forum to:

- Reflect on the incident
- Share their reactions and feelings in a supportive environment
- Consider what might be learned from the experience.

A debrief can be arranged at the discretion of the team leader, but a good knowledge of staff members, their attitudes and normal workplace dynamics will assist in determining whether one is needed. A formal debrief is especially beneficial where the incident was serious enough to cause stress, trauma or distress to those who were involved.

Alternatively, for low-level, less serious incidents, staff may request the opportunity to have an open conversation about the incident, or arrange one informally among themselves. In some cases staff may not wish to debrief and may simply wish for the incident to be acknowledged. Staff should be offered other types of support, such as one-on-one meetings and formal psychological interventions (i.e. counselling or therapy) where needed.

Debriefs should have either emotional or educational objectives. Trying to address both in one meeting runs the risk of blurring its focus and may even make what should be a supportive atmosphere feel punitive. These different types of objectives should therefore be dealt with in two separate meetings and the experience is always best for everyone when all meetings are purely supportive.

Consideration should also be given as to whether follow-up sessions are required to prevent or reduce the severity of post-traumatic stress disorder (PTSD), depression, anxiety or general psychological morbidity found in affected staff.

While the utmost sensitivity is required with regard to the possible emotional and psychological trauma experienced by staff members, challenging episodes offer lessons about effective care. Debriefs are invaluable for reflecting on an incident and refining practice. This process, known as 'reflective practice', is an important source of personal professional development, enabling individuals to learn from their own experiences.¹⁸

The timings for debriefs should be determined by the circumstances. For less serious incidents, debriefs may be held soon after the incident. However, for serious incidents, if the debrief is held too soon it may not allow enough time for the stress or trauma symptoms to fully manifest themselves so that people are able to talk about them.

The patient or service user (and their family) should also be given the opportunity to debrief, so they can learn from the situation and be reassured.

Finally, it is also important to celebrate and learn from good practice – what did we do well?

¹⁸ See as an example Christopher John's (1995), Model of Structured Reflection.



Section 4

Medical assessment and management

Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

Medical assessment and management

Introduction

Challenging behaviour can be caused by physical ill health and/or mental health problems and staff need to be skilled in diagnosing its underlying causes. This section provides strategies for both the immediate and longer term medical assessment and treatment of common physical causes of challenging behaviour.

Diagnosis and drug prescription is mostly specific to medical practitioners. Other clinical aspects and responsibilities, including information gathering, liaising with families and other carers, monitoring, review and decision making will be shared with multi-professional colleagues. These factors have been included to encourage a consistent approach.

All professionals need to be flexible and vary their approach according to the situation that presents itself. Good communication with the team and close working with others, especially in dangerous situations, are required. The advice set out in this section applies to all groups, including doctors.

Emergency situations¹⁹

- First, make a rapid assessment of the situation and the safety considerations that apply:
 - If there is a threat to your personal physical safety, ensure that where possible you have the help of one or more other healthcare professionals who are trained in how to work in close proximity to the patient, position themselves safely and apply physical intervention techniques.
 - Is the physical environment safe? (e.g. risk of the individual falling from a trolley)
 - Can accompanying persons help? (e.g. family, security, police). Might they represent a threat as well?
 - It may be necessary to clear the area of other patients, visitors and staff. Crowds can be threatening or intimidating, and reducing levels of arousal may help some patients to calm down.
- Assess for resuscitation needs using the ABCDE approach (Airway, Breathing Circulation, Disability, Exposure), including hypoglycaemia and fitting.
- If you need to get immediate control of an emergency situation in which an individual is uncooperative, agitated or physically aggressive, you may elect to deliver rapid tranquillisation and/or safe physical intervention to maintain safety and facilitate a medical assessment or immediate treatment. This must follow a treatment algorithm and be in accordance with national guidelines²⁰ (see also Section 2 Part 2).
- Should rapid tranquillisation be required, it must be delivered by appropriately trained and competent staff.²¹ Physical intervention, where necessary, must also be delivered safely where at all possible by appropriately trained staff. You must document your assessment of the situation, your (rapid) assessment of mental capacity (in line with the MCA) and justify the decision to use restraint or rapid tranquillisation.
- Make a clinical assessment:
 - Take a history if possible. At a minimum ask about current symptoms, worries, problems and general health (people with dementia can often report accurately on the here and now, even if their recent recall is poor). Prompt about pain, headache, breathing, need for the toilet, hallucinations and delusions, recent falls or trauma.
 - Try to get further information from a collateral source if one is immediately available. Ask about the current problem, previous memory or mental health problems, previous general health and physical function, drug history, alcohol or illicit drug use.
 - Complete any examination not done under 'ABCDE', including level of consciousness, temperature²², cognition (e.g. use AMT score), delirium assessment (e.g. CAM), neurological examination and other aspects of mental state. Seek evidence of delirium, hypoxia, infection, metabolic derangement, poisoning or drug toxicity, causes of pain,

19 Harwood R et al (2012), Guidelines on the emergency control of the acutely disturbed adult patient, Nottingham University Hospitals NHS Trust.

20 NICE CG25 (2005), The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.

21 NICE CG25 (2005), The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.

22 NICE CG 50 (2007), Acutely ill patients in hospital - recognition of and response to acute illness in adults in hospital.

full bladder and constipation.

- Assess communication ability, both understanding and expression, including hearing and vision.
- Order investigations, including FBC, U&E, Ca, CRP, LFT, urine analysis and chest X-ray. If specifically indicated, CT head scan and other tests.
- Consider (later if needs be) tests for vitamin B12, folate, MRI, EEG, LP, blood or urine toxicology, CK (for NMS) and autoantibodies.
- If collateral information is not immediately available, seek it (e.g. by telephone) as soon as possible.

Sub-acute or longer term situations

Assessment

- Try to prevent (or minimise) distress behaviours arising using approaches that meet the person's needs (see Section 3).
- Identify the exact nature of the behaviour, circumstances and possible provoking factors and establish whether these have changed over time. Consider an ABC chart.
- Assess for delirium: <1 week history of increased confusion, fluctuation, inattention or drowsiness. Consider risk factors for delirium in all admissions (i.e. age over 65, cognitive impairment, dementia, #NOF, severe illness)²³ and specifically as a potential cause if there is distress or challenging behaviour.
- If delirium present seek a cause (drugs, drug withdrawal, infection, hypoxia, metabolic, neurological, some combination, something else) and follow a management guideline. Assess clinically as for emergency situations.
- Assess for evidence of other serious mental disorders, e.g. psychosis, depression, anxiety. Seek specialist advice if unsure or for help with managing unfamiliar conditions.
- Identify, document and address provoking or exacerbating factors:
 - Physical problems: pain, constipation, urinary symptoms, fatigue, earache, thirst or hunger.

- Activity-related: boredom, misinterpretation of care tasks.
- Treatment related: catheters, monitors, infusions, effects of medication.
- Environment: noise, temperature, lighting, change of room, ward or bed space.
- Make a formulation (explanation) or diagnosis for the problem behaviour.

Non-pharmacological approaches

- Use approaches based on the care needs of the individual. Review information already collected and seek any missing data, by re-contacting a collateral source if necessary. Work with nursing and other multi-professional colleagues to develop a care plan. Ensure you have information on biography, preferences, routines and previous exacerbating and relieving factors.
- A low stimulus environment (e.g. single room) may be needed.
- Try to involve family or other carers if available.
- Reassure (as often as required), or consider one-to-one nursing care (fear or anxiety is often driving difficult behaviours). Do not confront, punish, embarrass or humiliate.
- If possible try 'leave and return' for things that do not need doing immediately. If possible attempt to engage in activity or distraction. Consider taking the individual to a quiet space to calm down.
- Consider 'watchful waiting': the symptoms may settle over 2-3 days.

Drug treatments

- If symptoms remain problematic, identify the dominant target symptom:
 - Psychosis: delusions or hallucinations (but care over 'delusions' due to forgetfulness)
 - Depression, anxiety
 - Emotional lability; distress (e.g. crying, anger) disproportionate to emotional stimulus
 - Apathy

- Aggression, agitation
- Sleep disturbance
- Wandering
- Vocalisations, shouting, calling out.
- Consider drug treatment if there is distressing psychosis, or behaviour that is harmful or severely distressing to the individual or puts others at risk, or if drug or alcohol withdrawal is likely. Continue individualised care approaches.
- Consider if this could be Dementia with Lewy Bodies or Parkinson's Disease Dementia? Key features: Parkinsonism, visual hallucinations, delusions, fluctuating cognition. If unsure get specialist advice and avoid anti-psychotic drugs.
- Assess capacity to give or withhold consent to treatment. If absent, assess best interests (involve the individual, take account of current and past expressed wishes, values and beliefs, consult family or other carers, use least restrictive option). If unbefriended consult an Independent Mental Capacity Advocate (IMCA) (but do not let this delay treatment which is immediately necessary). Consider if the extent and duration of any intervention constitutes a Deprivation of Liberty and apply for authorisation if necessary.
- Follow a treatment guideline depending on symptoms. See guideline for managing

psychological and behavioural distress in patients with diagnosed or suspected dementia.²⁴

- Consider best location of care. If initial management is unsuccessful, or behaviours cannot be contained, take further senior advice. Refer to mental health services, urgently if necessary.

Follow up

- Review for effects and side effects. Discontinue ineffective treatments. Review again after 6 weeks and three months.
- Consider need for referral to mental health services or community mental health or learning disability teams.
- Communicate treatment changes with GPs and other interested clinicians (e.g. mental health).

24 Harwood R et al. (2012), Managing behaviour and psychological problems in patients with diagnosed or suspected dementia Nottingham Area Prescribing Committee.



Section 5 Training

Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

Training

This section should be read in conjunction with Annex 1, Appendix 3 and case study 7.

Introduction

All staff in direct contact with patients or service users need to be made aware of the key messages contained within this guidance that are relevant to their roles and environment. This will range from basic awareness of challenging behaviour, its causes and how to prevent it, to role specific guidance and training, for example on using ABC analysis charts, care plans and behaviour management strategies.

This training section is intended to help organisations establish the level of knowledge and skills required within different roles and environments and how this can best be delivered. The main focus of this guidance is on preventing challenging behaviour; fundamental to this is understanding the reasons for someone's distress, attentive treatment that meets the person's needs and high quality clinical care delivered by medical, nursing and allied healthcare professionals.

Qualified and experienced staff may have much of the core knowledge and skills required but they will benefit from understanding more about challenging behaviour and the specific tools and strategies that will aid its identification, prevention and management.

Additionally, those performing support roles including care, domiciliary and portering staff in regular contact with patients or service users need to have some understanding of challenging behaviour so that they can recognise triggers and reduce risks to themselves, other patients and service users.

In communicating this guidance, organisations have an opportunity to reinforce key policy messages, including those in directly related areas such as safeguarding, consent and mental capacity.

It may help to consider training at three levels:

- 1. Core learning needs:** An awareness of challenging behaviour for all staff that interact with patients, including non-clinical ward based staff, plus existing Conflict Resolution Training (CRT) requirements.²⁵ Core learning may also include additional training requirements such as dementia or learning disability awareness.²⁶
- 2. Role specific input:** Guidance and training relevant to specific job roles where there are defined responsibilities for the prevention and management of challenging behaviour, such as clinical assessments, care planning, special observations, ABC analysis and delivering individualised care.
- 3. Targeted training and support:** Additional risk based training and support that can be planned, for example in an environment where challenging behaviour and injuries are generally more prevalent, or care is more reactive, i.e. responding to quickly changing needs.

²⁵ Promoting Safer Therapeutic Services (PSTS) training in mental health settings.

²⁶ Alzheimer's Society, person-centred dementia care training, www.alzheimers.org.uk/site/scripts/documents.php?categoryID=200307; and Mencap, learning disability awareness training www.mencap.org.uk/training

These three levels of training are described in more detail under the following headings:

1. Core learning needs

It is important that all staff, whether providing care directly or in a support role, have a basic awareness of challenging behaviour and a common language to describe and deal with it. For many this will be enough to recognise and reduce risks, whereas for others this will simply form a foundation.

This core learning can be delivered in various ways and should include:

Challenging behaviour awareness

A central theme of challenging behaviour awareness should be communication: how, done incorrectly, it can reinforce negative behaviours and how it can be used properly in a positive, preventative way.

Conflict resolution training (CRT)

Frontline NHS staff should also receive training in conflict resolution. This provides input on positive communication and calming skills, but not specifically with regard to challenging behaviour, where communication may be temporarily or permanently impaired. Organisations may choose to provide challenging behaviour awareness as part of a combined course with CRT or include it in other training initiatives such as those addressing staff training needs around dementia²⁷ or learning disabilities.

It is important therefore that all staff interacting directly with patients receive both CRT and the challenging behaviour awareness core learning needs outlined above.

This guidance includes a set of corresponding core learning outcomes. These can be used to support the delivery of challenging behaviour awareness training as part of an enhanced CRT package, see **Appendix 3** or www.nhsprotect.nhs.uk/reducingdistress.

Promoting Safer and Therapeutic Services

The Promoting Safer and Therapeutic Services (PSTS) training in mental health settings may already combine CRT with challenging behaviour awareness. The core learning outcomes that accompany this guidance can be mapped across to PSTS, see Appendix 3.

2. Role specific input

This guidance provides a range of tools and strategies for preventing and managing challenging behaviour which include role-specific responsibilities. Certain roles will require additional focused input on top of the core learning outlined above.

Most people in these roles already have extensive knowledge and training, and the focus is on building upon this in the context of challenging behaviour and the specific responsibilities each of them has in its prevention and management.

²⁷ Department of Health (2012), Common core principles for supporting people with dementia: a guide to training the social care and health workforce, <https://www.gov.uk/government/publications/common-core-principles-for-supporting-people-with-dementia>

The following list, while not exhaustive, provides some examples:

- **Managers** need to be aware of their responsibilities for implementing this guidance and monitoring compliance with it and around risk assessment, encouraging reporting, reviewing incidents and identifying additional training and support needs.
- **Doctors** require training on medical assessment, diagnosis and treatment protocols and tools for challenging behaviour.
- **All clinical staff (doctors, nurses, HCAs, allied healthcare professionals)** require training on developing personalised care strategies and plans for preventing and managing challenging behaviour.
- **Security and/or emergency response team members** need to have a full understanding of their powers, rights and responsibilities, including in relation to procedures such as clinical holding, detention, removal and special observation. They need training in how to prevent, calm and manage challenging behaviour and may need training in the medical risks associated with the use of physical intervention in individuals who may be acutely unwell.
- **Support staff (receptionists, domestic staff, porters, catering staff, cleaners)** need to have an awareness of the common signs and triggers of challenging behaviour, related risks and simple prevention and calming strategies. They also need to understand their role in preventing and managing challenging behaviour.
- **Other agencies** such as ambulance and police services, also need to be made aware of relevant trust guidance and protocols if it is foreseeable that their personnel may also become involved in an emergency situation and/or in physical intervention on an individual, where these can involve substantial risk.

3. Targeted training and support (planned and reactive)

In addition to core and role-specific learning needs, there will be areas within each organisation where there is a higher prevalence of challenging behaviour and where staff will need additional training and support. This can be influenced by such factors as the care environment, patient groups and the nature of the procedures and treatments provided. For example, although an individual with dementia may be treated for a medical matter in various parts of an organisation, some wards may receive a higher number of such individuals for longer periods of time. Similarly, drug and alcohol complications can impact on a range of services yet may be most problematic in a medical admissions ward/unit. There will also be units which can foresee specific challenges relating to, for example, a procedure, a condition, response to treatment or post-operative care.

Organisations should review the risks and needs within each area and identify what, if any, additional targeted training is required. Incident data, supported by staff and stakeholder consultation, will help in identifying any priority areas. As with any risk based approach, the better the reporting and analysis of information on risks and trends, the easier it will be to identify needs and focus support.

Much of the risk can be predicted, allowing training to be planned and reviewed on an ongoing basis; however, there will be situations that occur with little warning and require a quick response. An example could be where an individual is admitted who has complex needs and presents a high degree of challenging behaviour. Organisations should still prepare for such scenarios, for example by having specific environments and appropriately skilled staff to support the individual and their needs safely. It is also important to be able to provide focused/individual-specific problem solving support to areas experiencing difficulty, plus focused guidance and training if needed (see Figure 3).

Figure 3 – Targeted training needs assessment: A risk-based approach



Delivering learning

Core learning is focused mainly on raising awareness of challenging behaviour and the simple steps everyone can take to help prevent it. This can be achieved through one, or a blend of learning methods, including e-learning and course based training. There is an important part to play for role modelling by skilled practitioners (such as mental health and learning disability liaison services) and clinical mentoring.

NHS Protect recommends that CRT must include face to face training.²⁸ Which ever methods are used, it is important that organisations can evidence that key messages are received and understood by staff. This is more likely to be achieved where a learner is actively engaged in activities, interactions and case studies which require them to apply knowledge.

Role specific learning can also vary in approach but it is important to ensure that those undertaking specific assessments and care plans as well as those engaged in behaviour management and response roles are competent

to do so. Staff involved in observations must have their training needs identified.

Medical staff should assess their training needs and how these will be met during appraisal and personal development planning.

Consideration should be given to including key learning within induction and refresher training and threading it into existing pre- and post-registration training and postgraduate medical training.

Targeted training may need to include practical training for staff who are particularly vulnerable and for those that respond to risk behaviours. Nursing, clinical support and medical staff in areas of heightened risk of challenging behaviour may need practical input on how to position themselves and work safely in close proximity to an individual who may be confused, unpredictable and vulnerable. This may include avoidance and disengagement skills and low level skills for containing, guiding and re-directing. For some this may extend to low level holding skills to allow essential treatment and care.

²⁸ NHS Protect (2013), Conflict resolution training: implementing the learning aims and outcomes
www.nhs.uk/documents/securitymanagement/conflict_resolution_training_guidance_july_2013.pdf

Security and/or response teams and nurses in specialist settings such as mental health units may need additional skills to hold an individual who is extremely physically challenging and presents a serious risk to themselves and/or others.

The strategies and skills used to physically manage an individual whose challenging behaviour is non-deliberate in a clinical context can be very different to those taught during conventional breakaway and physical intervention training. It is important therefore that such management strategies are highly relevant to the task or activity performed and appropriate for the patient or service user.

All such training should place emphasis on prevention and CRT, include relevant law and reference NICE, CQC and Deprivation of Liberty Safeguards (DoLS) guidance.

Reinforcing learning

Organisations should also take every opportunity to refresh and reinforce key messages on the prevention and management of challenging behaviour and embed them in core inductions and refresher training.

It is vital that organisations monitor compliance with the training and evaluate the transfer of knowledge and impact of training in a reduction of injuries and restrictive practices.



Section 6

Communication and information sharing

Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

Communication and information sharing

Introduction

Sharing patient identifiable information within the NHS to safeguard patients and protect staff is not a breach of confidentiality.

Patient confidentiality is a core principle of the NHS. However, it is important that the duty to preserve a confidential health service, which is clearly in the public interest, does not impede the sharing of relevant patient information where it is also in the public interest to ensure the public's safety.

The Department of Health's NHS confidentiality code of practice and supplementary guidance should be read in conjunction with this section.²⁹ This will aid the decision making process for sharing patient confidential information where it is necessary to do so. The code of practice specifies that disclosure is permissible where it is made in the public interest to prevent serious harm to others:

In some cases, it will be clear that a proportionate disclosure is required in order to: Prevent serious harm being caused to one or more other individual(s), such as... a serious assault[.]

Methods of communication

Communication and information sharing should be open and transparent and involve the person, family and carers from the outset. A number of methods can help to achieve this.

Transfer

The maintenance of meticulous medical records and care plans which include information on what causes a person's distress and what their specific needs are is vital when an individual is transferred from one care setting to another.

Staff have a legal obligation to relay information (verbally and in written form) on known risks of challenging behaviour and mitigation strategies to the professionals receiving the individual (e.g. behaviour which occurs at the care home, in the back of the ambulance, in A&E, from ward to ward, from ward back to the community).

Information exchange also needs to take place where an individual has been sent for diagnostic tests and returns to their original care setting.

Care plans

Promoting emotional and psychological wellbeing should be a routine part of all care planning. Specific care planning is needed where there is significant distress or challenging behaviour. This should be discussed with the MDT, reviewed regularly and communicated at the transfer of care. Care planning should include the individual where possible or their family, carers or advocate if not. It should incorporate patient profiles, formulations (explanations) of the behaviour, risk assessments and information on the individual's health and social care needs.

Care plans will describe the specific care interventions that have been discussed with and agreed by everyone concerned; they should include all strategies to prevent situations that precipitate challenging behaviour.

In some instances, a copy of the care plan should be given to the individual to discuss treatment goals. If this is not appropriate, its content must be communicated to them by whatever means are necessary in order to aid their understanding. Where an individual is cognitively impaired, care plans should be discussed and agreed with their family, carer or advocate.

Regular review meetings should be held to ensure that the identifiable behaviours have been resolved, or to start the process again if new behaviours are identified.

Shift handovers

Handovers are best practice for continuity of care and serve as important forums to provide feedback on challenging behaviour that occurred during previous shifts and to inform oncoming shifts. Although it is acknowledged that there may be time constraints, the nurse in charge should allocate sufficient time during handovers for communication on changes in the individual's behaviour and solutions for staff taking over care. These should be documented in the care plan. Handovers may be a particularly suitable forum to review low level incidents.

²⁹ Department of Health (2003), Confidentiality: NHS Code of practice; and (2010), Confidentiality: NHS Code of practice - supplementary guidance: public interest disclosures, <https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice>

Profiles and passports

Individual profiles and passports are a way to transfer care information along with the individual, for example when they move from a care home to a hospital ward and back again. The profile or passport should ideally be completed prior to admission by those responsible for the individual's care, or by the primary nurse, family and carers on admission; it will become a valuable running document for staff to add more information to as the individual is moved between care settings.

Post incident reviews

Thorough post incident reviews are vital for learning lessons from a staff and patient safety perspective, updating the care plan and sharing information with all those responsible for delivering care. At a wider department and organisational level, a review of incidents may help to identify shortfalls in the delivery of care (e.g. where a disproportionately high level of interventions have been used) and may require disseminating best practice to staff, updating policies and training programmes.

Markers and alerts

Markers and alerts may be considered to communicate information regarding challenging behaviours. They may refer staff to the care plan or highlight behaviours and simple care interventions. Their use is widespread in mental health and ambulance settings (address flagging) as an integrated part of a risk assessment process.

All individuals deserve equal treatment and care and any decision to add a marker/alert to electronic or paper records should be based on current information (avoiding opinion or hearsay). Staff should avoid forming pre-conceived attitudes towards an individual based on the presence of a marker/alert, and markers should never be used punitively.

Organisations must have arrangements for sharing marker information with other organisations to which the individual is transferred, even where systems for sharing information are incompatible.

There must be clear criteria for notifying a person, their family and carers before adding a marker (if there is an immediate threat this should be done retrospectively), as well as proper review

procedures to delete and remove a marker when there is no longer a risk.

The following CRT descriptors may be adapted for a challenging behaviour marker:

- Compliance – individual does what is requested
- Verbal resistance – saying “no”, swearing, threats (depending on severity can be part of aggressive resistance)
- Passive resistance – non-response to requests, sits or lies down, refuses to move, refuses to take medication etc
- Active resistance – avoids being held, pushes away, puts obstacles in way
- Aggressive resistance – verbal abuse and threats, physical action, e.g. pinching, scratching, biting, slapping, grabbing etc
- Serious or aggravated resistance – throwing objects, objects as weapons, attacking etc.

For further information, see the NHS Protect guidance *‘Procedures for placing a risk of violence marker on electronic and paper records’* (2010):

www.nhsbsa.nhs.uk/SecurityManagement/Documents/SecurityManagement/Procedures.pdf

External information sharing

Information sharing protocols

Any organisation looking to share confidential information externally about a person's challenging behaviour, especially with colleagues working in the community who may be particularly vulnerable, should take advice from their Caldicott Guardian. This is a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing between the NHS, local authorities, social services and partner organisations which satisfies the highest standards.

The Department of Health's NHS code on confidentiality provides the following guidance:

‘NHS organisations should have developed, or be in the process of developing, information sharing protocols that set out the standards and procedures that should apply when disclosing confidential individual information with other organisations and agencies. Staff must work within these protocols where they

exist and within the spirit of this code of practice where they are absent.'

It is recommended that organisations develop information sharing protocols to prevent and manage challenging behaviour, in accordance with the legal framework described under the following headings:

Common law

Confidential personal information can be disclosed with the consent of the person, or without their consent where it is in the public interest or it is required by law. It is in the public interest to share proportionate patient confidential information in relation to challenging behaviour where there is a risk of harm to patients or staff.

Crime and Disorder Act 1998

Confidential patient information can be disclosed in the public interest where the information is needed to prevent, detect or prosecute a crime or disorder and for crime reduction purposes. These principles are in accordance with Section 29 of the Data Protection Act.

European Convention on Human Rights

The sharing of personal data must be in accordance with Article 8 of the European Convention on Human Rights:

'Article 8

- 1. Everyone has the right to respect for his private and family life, his home and his correspondence.***
- 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.'***

Public authorities have a duty to share confidential information concerning challenging behaviours in the interests of public safety.

Data Protection Act 1998

The processing and disclosure of personal data must adhere to eight 'Data Protection Principles'. These specify that personal data must be:

1. Processed fairly and lawfully
2. Obtained for specified and lawful purposes
3. Adequate, relevant and not excessive
4. Accurate and up to date
5. Not kept any longer than necessary
6. Processed in accordance with the data subject's (the individual's) rights
7. Securely kept
8. Not transferred to any other country without adequate protection in situ

The Information Commissioner's Office (ICO) advises on and enforces the Data Protection Act 1998 in relation to the sharing of confidential information:

http://www.ico.gov.uk/for_organisations/data_protection/notification/need_to_notify.aspx

Caldicott Principles

Information sharing protocols governing information sharing between organisations should adhere to the following principles:

Principle 1

Justify the purpose(s).

Principle 2

Do not use patient identifiable information unless it is absolutely necessary.

Principle 3

Use the minimum necessary patient identifiable information.

Principle 4

Access to patient identifiable information should be on a strict need-to-know basis.

Principle 5

Everyone with access to patient identifiable information should be aware of their responsibilities to maintain confidentiality.

Principle 6

Understand and comply with the law.



Section 7

Organisational responsibilities

Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

Organisational responsibilities

Introduction

Healthcare providers must face up to the challenge of preventing challenging behaviour. The Winterbourne review³⁰ highlighted the failure of residential care managers to recognise the warning signs and address the poor delivery of care which led to a culture where abuse could happen. The Francis Report³¹ highlighted shortfalls in care, higher than normal mortality rates and numerous complaints by staff, patients and relatives that went unheeded by senior managers and the trust board.

Both reports recommend that providers should be accountable for having in place good systems of governance and processes to deliver the highest quality of care.

PART ONE – Responsibilities

Chief executives, boards and senior managers should demonstrate strong leadership, to effect the delivery of high quality and safe individual care. This should be a central strand of clinical governance and effectiveness.

Providers of NHS care must liaise with commissioners to optimise the individual's positive experience of care and protect them from harm; see Domain 4 and 5 of the NHS Outcomes Framework domains for commissioning health services from 2012-13:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131700

A board strategy to prevent challenging behaviour must require:

- The delivery of planned care of the highest quality, where the individual experience is of equal importance to any other organisational goal
- A commitment to the safety of patients, service users and staff
- A commitment to a reduction in restrictive interventions
- An emphasis on compassionate, person centred care³²
- Availability of sufficient resources, access to training, teaching and supervision by specialist staff and commitment to a highly skilled workforce
- Having a challenging behaviour group/lead, where appropriate, to roll out a prevention strategy across the organisation
- Strong leadership from senior clinicians, directors of nursing, general and clinical managers and ward managers, to oversee the care delivered by ward staff
- Approval and implementation of effective policies and procedures which are strongly weighted towards prevention
- Gaining assurance that these priorities are being met through regular feedback, evaluation of outcomes and incident analysis.

Costs to the organisation

There is a lack of evidence on the true financial cost of challenging behaviour in the NHS, although it is generally agreed to be very high.³³ NHS Protect estimated that the total financial cost to the NHS of physical violence was £60.5 million during 2007-08.³⁴ Attributable costs include staffing (sickness, absence and replacement), litigation and damages, provision of Conflict Resolution Training (CRT), extra policing and staff turnover.

At an organisation level, the costs are significant. One 'typical' large mental health trust reported 759 physical assaults and 1,427 non-physical assaults in 2009-10. The number of staff days lost through absence immediately following an incident was 872 days. When replacement costs were added, the overall loss to the trust was £122,000.

In another 'typical' large acute trust in 2012, its

30 Department of Health final report (2012), Transforming care: A national response to Winterbourne View Hospital, <https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response>

31 Robert Francis QC (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, www.midstaffspublicinquiry.com/report

32 Department of Health (2012), Compassion in Practice, nursing, midwifery and care staff, our vision and strategy, www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

33 Studies have found links between the increased costs of providing services for those with learning disabilities and challenging behaviour (Knapp et al 2005).

34 NHS Protect (2010), Cost of violence against NHS staff – A report summarising the economic cost to the NHS of violence against staff.

security pay budget was around £1.4 million and the bulk of this cost was attributable to managing challenging behaviour. The security team dealt with 142 physical assaults and 185 non physical assaults, 80% of which were linked to clinically related challenging behaviour. They also responded to 263 calls for assistance with confused patients, conducted 87 clinically related restraints and attended 209 calls to help deal with patients with mental health issues and patients leaving wards or A&E against medical advice. Attributable costs include £63,000 spent on security officer 'bed watches' and £50,000 on CRT and physical intervention training.

Benefits to the organisation

Preventing challenging behaviour has numerous benefits including:

- Financial savings, with reductions in lengths of stay, re-admission rates, staff absence, staff turnover, observations, and stocks of items, safety equipment and medication
- More efficient, effective and productive delivery of healthcare, fewer physical interventions and better outcomes
- Delivery of important national priorities around better quality of care, compassion in healthcare, and dignity and respect
- Increased staff confidence, satisfaction and motivation, and improved staff retention
- Increased patient, service user and carer satisfaction and reduction in complaints and litigation
- Better systems for communication, reporting and discussing solutions
- Enhanced organisational reputation.

Legal responsibilities

Care Quality Commission outcomes

Healthcare organisations must comply with the Care Quality Commission's (CQC) regulatory framework: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect.

Preventing challenging behaviour is essential to demonstrate compliance with CQC

outcomes around Involvement and information; Personalised care, treatment and support; Safeguarding and safety; Staffing; and Quality and management.

More information is available at:

www.cqc.org.uk/sites/default/files/media/documents/gac_-_dec_2011_update.pdf

Health and safety legislation

Ensuring the health and safety of staff is coterminous with minimising challenging behaviour. The Health and Safety at Work etc Act 1974 is the primary piece of legislation covering occupational health and safety in the United Kingdom and is enforced by the Health and Safety Executive. A breach of an employer's duty under the act may be dealt with through criminal law.

Under the act, organisations have a legal duty to ensure, as far as reasonably practicable, the health, safety and welfare of their employees and other people who might be affected by their business, i.e. patients, service users, visitors and the public.

The following regulations, made under the act, must be considered when managing the risks from challenging behaviour:

- The Management of Health and Safety at Work Regulations 1999 require employers to assess risks to employees; identify the precautions needed; make arrangements for the effective management of precautions; appoint competent people to advise them on health and safety; and provide information and training to employees.
- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) put duties on employers to report serious workplace accidents, occupational diseases and dangerous occurrences (near misses). This includes any act of physical violence to a person at work which results in sickness of over 7 days.

More information is available at:

www.hse.gov.uk

Other responsibilities

Local Security Management Specialist

Where applicable, organisations must employ or have access to a Local Security Management Specialist (LSMS) to ensure the safety and security of those who work within and use the NHS. The LSMS's responsibilities include:

- Ensuring that the organisation has robust and up-to-date policies and procedures for the prevention and management of challenging behaviour
- Advising on physical security measures, to improve the safety of staff (e.g. personal alarms, physical security, CCTV)
- Assistance in ensuring that technology is available to protect lone workers
- Playing an active part in incident reporting, risk assessment and advising on appropriate security and training provisions to protect staff
- When necessary, liaising with and assisting the police with their investigations
- Assisting clinical staff where necessary in a post-incident review to identify lessons learnt.

PART TWO - Organisational strategy for preventing challenging behaviour

An organisational strategy to fulfil the requirements outlined in Part One should be underpinned by policies and procedures that incorporate the following:

Changing culture

Putting patients and service users first in everything that is done is the starting point for delivering the highest quality care which minimises the risk of challenging behaviour.³⁵

Ensuring that organisations have a patient focused culture which prevents challenging behaviour takes time, resources, leadership,

continuous effort and a commitment by all. It includes all staff having a shared vision and values based on the NHS Constitution.³⁶

Cultural change to prevent challenging behaviour requires the same level of commitment in any clinical setting, from emergency settings to older persons' care. This may require redesigning models of care where necessary, e.g. the delivery of direct care putting an emphasis on staff having time to engage and talk to patients whilst undertaking their duties.

Staff should be encouraged to provide regular feedback about the standards of care and should feel supported to raise issues without fear of recrimination. Regular 'clinical supervision' may assist staff in sharing concerns.

Staff should have a clearly established confidential route to make complaints or whistle-blow if they have serious concerns about safeguarding and/or staff safety, in line with local policies and reporting procedures.

Reporting

Data from the latest NHS Staff Survey suggests that just under two-thirds of incidents of physical violence and 44% of bullying, harassment and abuse cases were reported.³⁷

Some of the reasons for underreporting include:

- Stoical acceptance and tolerance on the part of staff in the face of adversity
- Staff empathising with the ill person and not blaming them
- Staff concern that reporting may reflect poorly on their ability to manage an incident
- Reporting being too complicated, time consuming or not suitable for lower level incidents
- Staff perception that no action will be taken to give them adequate support
- Lack of management feedback on actions taken to tackle or reduce incidents.

Key messages for managers to pass on to staff to encourage reporting include:

³⁵ Department of Health (2013), Patients First and Foremost, The initial government response to the report of the mid Staffordshire public enquiry https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

³⁶ Department of Health (2013), The NHS Constitution-The NHS Belongs to all of us, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

³⁷ NHS Staff Survey, (2012), <http://www.nhsstaffsurveys.com/cms/>

- A high level of reporting is an indication of good organisational governance, a commitment to ever improving care and recognition of the need to support victims.
- Reporting assists risk departments in identifying trends, patterns, 'hotspots' and lessons learnt. It helps identify whether incidents were down to the behaviours of one or two individuals, or indicative of wider phenomena requiring action across a service or organisation.
- Reporting has an inherent value to risk management and improved care by:
 - Enabling immediate changes to the care plan and the delivery of care
 - Enabling improvements to the delivery of care, e.g. modifications to the environment making care more needs focused
 - Providing a mechanism for staff to receive support and feedback
 - Providing a learning opportunity for staff to problem solve and develop solutions.
- Managers should provide feedback to clinical teams summarising what incidents occurred in the preceding month and changes made to respond to them.
- Reporting should be made as easy as possible, by looking to reduce duplication on incident forms and other risk and care planning documentation.
- Wards may find it impractical to complete a detailed incident form for low level incidents and may consider incorporating a less detailed form into existing systems.
- Wards may consider keeping an incident tally. This gives staff a sense of ownership in the implementation of local strategies to prevent future incidents, and gives them confidence and control over their working environment.³⁸

Risk management

If organisations do not have robust processes for assessing risk, decision making may well be based on anecdotal evidence and perceptions of risk. Risk assessments, underpinned by incident reporting, can take place at different levels:

- Individual risk assessments on admission or

post incident to feed into the person's care plan

- Unit/ward risk assessments that require a MDT response to change the delivery of care
- Serious incidents which threaten service delivery, staffing and resources and require a risk management group or committee and board/senior management level response.

Where risks of challenging behaviour are identified, risk reduction measures should include:

- Training needs analysis and new programmes
- Staffing: review of numbers, skills mix, use of agency staff and HCAs, shift patterns
- Environmental audit and redesign
- Review of current working practices
- Better protection of vulnerable staff, e.g. lone workers.

Protection of lone workers

Lone workers, especially those who are community based, are particularly at risk from challenging behaviour. Lone workers need to be identified, their duties risk assessed and prevention measures put in place. These may include access to personal safety training, specific technology, a buddy system, support from other colleagues, an escalation process and when to withdraw to places of safety. See NHS Protect lone worker guidance:

www.nhsbsa.nhs.uk/4248.aspx

Training

Training programmes for preventing challenging behaviour should be underpinned by training needs analysis and the delivery of bespoke training. A 'broad brush' approach does not meet the needs of staff, leads to low levels of compliance and satisfaction and is a poor use of resources. To be effective, clinical staff must be released to attend face-to-face and refresher training programmes.

A tailored programme should include:

- Core skills (challenging behaviour awareness and CRT/ PSTS, accompanied by additional training such as dementia or learning disability awareness)

³⁸ Design Council (2011), Reducing Violence and Aggression in A&E, <http://www.designcouncil.org.uk/our-work/challenges/health/ae/>

- Role specific learning (delivering individualised care, clinical assessment and care planning)
- Targeted training (assault reduction and physical intervention).

Role specific learning should be part of continuous professional development. This must be available to all healthcare professionals both pre- and post-registration, and to healthcare assistants and assistant practitioners as appropriate to their role (see Section 5 Training).

Staffing

Even if staffing levels are not considered low in relation to the normal nursing template for a particular patient group, it only takes one or two individuals showing challenging behaviour to skew the allocation of staff on a ward and create a situation where it is impossible to deliver good quality care.

Delivering compassionate care requires staffing levels to be sufficient.³⁹ The RCN links minimum staffing levels to better outcomes for patients, better quality of care, better experience, more efficient and effective working and fulfilling CQC's inspection requirements to safeguard the health, welfare and safety of patients and service users.

See:

www.rcn.org.uk/__data/assets/pdf_file/0009/439578/03.12_Mandatory_nurse_staffing_levels_v2_FINAL.pdf

When planning care, organisations need to consider:

- Optimum staffing levels to deliver compassionate care
- Mapping of staff skills levels and mix to the provision of care
- Recognition of the positive contribution that continuity of care makes to preventing distress and meeting needs
- Decisions on the best use of temporary staff and HCAs
- A central register of those with physical intervention training.

Delivery of care

According to the NHS Institute for Innovation and Improvement, ward nurses in acute settings spend an average of just 40% of their time on direct individual care. The Productive Ward programme aims to help healthcare professionals to evaluate the processes of care within their ward/unit, to free up staff time to enable them to provide more direct care. This includes organising the ward space so that the delivery of care is more reliable, efficient and safe, thereby improving the experience of both staff and patients or service users.

One proviso, there is an inevitably a degree of paperwork involved in care planning, and although this is not classed as direct care, it is an important part of planning care.

See:

www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

Care environment

A well designed, maintained and managed care environment can minimise a person's agitation and distress, reduce staff stress levels and enable them to take ownership and help achieve an environment in which optimum standards of care can be delivered.

The King's Fund's Enhancing the Healing Environment (EHE) programme has shown that relatively straightforward and inexpensive changes to the design and fabric of the care environment can have a considerable impact on patient wellbeing, as well as improving staff morale and reducing overall costs. Early audits have shown a reduction in falls, incidents of violent and aggressive behaviours and the use of anti-psychotic medication in mental health settings. For more details on how this programme helped transform a dementia ward, see Appendix 2, Case Study 3.

See the overarching design principles and an environmental audit tool at:

www.kingsfund.org.uk/projects/enhancing-healing-environment

³⁹ Safe Staffing Alliance (2013) recommends an absolute minimum of one nurse to eight patients (1:8) otherwise patient care may be jeopardised.

The Design Council programme 'Reducing violence and aggression in A&E' recognised that violent and aggressive behaviour can result from personality characteristics, pain or anxiety and environmental factors. The following escalatory factors can push some individuals over their 'tolerance threshold':

- Crowds or clash of people
- Lack of progression and/or long waiting times
- Inhospitable environments
- Dehumanising environments
- Intense emotions
- Unsafe environments
- Perceived inefficiency
- Inconsistent response to challenging behaviour
- Staff fatigue.

The project produced three solutions:

- 1) Better information and communication to reduce a patient's anxiety levels
- 2) A staff centred programme to enable staff to engage directly with issues of violence and aggression
- 3) A design toolkit, including environmental layout and atmospheric recommendations.

See:

www.designcouncil.org.uk/our-work/challenges/health/ae/

Personalised care

Finally, when developing this guidance, one of the best guides we came across illustrating how to deliver good care is: Dementia: Understanding the risks and preventing violence, published in Canada by WorkSafe British Columbia.

See:

www2.worksafebc.com/Topics/Violence/Resources-HealthCare.asp

Annex 1 – Clinically related challenging behaviour - prevention and management training

Level	Core		Role specific	Targeted: Risk based	
Module	Clinically related challenging behaviour awareness	Conflict resolution training (CRT)		Clinical assault reduction training	Physical intervention skills
Content	<p>Awareness</p> <p>Recognition</p> <p>Risks</p> <p>Prevention</p> <p>Responsibilities</p> <p>Support</p>	<p>Risk awareness</p> <p>Dynamic risk assessment</p> <p>Responsibilities</p> <p>Communication</p> <p>Calming</p> <p>Reporting</p> <p>Support</p>	<p>Assessment and diagnosis</p> <p>Care planning</p> <p>Delivering individualised care</p> <p>Preventative strategies</p> <p>Special observations</p> <p>Behaviour management</p> <p>Problem solving</p> <p>Recording and support</p>	<p>Risk awareness</p> <p>Proxemics and positioning</p> <p>Safer practices</p> <p>Avoiding blows</p> <p>Relevant releases</p> <p>Guiding and re-directing</p>	<p>Policy, law and ethics</p> <p>Relevant and appropriate restrictive skills</p> <p>Medical risks</p> <p>Duty of care</p> <p>Teamwork</p> <p>Leadership</p> <p>Emergency response</p>
Audience	All staff with direct individual contact (can be a combined course)		As appropriate for doctors, nurses and managers	As appropriate for doctors and nurses working in heightened risk environments	Security and response functions
Links	Integrate with: Violence reduction policy, NICE, CQC, DOLS				



Appendices

Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

Appendix 1

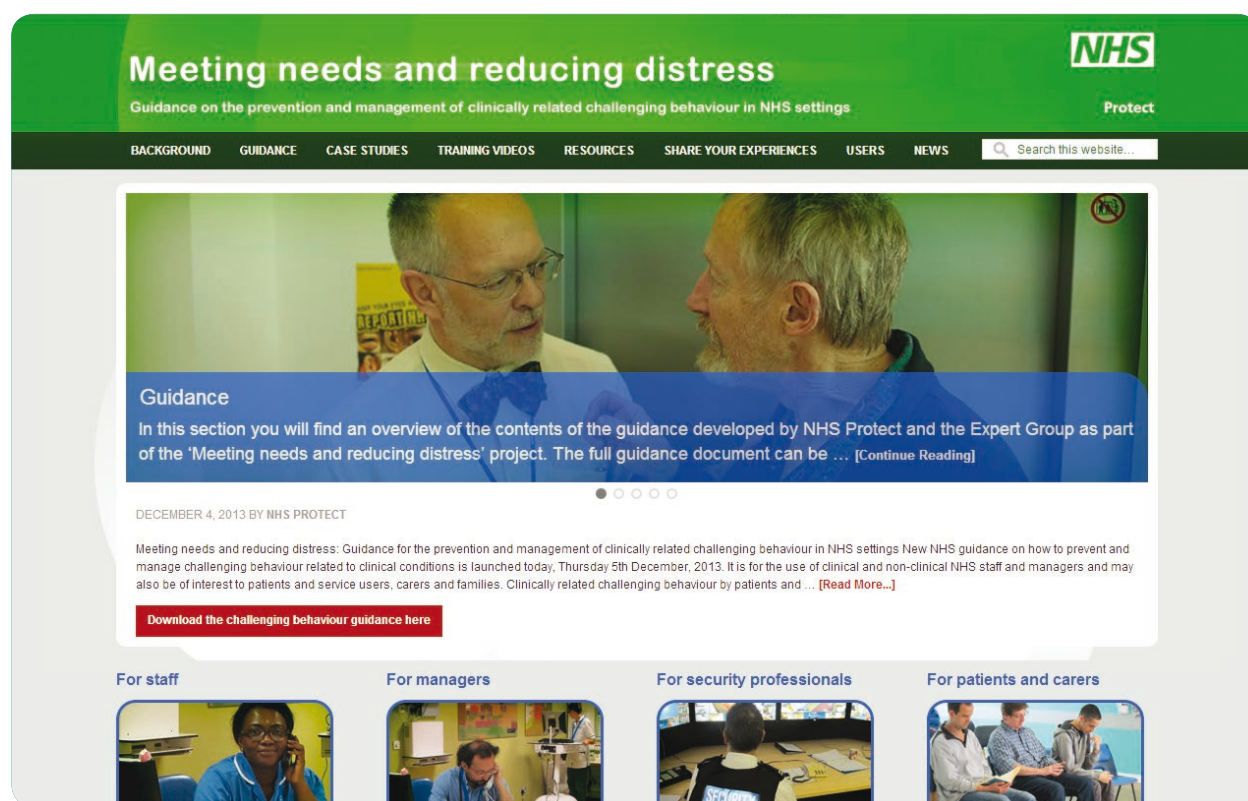
Challenging behaviour website

NHS Protect has developed this website as a point of reference and best practice for anyone who would like to learn more about the prevention and management of challenging behaviour:

www.nhsprotect.nhs.uk/reducingdistress

The website includes the following key content:

- A downloadable copy of this guidance, summaries of each section, case studies and useful tools for clinical staff
- A set of core learning outcomes to assist trainers in delivering challenging behaviour awareness training in clinical areas
- Scenario-based videos which can be incorporated into staff inductions and challenging behaviour awareness training or used as a separate learning resource for staff
- A valuable resource for staff to share their experiences in preventing and managing challenging behaviour.



Appendix 2

Case studies

1. Imperial College
Healthcare NHS
Foundation Trust

Learning disabilities

2. Sussex Partnership
NHS Foundation Trust

Learning disabilities

3. King's College
Hospital NHS
Foundation Trust

Dementia

4. South London
and Maudsley NHS
Foundation Trust

Dementia

5. Cambridge
University Hospitals NHS
Foundation Trust

Mental ill health

6. South London
and Maudsley NHS
Foundation Trust

Mental ill health

7. Brighton and Sussex
University Hospitals NHS
Trust

Training

1 Imperial College Healthcare NHS Foundation Trust

Background

A 40 year old woman was brought into a London emergency department by ambulance following an episode of prolonged fitting. Her arrival caused disruption, as she was very combative, both with the ambulance personnel and with the emergency staff. She presented as incoherent, uncoordinated and very unstable on her feet. Despite this physical vulnerability, she refused to sit on a trolley or on a chair and backed herself into a corner of the resuscitation room.

On presentation, the clinical team's judgement was that she had no serious injury or illness that put her in immediate physical danger.

Personalised interventions

Very little was known about this woman, which is often the case in the emergency department. The staff observed that initially she appeared to be mute but then became increasingly agitated on overhearing staff discussing her condition. All well-intentioned efforts to calm and reassure her were met with great resistance on her part. The woman appeared very frightened and anxious and the initial impression was that she had a severe neurological or psychiatric condition. Mindful of her safety and their own, the majority of emergency staff withdrew to an observable distance, leaving one senior member of nursing staff with her. This appeared to alleviate some of her anxiety and the nurse tried various different methods to communicate with her. The nurse had experience of caring for patients with learning disabilities and discovered the woman responded to sign language. It appeared that all she wanted to do was to walk. The nurse spent the next hour walking around the department with the woman, supporting her and calmly reassuring her but at the same time managing to assess her and find out more about her.

Outcome

The more the woman walked, the more her mobility improved and she then began to



talk. It transpired that she had a learning disability and suffered from epilepsy. What had happened that day was not unusual for her. After having a fit she would normally experience transient loss of speech and have difficulty mobilising. Once the woman had gained her equilibrium she was quite happy to sit down and be formally assessed.

Key messages

The emergency department is a fast moving environment; it is a bright, loud and at times intimidating place in which to treat patients. It is therefore essential that emergency staff recognise what effect this environment may have on their patients and are creative and adaptive in order to meet their needs effectively, rather than expecting them to conform to conventional hospital practices. The approach has to be centred on the individual involved and above all must be kind and compassionate. The woman in this case needed time, understanding and a period of one-to-one attention in order to be able to communicate effectively and recover. Among the competing demands of a busy emergency department, it is essential that staff recognise the importance of such interventions and give them the priority that they deserve.

Source: Julia Gamston, Senior Nurse, Emergency Department, Imperial College Hospital Trust

2 Sussex Partnership NHS Foundation Trust

Background

Gary is a 37 year old man with learning disabilities who also has a diagnosis of autism. These factors impact on him to the extent that he has no spoken language, major skills deficits and some challenging needs – he has behavioural outbursts which put himself and others at risk and cause serious damage to the environment. Like many people on the autistic spectrum, predictability and familiarity are very important to him, and he can become very distressed when faced with sudden and unexpected changes to his routine and when the world becomes a confusing place.

Gary moved out of the family home when he was 19 and entered residential care. Sadly, this did not go smoothly; for the next five years he was moved from one placement to another as each failed to provide appropriate care and support for him. There were a range of factors to account for this including inadequate planning, poor management, low staffing levels, unskilled and inexperienced staff, co-resident incompatibility and so on. By the end of a third unhappy placement, Gary was extremely distressed and his behaviour had deteriorated alarmingly.

Personalised interventions

It was at this point that a single person service was commissioned for Gary, predicated on the Positive Behaviour Support (PBS) model. PBS promotes a highly person-centred approach to service design so that the service is tailored to individual need. Accordingly, interventions are based on a proper functional analysis so that the causes of challenging behaviour, rather than the symptoms, can be effectively addressed. However, PBS is not simply concerned with reducing challenging behaviour; it is, equally importantly, designed to address the wider questions regarding lifestyle and personal development. In Gary's case a service has evolved which, increasingly over time, has provided him with:

- A timetable of activities that reflects his preferences and needs
- Opportunities to develop new skills relating to, for example, choice-making,



communication and daily living

- Predictability and consistency of routine
- A stable staff team who know him well and who are effectively managed; and
- A robust organisational framework of service delivery whose component parts work together in a logical and coherent way.

Outcome

Gary has now lived alone, with staff support, for 12 years. He has a rich and varied community based schedule which allows him to carry out the ordinary activities of daily life as anyone else might do, attend health appointments when necessary, have holidays and follow other leisure pursuits, eat out in pubs and restaurants and so on. Importantly, he now sleeps well at night – which had previously long been a problem – and this represents just one significant barometer of positive change.

He has come a long way from the forlorn figure he had become twelve years previously – angry, depressed, confused and disengaged from life. Since that time much productive effort has been invested in providing a truly person-centred service which has demonstrated the potential for change to occur even in the most unpromisingly extreme circumstances.

Sources:

Shephard (2012) In celebration: living a life through Positive Behaviour Support. Tizard Learning Disability Review Volume 17 Issue 2 2012.

Baker & Shephard (2005) The rebranding of behavioural approaches for people with learning disabilities and challenging behaviour. Learning Disability Review, 10,2. 12-15.

3 King's College Hospital NHS Foundation Trust

Background

Marjory Warren Ward is a 30-bed ward on the Health and Ageing Unit. The ward treats and cares for older people, many of whom will have dementia, delirium or a combination of the two conditions. The ward was not originally designed to specifically accommodate the needs of patients with dementia.

Hospital admission can be a distressing and overwhelming experience for patients with dementia. Environmental factors can trigger behavioural changes in this patient group, whereby patients often wander due to understimulation or because signage is inadequate and they are looking for something. It is recognised that boredom and a lack of stimulation can cause agitation.

With generous funding provided by The King's Fund 'Enhancing the Healing Environment' (Environments of Care for People with Dementia) programme, together with donations from the Friends of King's College Hospital and the trust itself, Marjory Warren Ward was transformed into a dementia-friendly environment in 2012. The main aim of the project was to improve the general ward environment for people with dementia by enhancing the décor to ensure it complies with current best design practices. The project team identified four main areas for improvement:

- Entrance to the ward
- Day room
- Nurses' station
- General orientation and clinical 'feel' to the ward.



Transformation of the ward

The entrance was transformed to make it more welcoming for visitors to the ward.

The ward corridors were transformed into pleasant walkways by the use of appropriate artwork, colour and provision of lighting and interactive tactile surfaces. The 'clinical feel' of the ward was dramatically reduced. Hand-rails and non-slip flooring were installed throughout to promote independence and safety when mobilising. Patterned, shiny floors which might confuse people with dementia were replaced throughout. Lighting and signage were improved and day and night clocks were put up to aid orientation.

The overall ward environment was 'de-cluttered' through innovative use of storage. Seating and artwork were installed around the nurses' station to encourage patient interaction.

Seating was installed outside the ward entrance to provide a 'quiet haven' for patients, staff and visitors and enable them to admire the views of London from the windows there.

The existing dayroom was transformed into a multi-sensory space. The room needed to be flexible enough to be used both for agitated patients who might require a low stimulus environment and as a space where structured and unstructured activity could also take place. Lighting, imagery and sounds can also be adjusted to suit mood in addition to the provision of reminiscence materials and atomisers. Portable sensory equipment is also provided to stimulate activity in patients who are bed-bound or who are confined to a side room for infection control reasons.

Artwork was installed in every bay to make each area distinct. Bed numbers are clearly shown to help aid orientation.

Artwork was installed throughout the ward including a tactile quilt created by patients, staff and carers with support from the Dulwich Picture Gallery. Images of the London skyline and local landmarks are seen throughout the ward to trigger conversations and memories and provide a more homely, less threatening environment of care for people with dementia.



Conclusions

Marjory Warren Ward is now one of the highest scoring wards in the trust's patient satisfaction survey, which includes the environment. Patients feel more confident when mobilising. Anecdotally, when patients are transferred to Marjory Warren Ward from the Medical Assessment Unit with one-to-one nursing, this is not required 24 hours after admission to the ward. The overall impression from patients, staff and visitors is that the environmental improvements have had a significant positive impact on patient wellbeing and also on staff motivation levels.



Feedback

Makes you forget about your problems for a while – Patient

Apart from the amazing environment, smells and views, I was struck by how contented the staff looked. It's brilliant. I want to work here – Visitor

The ward is very patient-centred, calm and homely – Visitor

The ward appears very friendly and relaxing. The flooring especially has reduced the falls. Patients can walk or mobilise without the fear of falling. Sensory Room - Very relaxing and calming environment for patients and families to sit. I am very happy to work in this environment. Much cleaner, tidier and relaxing - Junior Sister, Marjory Warren Ward

Not only has the new ward enhanced the environment for patients, the staff have clearly benefited. There is a renewed enthusiasm for work which is resulting in improved quality of care and improved perceptions of care from the patients. - Consultant Physician, Marjory Warren Ward.

Source: Emma Ouldred, Dementia Nurse Specialist, King's College Hospital NHS Foundation Trust

4 South London and Maudsley NHS Foundation Trust

Background

Mr J has been admitted to an acute older persons' mental health unit for assessment of non cognitive symptoms of dementia. He is finding it difficult to get used to the unit and cannot remember why he is here. At busy times of the day, Mr J will attempt to leave the unit, which will affect his well being and safety. At times he can become verbally aggressive and there have been a few occasions when he has pushed staff out of the way in order to leave the ward. Mr J verbalises repeatedly "why are you keeping me prisoner, who are you?"

Personalised interventions

Mr J's primary nurse spent time with him and the family to obtain a life story at the time of admission. The primary nurse used the 'This is me' tool to obtain Mr J's likes and dislikes, activities he enjoys, his role in society and the values he finds most important. This tool enabled staff to be clear about Mr J's preferred names, what he likes to eat, his favourite clothes and what is helpful at times of distress. Mr J really enjoys a clean shave and his wife demonstrated how he likes this done. All this information was used to inform his care plan.

Based on the information received and what has been observed since he has been on the ward, at the times when Mr J is distressed the following has been helpful:

- Speaking clearly, slowly, using his preferred name and ensuring he has time to respond in every interaction
- Answering any of Mr J's question honestly and as succinctly as possible
- In any interaction, ensuring that Mr J is orientated to the environment
- Increasing staff one-to-one time at these times
- Showing Mr J familiar objects that he likes
- Providing an activity that he enjoys at the times he is likely to be distressed. This could include listening to music, reading a



newspaper to him, walking in the garden, looking through his family photo album with him, talking about past positive memories, use of therapeutic touch and offering drinks that he likes

- It has been observed that Mr J is less distressed at busy times when his wife visits – flexible visiting for his wife and family to attend has been implemented
- Helping Mr J to speak with his wife on the phone
- Involving Mr J in helping staff with tasks so that he feels useful and significant.

Outcomes

- Overall reduction in Mr J's distress; as a result of a team approach that delivers responsive care, incidents are resolved quickly
- Staff feel supported and enabled to provide responsive care
- The family state that they feel involved in Mr J's care and feel that he is safe in hospital
- Mr J is spending less time at the door and has made no attempts to leave
- Mr J appears to recognise staff and positively interacts with them.

Key messages

- The critical dimension of **ALL** care is to be kind, compassionate, respectful and to treat the person how you would like to be treated
- Always look behind the behaviour that the person is presenting with and try to understand it
- Challenging behaviour in dementia is the person communicating something and it is our role to know the person so we have a better understanding of what they are trying to say
- Staff must always see the **PERSON** with dementia rather than the person with **DEMENTIA**⁴⁰
- Family and informal carers are crucial to understand the needs of the person and their full involvement in care will lead to better outcomes.

Source: Vanessa Smith, Assistant Director of Nursing and Quality: Mental Health of Older Adults and Dementia Clinical Academic Group, South London and Maudsley NHS Foundation Trust.

⁴⁰ Kitwood, T.M. (1997) Dementia Reconsidered: The Person Comes First. Buckingham: Open University Press.

5 Cambridge University Hospitals NHS Foundation Trust

Background

The individual is a 38 year old female. She has a personality disorder of the anti-social and impulsive type and a heavy substance misuse problem. She has some forensic history, having being detained in a secure forensic unit, and has also been in prison for burglary. She has been treated under the Mental Health Act three times in the last eight years and has one admission to a Psychiatric Intensive Care Unit (PICU).

Her mother died of a drug overdose when she was 8 years old. Her father, an alcoholic, died 3 years ago; they had lost touch but were briefly reunited before he died. She has one sibling, a professional, although she has no contact with them. She was born in London and had a very difficult childhood. She was sent to special school for behavioural disturbance, was bullied by other local children and called "stupid" and worse. Her poor reading and writing abilities indicate that she is dyslexic. Her father physically abused her and she hid in a cupboard frequently to avoid him. She left home at 14 years of age to live with travellers; her mother had also been a traveller. She has a heavy drug habit (less so now as has come off crack cocaine by herself and heroin) and misuses alcohol.

For her current admission, she went to the emergency department saying she was suicidal, however she was deemed at low risk and discharged. Following discharge, she jumped 20 feet and fractured both ankles.

Her challenging behaviour followed admission to a busy orthopaedic ward and she was placed in a single room to try and manage the disruption. She shouted abuse at nurses from the room saying she needed painkillers. The nurses found it difficult to care for her as she was very intimidating. They also found it difficult to develop a rapport with her. She would lower herself from the bed and shuffle into the corridor on her bottom and shout verbal abuse at the nurses, ignoring all other patients. Security was frequently called to get her back into her room. She was



closely observed by a nurse outside her room providing one-to-one care.

A nurse specialist was called in after a weekend when security had been with the patient six times just on the Sunday. She had an intimidating manner when the nurse arrived.

Personalised interventions

1. Engagement

The nurse worked by treating the patient as politely as possible at all times with a calm voice and low expressed emotion, introducing herself and sitting down to demonstrate that she was willing to spend time with the patient. The patient was asked what she would like and the nurse tried to fulfil her wishes if at all possible, or else gave a clear explanation as to why not.

The patient wanted to go out for a break from the ward, which they did. This was an opportunity to begin engaging the patient by asking her what had happened (getting the patient's narrative of recent events rather than reading medical and nursing notes). This is when she spoke about her abusive past history (corroborated by medical notes). She talked about her challenging behaviour and she said she was in pain and no one would give her painkillers.

2. Aim of care

The aim is to enable staff to see her as a person with individual needs; and to reduce her verbal aggression and the need for security.

3. Nursing care plan

Staff negotiated with her so she understood what the nurses were trying to do and she could see how she could benefit from it. The aim of the plan was to ensure her needs were met so she did not have to exhibit challenging behaviour to be noticed.

Staff instigated a Positive Behaviour Programme (positive behaviour for the nurses not the patient) where they were to go into her room every hour, ask if she wanted anything and have a chat. When drawing up the plan it was made quite clear what kinds of requests were appropriate e.g. requests for painkillers, drinks, breaks from the ward etc.

A record of these visits was kept on the patient's wall where she could see it and also outside (thinking about confidentiality and minimal information) on her door to remind the nurses to do them.

The nurses discussed her difficult past history so they could see that she had no pattern of her needs being met. The only way she knew how to function in an institution was to be aggressive, as in that way some needs would be met. They were very sympathetic as they had no knowledge of her past history and so had been frightened of her. She was regretful about some of her behaviour and said that she was aware that she had frightened an old lady when she was swearing in the corridor, which demonstrated that she had some control over her behaviour.

4. Daily evaluation

On the first night after the start of the intervention the patient had one verbally aggressive outburst at 3.00am but there was no need for security. Since then, she has had no verbal aggression, no shuffling into the corridor and there has been no need for security or for close observations. Initially nurses spent up to 3 hours a day with her at various times but that went down to 1 hour within 4 days.

The programme has been in place for a week and she is currently awaiting surgery.

Source: Dr Joy Bray - Mental Health Specialist Nurse, Cambridge University Hospitals NHS Foundation Trust.

6 South London and Maudsley NHS Foundation Trust

Background

This person has had a number of experiences within mental health services. Having had a few admissions to the acute service, he has eventually found himself in the forensic service. He has had varied experiences in the community before admission to the forensic service, and during this time he had also had re-admissions to the acute service.

He was treated for a two week period, given medication and when he went on leave and did not return on time he was discharged. For a second time he again tried to seek help and was given medication which he took during the admission and for a while after, but he got forlorn and stopped taking it because it did not appear to be doing anything and there was very little follow-up care.

He is a young man with a number of issues which he feels need to be addressed. The main one is his mood and this has been the main area which needed to be addressed on each of the preceding admissions. During his initial admissions, he explained he was asking for help but again as soon as he appeared well enough or it was possible to send him on leave he was discharged.

His latest admission to the forensic service has been under the Mental Health Act 1983 which initially he was upset about and still felt that if he was given the care and attention he had asked for in the past, it would have avoided a criminal history appearing on his file. This he felt would restrict his plans for the future.

In terms of his experiences, he spoke of the variations in communication in different wards. He has also found that even in the forensic service, there are variations in staff approaches, from those staff members who focus on obeying rules to those who are encouraging and have a positive influence on him. He explained that there were differing styles of interaction with him and he experienced various responses and attitudes by both staff members and other patients.



Personalised interventions

He found that the acute service was very busy, he was very much 'in the shadows', staff had done plans for him and the doctors told him what they thought he needed. He did not feel listened to by many members of staff. However, there were a few who spoke to him and made him feel comfortable on the ward, although he thought that they were nursing assistants, as the qualified nurses seemed to be very busy. He felt that the people who helped him most were those who treated him as a human being, not as a patient and were not necessarily being nice to him all of the time but who treated him with respect.

One approach he found particularly useful in the forensic service was the Primary Patient Pathway Meeting where all staff and the patient are responsible for setting and achieving targets and all are accountable for things not being done, including the primary and associate nurse. This meeting also had the benefit of giving him direction and some idea of what he had to achieve and what this would mean for him.

This meeting included him doing daily illness awareness work, which helped his communication with the team and reduced the number and level of incidents. It gave him more confidence in the system and his own ability which aided his progress to lower levels of security and eventual discharge.

SAMPLE PPP: PRIMARY PATIENT PATHWAY MEETING

Date:

Present: X (service user), Y, Z (staff)

Discussed:

- One-to-one work: X has drawn up a list of 5 reminders or guidelines for himself as reference to pursue his goals. These are:
 1. Never let people or what people say ever get you down.
 2. Save some money so you will have some money when you need it.
 3. Always keep clean because when you are clean your self-esteem is higher and it also makes you wear clean clothes.
 4. Always make sure you plan your day and keep to your schedule.
 5. Make sure you eat well and drink plenty of fluid because good eating and drinking makes you feel healthy.
- X is also practising deep breathing and focusing on a point which helps to clear the mind, it was evident from the feedback he had written that he had put a lot of thought and effort into these tasks.
- X is doing work with the psychologists, they have been completing questionnaires and are doing something with objects, he says the sessions are OK.
- Group work – X has managed to attend all groups, his participation is very good especially at sports and he is becoming more involved in discussion groups.
- X has managed to use leave almost daily and the feedback from staff is that he is very engaging when out on one-to-one off the ward.

Plans:

- X may try to be the organisational group chair in two weeks' time. He will set this as a goal during a review of that week.
- Computer use - X to have half an hour each week, looking at how to enter and exit the computer and also practice using the mouse.
- X to have a one-to-one with Primary Nurse J at the end of the week.
- At reviews, X to ask for hospital grounds leave.
- X to think about whether he is interested in attending KGV assessment sessions¹ with the Associate Nurse P; the session would be taped to discuss in the future.
- X to undertake illness awareness work to identify early warning signs and trigger factors for behaviour and anxiety and develop action plans.

¹ Lancashire, S. (2004) KGVM Symptom Scale, King's College London.

Helpful

- Spending time with me
- Smiling when they meet me
- Listening when I need to talk to someone
- Showing they are trying to help
- Getting information for me
- Telling me the truth
- Helping me get accommodation
- Talking in the day area
- Coming to see me when they see I am quiet
- Working with me to do illness work to help get leave
- Telling me what pathway I would benefit from
- Helping me through problems
- Giving me ideas on what to do
- Motivating me to help myself
- Helping me to understand things
- Treating me like a person
- Getting leave and moving on.

Unhelpful

- Not having time
- Listening to what I am saying but not hearing what I say
- Strict with rules but no explanation
- Being too busy
- Not explaining things
- Being rude
- Being abrupt
- Saying you are here because you are not well
- Diverting me to the doctor for answers
- When I think they are judging me
- When I feel alone and no one cares
- When I pass each day without knowing when I will get released or get some help or my mood will improve
- Stopping medication because they think it is in my best interests
- Being treated differently when rules are bent for others and I am picked on
- Not getting help but feeling I was in the way, just a number and the bed needed.

These are some of the statements made by X, which often show poor reflection on the part of the nurses. In some cases a move away from controlling the patient towards exploring and accepting decisions made by him appears essential in facilitating greater engagement. It is noticeable that the Primary Patient Pathway is of great benefit because without meaningful engagement we have nothing.

Source: Jim Tighe, Team Leader, Cane Hill, South London and Maudsley Hospital NHS Foundation Trust.

7 Brighton and Sussex University Hospitals NHS Trust

Summary

Over an 18-month period in 2012-13, Brighton and Sussex University Hospitals NHS Trust (BSUH) has seen a reduction in assaults, restraints and safeguarding incidents on wards following the introduction of a new training programme. The programme has been delivered within existing budgets and with minimal additional costs through integration of Conflict Resolution Training (CRT) and clinically related challenging behaviour awareness and assault reduction skills training.

Key success factors:

- Thorough research of risks, causes and training needs
- High relevance to staff by using real scenarios taught on a training ward
- Buy in of the chief nurse and matrons aided staff release from wards
- Security team support to wards post training has further improved communications and relationships, and encouraged transfer of learning into working practices.

Background

The trust identified that a substantial number of reported assaults on staff were related to the clinical condition of the patient. This ranged from physical conditions to mental health issues such as dementia, and sometimes a combination of these. This situation is not unique, as NHS Protect has identified that 79% of assaults occurring nationwide in 2012-13 were clinically related.

The existing CRT and conventional 'breakaway' training, although effective in de-escalating conflict, is not appropriate for complex causes of clinically related challenging behaviours. The trust security function set out to address this gap by gaining trust wide support and the full backing of the Chief Nurse.



It engaged conflict specialists⁴² to help research and design a bespoke programme that met CRT requirements and built an understanding of how to recognise, prevent and respond to clinically related challenging behaviour.

For staff in services experiencing higher levels of challenging behaviour, practical skills were included to help reduce risks when undertaking tasks in close proximity to patients. This included positioning awareness and simple skills to re-direct and guide individuals, and guidance on how to reduce risks of harm to confused and vulnerable patients.

The initiative set out to achieve two complementary goals:

- To design and deliver a bespoke training programme to help security and clinical staff teams work together to reduce clinically related challenging behaviours
- To reduce the use of restraint and ensure patient safety and dignity is maintained when intervention is necessary.

Method

The first step was to analyse incident data to understand the nature and causes of challenging behaviours and identify priority areas for learning. As such incidents are often underreported, a staff survey helped provide

⁴² Maybo, www.maybo.co.uk.

a fuller picture and identify key scenarios that would form part of the training.

“The training design was based on a comprehensive Training Needs Analysis informed by a bespoke staff survey and review of incidents. It has been an incredibly thorough and risk/evidence based approach”
Security Operational Manager

Staff attended a one day course which covered CRT outcomes and included additional knowledge and skills to:

- Recognise, prevent and defuse conflict and challenging behaviours
- Avoid clinically related assaults through safer positioning and working practices
- Safely guide and re-direct confused patients.

Security staff had two further days of training including safer holding skills, ejection and incident response.

The training was mapped to the NHS CRT syllabus and to the National Occupational Standards for Work Related Violence, and it was City & Guilds accredited.

Bespoke e-learning also provided a foundation knowledge of conflict management which was assessed and recorded through a sophisticated learning management system. The face to face training is delivered on a training ward with wheelchairs, patient trolleys and beds to provide extra realism and opportunities for manual handling; dementia trainers have been closely involved to ensure full integration.

A further key success factor has been ward based ‘coaching’ and the support internal trainers and the security team have provided to clinical staff. This has helped to ensure transfer of knowledge gained in training into working practices and safer behaviours i.e. Level 3 Kirkpatrick evaluation.

“Everyone is now talking a common language about communication strategies, personalised care, de-escalation strategies and, where it becomes necessary, safer physical intervention.”
Chief Nurse

Roll-out

The programme has been rolled out to 32 security officers and 761 clinical staff on a priority basis, i.e. to those wards experiencing the highest levels of clinical assaults and challenging behaviour. Members of the security team also attended the clinical courses to promote communications and teamwork between functions.

Resourcing and sustainability

When it started, the training programme faced a twofold challenge: covering costs of training delivery and securing the release of operational staff, who would need to be covered. To achieve support from local clinical managers to release and cover staff, the team presented their research on risks and needs at a stakeholder workshop with a taste of the proposed training.

The success of this initiative over the past 18 months has helped secure additional investment and in-house trainers are now in place to further ensure its sustainability and reduce direct delivery costs to as little as £12 per head.

“We have delivered a greatly enhanced training package within the same training time and at similar cost to the trust.”

Security Operational Manager

The thorough review of risks and training needs was key to getting senior managers’ buy in to the training and the stakeholder workshop and pilot courses helped win the support of local matrons and managers who had to release staff.

The feedback from the initial courses was excellent, which spread good news and led to staff asking to go onto the training. A matron for older people who came on one such course said *“Why didn’t someone show me this 20 years ago?”* and immediately instructed her ward managers to come on the training and get their staff trained.

The commitment of the Health and Safety, HR, Clinical Divisions and Safeguarding and Security teams was excellent and the biggest turning point for the programme was obtaining the active backing of the Chief Nurse.

Results

There is strong evidence to show this training has resulted in a drop in assaults and restraints and has informed the development of good practice guidance in this area.

Targeting of highest risk areas has been effective and the fully trained neurology unit has seen a reduction from 15 to 6 assaults in 12 months, which it attributes to the training.

“Evaluation of this training by security and clinical staff has been very positive and we have seen a 11% reduction in the number of reported physical assaults across the trust so far and a reduction of up to 60% in targeted wards.”

Security Operational Manager

Staff training evaluations post training consistently rate the training as ‘excellent’ and comment on its practicality and relevance to their work.

“All staff trained felt very positive and more confident in dealing with confused and aggressive patients and I see them putting the training into practice. Through teams training together, working relationships have improved and nurses are quicker to call security. This is the first course I have seen of its kind after 30 years of working with ‘challenging’ patients. Thank you.”

Matron, Neurosciences

Following implementation, restraints for a clinical reason are down from 87 to 69 and the security team are now using low arousal methods instead of the traditional ‘pain compliant’ techniques.

“Since the training the adult safeguarding team have seen a reduction in the number of safeguarding alerts raised in relation to allegations of physical abuse due to intervention by staff to manage violent or aggressive behaviour.”

Associate Director, Quality/Safeguarding Adults

Conclusions

This training programme is successfully addressing one of the most complex areas of behavioural safety, which was also proving costly due to staff injuries and presented safeguarding concerns. The programme is an excellent example of partnership in

developing and implementing training.

Learning has been successfully transferred to working practices by securing full management buy-in and ongoing support to wards from the trainers and security team. Relationships and respect between clinical and support staff have improved. The training has delivered a win-win outcome by improving staff safety and contributing positively to patient-centred care and safety.

“The programme we have piloted and implemented has strengthened relationships and had a positive effect on staff confidence and patients’ perception of safety.”

Chief Nurse

Source: Simon Whitehorn, Security Operations Manager, Brighton and Sussex University Hospital NHS Trust and Bill Fox, Executive Chairman, Maybo.

This BSUH programme won the ‘Training initiative of the year’ category at the 2013 Security Excellence Awards

Appendix 3

Clinically related challenging behaviour – awareness level learning outcomes

All staff interacting with patients need to be aware of clinically related challenging behaviour and the common causes and indicators of it. They need to recognise simple steps they can take to help prevent such behaviour and to ensure their safety and that of the patient when it occurs.

Some roles will have additional responsibilities and development needs in this area, for example relating to diagnosis, treatment, care planning and emergency incident response.

The following learning outcomes may form part of a stand alone learning programme or be integrated with existing core training such as Conflict Resolution Training (CRT), forming an enhanced 'CRT and Challenging Behaviour Awareness' course.

As far as practicable learning will:

- Be delivered in the context of the staff group, patients and environment to ensure its highest relevance.
- Include organisational information, policy and guidance relevant to the prevention and management of clinically related challenging behaviour.
- Make staff aware of their important role in helping to recognise and prevent challenging behaviour and of the support available to them in this.

Understand what is meant by clinically related challenging behaviour and recognise its common causes and signs:

- State the definition of clinically related challenging behaviour.
- Give examples of how it can present in the behaviour of a patient and its early signs (precursors).
- Describe how challenging behaviour can result from unmet needs and communication difficulties.
- Give examples of common causes and triggers including physical, cognitive, psychological/emotional and environmental/social factors.

Be able to identify, reduce and manage risks associated with clinically related challenging behaviour:

- Describe how a patient presenting clinically related challenging behaviour may be vulnerable.
- Give examples of steps staff can take to reduce patient vulnerability.
- Describe risks for staff in contact with a patient presenting challenging behaviour.
- Give examples of how staff can reduce risks when in close proximity to the patient.
- Describe key principles in managing the risk of challenging behaviour.
- State action to be taken in an emergency situation and how assistance can be obtained.

Identify positive steps all staff can take to help prevent clinically related challenging behaviour and provide best support and care for patients:

- Explain the individual's rights, including the right to make choices and to be treated with dignity and respect.
- Explain why it is important to positively engage and learn from patients and their families in understanding their needs and concerns.
- Explain how positive staff attitudes, communication skills and good individualised care are critical in helping prevent and manage challenging behaviours.
- Describe how to record and report information and observations to support care planning.
- Explain why it is important to share information with colleagues and hand over professionally.
- Describe action to be taken when there are concerns over the treatment, care or safety of a patient.
- State where advice and support can be found.

Appendix 4

Glossary

ABCDE

An approach used for resuscitation in an emergency situation: A=Airways; B=Breathing; C=Circulation; D=Disability; E=Exposure.

Challenging behaviour

Any non-verbal, verbal or physical behaviour exhibited by a person which makes it difficult to deliver good care safely.

Delirium

A short term state of confusion, or a worsening of pre-existing confusion, due to a physical cause.

Delusions

A falsely held belief that is firmly maintained in spite of unquestionable and obvious proof or evidence to the contrary.

Dementia

A set of symptoms which includes loss of memory, communication and reasoning functions. These symptoms occur when the brain is damaged by certain diseases, such as Alzheimer's Disease. Dementia is progressive, which means the symptoms will gradually get worse.

Emergency

A situation of immediately apparent risk to the health, safety and wellbeing of the person, staff or third parties.

Hypoxia

A condition in which the whole body or a region of the body is deprived of an adequate oxygen supply. Severe or the rapid onset of hypoxia can lead to changes in levels of consciousness, seizures, coma and death.

Information sharing protocol

An agreement for the necessary, appropriate and lawful secure sharing of personal confidential information across organisations, to meet the public interest while protecting the individual rights of the person(s) the information relates to.

Personalised care

An approach that places the individual as an equal partner in planning, assessing and designing care to make sure it is appropriate for their needs.

Personality disorder

A type of mental health condition in which the person has difficulty perceiving, feeling and relating to situations and to people and foreseeing the consequences of their actions.

Physical intervention

Any physical contact between persons involving the use of reasonable force to restrict movement or mobility and intended to prevent serious harm to a patient, service user or staff member.

Positive behaviour support

A framework for developing an understanding of an individual's challenging behaviour and using this understanding to develop effective support.

Psychosis

A mental health condition that stops the person from thinking clearly, telling the difference between reality and their imagination and acting in a 'normal' way.

Appendix 5

Expert group responsible for developing this guidance

Dr Peter Baker

Consultant Clinical Psychologist, Sussex Partnership NHS Foundation Trust (representing the British Institute of Learning Disabilities)

Dr Tony Bleetman

Lead Consultant Emergency Medicine, The North West London Hospitals NHS Trust (representing the College of Emergency Medicine)

Dr Joy Bray

Mental Health Specialist Nurse, Cambridge University Hospitals NHS Foundation Trust

Nicole Casey

Senior Policy Officer, NHS Protect

Adrian Clarkson

Area Security Management Specialist, South West, NHS Protect

Rebecca Cooper

Policy and Prevention Development Manager, NHS Protect

Mary Dawood

Nurse Consultant Emergency Medicine, Imperial College Healthcare NHS Trust

Dr Duncan Forsyth

Consultant Geriatrician, Cambridge University Hospitals NHS Foundation Trust

Bill Fox

Executive Chairman, Maybo

Julia Gamston

Senior Nurse, Emergency Department, Imperial College Healthcare NHS Trust

Professor Rowan Harwood

Consultant Geriatrician, Nottingham University Hospitals NHS Trust (representing the Royal College of Physicians)

Stephen Hines

Paramedic, London Ambulance Service

Peter Lester

Trust Security Advisor, Cambridge University Hospitals NHS Foundation Trust

Louise Maris

Divisional Lead Nurse Neurosciences, Cambridge University Hospitals NHS Foundation Trust

Andrew Masterman (Chair)

Policy Lead - Violence Strategy, NHS Protect

Emma Ouldred

Dementia Nurse Specialist, King's College Hospital NHS Foundation Trust (representing the Royal College of Nursing)

Dr Brodie Paterson

Senior Lecturer, University of Stirling, School of Nursing, Midwifery and Health

Dr Anand Ramakrishnan

Consultant Old Age Psychiatrist, Nottinghamshire Healthcare NHS Trust (representing the Royal College of Psychiatrists)

Vanessa Smith

Assistant Director of Nursing and Quality: Mental Health of Older Adults and Dementia Clinical Academic Group, South London and Maudsley NHS Foundation Trust

Professor Graham Stokes

Director of Dementia Care, BUPA Care Services UK

Davina Teeluck

Policy Officer, NHS Protect

Dr Ben Thomas

Director of Mental Health and Learning Disability Nursing, Department of Health

Jim Tighe

Team Leader, Surrey and Borders Partnership NHS Foundation Trust

Simon Whitehorn

Security Operations Manager, Brighton & Sussex University Hospitals NHS Trust

