GUIDANCE

Clinically related challenging behaviour – Prevention and management

CONSULTATION DRAFT April 2013
# Roles and responsibilities checklist

<table>
<thead>
<tr>
<th>Staff</th>
<th>Roles and responsibilities</th>
<th>Achieved</th>
</tr>
</thead>
</table>
| **Chief Executive, Board**  | - Ratify, oversee and monitor the effectiveness of policies, systems and procedures to prevent challenging behaviour  
- Ensure the safety and security of staff and patients/service users in compliance with legal and regulatory requirements  
- Prioritise high quality compassionate person centred care  
- Take swift, decisive action if the care delivered is suboptimal  
- Make available resources, training and a highly skilled workforce  
- Ensure strong organisational and clinical leadership to prevent challenging behaviour  
- Seek assurance that these priorities are being met through regular feedback, outcomes and incident analysis.                                                                                                                                                                                                 |----------|
| **Doctors, nurses, allied healthcare professionals with a supervisory role** | - Provide leadership and foster a culture in which compassionate person centred care is delivered  
- Help formulate policies/protocols to ensure there is a staff awareness of clinically related challenging behaviour  
- Ensure emergency situations are appropriately managed (including physical interventions as a last resort)  
- Encourage the reporting of all incidents of challenging behaviour through the incident reporting system  
- Ensure post-incident clinical reviews are appropriately managed  
- Manage risk assessments, post incident review, debrief and implementation of lessons learnt  
- Identify and provide access to targeted training commensurate to the risks that staff face  
- Ensure information sharing with clinical staff, security staff, training staff, the police and appropriate external agencies.                                                                                                                                                                                                 |----------|
| **Doctors, nurses, allied healthcare professionals** | - Follow all policies, advice, guidance, updates to keep safe.  
- Understand challenging behaviour, how to recognise it, how it relates to clinical conditions, how to prevent and manage it  
- Support/instruct/advise on the emergency and long term clinical assessment, diagnosis, and management of challenging behaviour (including physical interventions as a last resort)  
- Support/instruct/advise on the care strategies to prevent and manage challenging behaviours (including physical interventions as a last resort)  
- Report all incidents of challenging behaviour (to their line manager and through the incident reporting system)  
- Understand risks and reduce risks as is reasonably practicable  
- Undertake all necessary training, education and updates to keep safe whilst providing the highest quality care.                                                                                                                                                                                                 |----------|
| **Security and emergency response** | - Understand challenging behaviour, triggers and prevention strategies  
- Understand role in the management of challenging behaviour in an emergency (including legal requirements around physical interventions)  
- Understand role in longer term care to prevent challenging behaviours (including legal requirements around physical interventions).                                                                                                                                                                                                 |----------|
Contents [Each section to be colour coded]

Foreword
[applies to all]

Introduction to this guidance
[applies to all]

Section One – Understanding challenging behaviour
[applies to all]

Section Two – Managing risk and assessing behaviours
[Supervisors, clinicians and nursing staff, response teams]

Section Three – Clinical Assessment
[Clinicians and nursing staff, response teams]

Section Four - Care strategies
[Clinicians, nursing staff, carers and family members, response teams]

Section Five – Training
[Managers, clinicians and nursing staff]

Section Six - Communication and information sharing
[Supervisors, clinicians and nursing staff]

Section Seven - Organisational responsibilities
[clinical and non-clinical supervisors]

Section Eight – Appendix
  - Case studies
  - Core learning outcomes
  - Glossary
  - Expert group
Introduction to this guidance

Clinically related challenging behaviour is often a manifestation of a patient’s distress. It is an attempt by the person to communicate their unmet needs.\(^1\) This may result from an individual feeling threatened, fearful or anxious, suffering delusions or hallucinations, in response to a difficult situation, or a misinterpretation of the actions of other people. Alternatively, it may simply be as 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 and the delivery of care, in particular, one which relies on engaging, occupying and talking to the person.

It may require sustained efforts to change existing cultures. There may need to be a change in perceptions about certain conditions and types of patients/residents. For example, an elderly individual exhibiting challenging behaviour needs to be treated with the same concern and expediency as any other individuals.

Negative staff attitudes can also be a factor in provoking challenging behaviour and the approach in this guidance relies on compassion, empathy and respect for the person.

Previous Government strategies have pursued a ‘Zero Tolerance’ approach to tackle violence and aggression in the NHS and whilst this has been a helpful starting point to tackle assaults, it is problematic in the context of this work. This approach is concerned with a person-centred approach that relies on greater tolerance and understanding.

Nature of challenging behaviour

Challenging behaviour, although underreported, is a significant problem in health and social care. This includes behaviour which results from an inability to communicate needs e.g. arising from dementia, delirium, injury to the head and brain, tumour, 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 listening or hearing.

This type of behaviour has been well publicised, when associated with an elderly person with dementia, however it could instead be a young person who is otherwise physically fit and is recovering from a head injury. Statistically however, the former much outweighs the latter.

Behaviours that are challenging such as grabbing, biting, scratching, pinching, poking, hair pulling, punching, hitting, 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 cause alarm and distress to other patients and visitors.

It can take place in any health and social care environment, however the picture in terms of prevalence is complex. In the acute sector, reported incidents suggest that most problems in staff attempting to restrain individuals who are challenging did not take place in A&E as is often thought but occurred on acute medical wards.²

It is important to stress that these individuals, many of whom are vulnerable and may have problems communicating the reasons for their distress, should not be labelled or stigmatised as being violent and aggressive. Challenging behaviour is usually an act of an individual who is not responsible for their actions and it does not form a necessary ‘part of their condition.’

With this in mind, the principles of dignity in care should be adhered to at all times:

- Choice and control
- Communication
- Eating and nutritional care
- Management of pain and other unpleasant symptoms
- Personal hygiene
- Practical assistance
- Privacy
- Social inclusion.³

**Consequences of not addressing challenging behaviour**

The consequences of challenging behaviour to the delivery of care can be severe, especially over the long term resulting in:

- Exclusion of the individual and restriction of opportunities to engage in everyday living
- Ineffective delivery of health and social care
- An overreliance on anti-psychotic medication, seclusion and physical interventions
- Increased physical injuries and psychological ill health to patients/residents and staff
- Reductions in staffing due to sickness and absence
- Reduced morale and confidence, especially in those who repeatedly face challenging behaviours with nothing seemingly been done to prevent it from recurring
- Higher staff turnover, reductions in permanent staff and more agency cover
- 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 such as the National Dementia Strategy
- Diminished organisational reputation and negative publicity
- An increased number of complaints.

**Rationale for this guidance**

The purpose of this guidance is to provide practical strategies to help identify, assess, prevent and manage challenging behaviour, to improve the quality of care given to individuals by preventing or minimising their distress and to ensure that care is delivered within a safe environment for staff and all service users.

² National Patient Safety Agency (NPSA) National Reporting and Learning System (NRLS) data 2012
Scope

The scope of this guidance is improving the safety and experience of:

- All individuals, many of whom may be vulnerable, who commit harm to themselves and or to others
- Staff who deliver essential treatment and care, after care and rehabilitate patients
- 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 such behaviour relates to specific clinical conditions and unmet needs
- Improving the approach, skills and attitudes that minimise distress
- Providing practical strategies to risk assess and manage challenging behaviour
- Providing managers with guidance to provide staff with appropriate training and make available resources to prevent and manage challenging behaviour.

How should this guidance be used?

The guidance applies where individualised care strategies are needed, in any health and social care setting. It can be read as a whole, however staff should identify which sections are most applicable to them, dependent on their role and which setting/client group they work with.

Legal framework

The following applies when preventing and managing 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**

  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.

- **Human Rights Act 1988 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, in relation to the following articles:

  *Article 2 – Right to life*
  *Article 3 – Prohibition of torture, inhumane or degrading treatment*
  *Article 5 – Right to liberty and security of person*
  *Article 8 – Right to respect for privacy and family life*
  *Article 10 – Freedom of expression*
Article 14 – Right to freedom from discrimination.

- **The Mental Health Act 2007 (as amends the Mental Health Act 1983)**

Under the Code of Practice, people with mental disorders should get the care and treatment they need for their own health or safety and for the protection of others, including staff and third parties. The main principles include:

1. Respect for person’s past and present wishes and feelings
2. Respect for diversity including religion, culture and sexual orientation
3. Minimising restrictions on liberty
4. Involvement of person in planning, developing and delivering care and treatment
5. Avoidance of unlawful discrimination
6. Effectiveness of treatment
7. Views of carers and other interested parties
8. Wellbeing and safety of person receiving care and public safety

- **The Mental Capacity Act 2005**

This 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 best interests, 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. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

- **Deprivation of Liberty Safeguards (under the MCA 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:

1. to provide the person with a representative
2. to allow a right of challenge against the unlawful deprivation of liberty
3. to provide a right for deprivation of liberty to be reviewed and monitored regularly.

Health and social care providers when making arrangements for the care of someone who lacks capacity must apply for authorisation for the deprivation of liberty based on:

1. is it in the person's best interests?
2. is it needed to keep the person safe from harm?
3. Is it a reasonable response to the likelihood of the person suffering harm?
Other behaviours

Patient-on-patient incidents

Patient-on-patient incidents may be an indicator of distress and unmet needs and are a potential precursor of challenging behaviour against staff. Staff may also risk collateral injuries when trying to intervene in these situations. Any patient-on-patient incident should be reported and managed as an incident of challenging behaviour.

Criminal behaviours

Challenging behaviour may be a result of clinical factors, as outlined in this guidance, or it maybe 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 temporary of permanently at the time that the incident takes place, this 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 either caused by intentional or reckless behaviour this may constitute a criminal offence and should be managed in line with tackling violence guidance produced by NHS Protect.4

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

The organisation’s nominated security management specialist will be able to provide further advice and assistance.

SECTION ONE: Understanding clinically related challenging behaviour

Definition

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

Other definitions are also widely available.

Common characteristics

A frequent characteristic of individuals who manifest such behaviour is that they often have some degree of cognitive impairment, either chronic (e.g. dementia, or learning disability) or acute (e.g. delirium, drug or alcohol intoxication). It may also be seen other mental health conditions such as psychosis or personality disorder.

Types of behaviour

It describes any deliberate or non-deliberate behaviour that is non-verbal, verbal or physical in nature, as outlined in the table below.

It can include other behaviours which may be judged as being on the fringes of challenging behaviour, such as apathy, lethargy, fatigue, hyperactivity, hypoactivity and non-compliance, if staff need to intervene because the behaviour poses a safety risk to staff, patients/residents or others e.g. an individual trying to get out of bed when they cannot stand and may fall.

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5 'Severely challenging behaviour refers to culturally abnormal behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities' (Emerson, 1993)
<table>
<thead>
<tr>
<th>Non Verbal</th>
<th>Verbal</th>
<th>Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wandering</td>
<td>Shouting</td>
<td>Scratching</td>
</tr>
<tr>
<td>Agitation</td>
<td>Swearing</td>
<td>Grabbing</td>
</tr>
<tr>
<td>Pacing</td>
<td>Crying</td>
<td>Biting</td>
</tr>
<tr>
<td>Following</td>
<td>Screaming</td>
<td>Hitting</td>
</tr>
<tr>
<td>Intimidating facial expressions</td>
<td>Repetitive statements/questions</td>
<td>Punching</td>
</tr>
<tr>
<td>Intimidating body posture</td>
<td>Personal comments/questions</td>
<td>Slapping</td>
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<tr>
<td>Cornering/invading personal space</td>
<td>Racist/sexist/offensive speech</td>
<td>Kicking</td>
</tr>
<tr>
<td>Staring</td>
<td>Bizarre/psychotic content/not based on known reality</td>
<td>Pushing/shoving/knocking into someone</td>
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<tr>
<td>Spitting</td>
<td></td>
<td>Throwing objects</td>
</tr>
<tr>
<td>Striking furniture/objects</td>
<td></td>
<td>Lashing out</td>
</tr>
<tr>
<td>Interference with equipment of property</td>
<td></td>
<td>Inappropriate touching (self or others)</td>
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</tbody>
</table>

Behaviours may escalate up from non-verbal, to verbal and physical actions, however there is no continuum of behaviour and where someone is sufficiently distressed or alarmed, their behaviour may instantly result in a physical action.

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 the reasons and triggers should reduce the likelihood of these potentially ‘unforeseen’ events from occurring.

Patterns of challenging behaviour
Patterns to behaviours will often emerge which when identified can assist with understanding the reasons behind the behaviour. Challenging behaviour has a tendency to occur in response to:

- Unmet care need (e.g. toilet, pain, thirst, hunger)
- Care tasks, including intimate procedures
- Administering medication (especially where the patient has to wait for pain relief)
- Gender issues (preference for male/female carer)
- Pressure on staff time
- Times when there are lower levels of staff (mealtimes, medication, handovers etc)
- Areas where there is a high number of less experienced staff (i.e. less aware of psychological issues)
- ‘Sun-downing’ (i.e. patterns of challenging behaviour are more prevalent during afternoon/evenings)
- Night time disturbance
- Inappropriate admissions
- Heightened activity (e.g. mealtimes)
- Lack of engagement by staff (i.e. staff not being on the ‘shop floor’)
- Relatives leaving
- Cultural, religious or spiritual needs
- Post-operative factors
- Staff not engaging with the behaviour
- Staff hostility
- Provocation by other individuals, distress in other individuals
- Over-stimulating or under-stimulating environments
- Patients mirroring behaviour by others that elicit staff response or additional attention/care.
- Individuals feeling that staff are not hearing/listening to what they are saying

**Triggers/antecedents**

Triggers/antecedents are environmental, situational or physical factors that when combined with the individual’s unmet needs result in challenging behaviour. These factors will vary depending on the individual, but they may include the care environment or setting, individuals, interventions, activities, objects, thoughts, 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 potential triggers can be the first part of a proactive strategy for minimising stressful or distressing situations. This is because, once identified, many triggers/antecedents can be avoided or changed.

**Precursors**

Challenging behaviours can occur without warning and staff need to be able to be aware of, recognise and identify precursors. Precursors are behaviours and are different to trigger factors which are environmental/situational/physical factors.

Precursors can often be very subtle and leave staff feeling ‘uncomfortable’ or they may be more apparent. Common recognisable cues as part of an assessment of risk include:
• Tense and angry facial expressions
• Increased 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 or behaviour similar to that which preceded earlier disturbed/challenging episodes
• Reporting anger or violent feelings
• Generally, anything that seems out of character: e.g. an individual crying excessively or laughing hysterically.

Reasons for challenging behaviour

The main reasons are often complex, however for the purposes of understanding behaviour and managing risk they can be categorized as:

1) Physical factors
2) Cognitive factors
3) Psychological /emotional factors
4) Environmental factors
### 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 includes features of an individual’s condition that pre-disposes to distress (such as sensory impairments – loss of sight, hearing, smell, taste, feel) unpleasant symptoms, pain and discomfort and can all cause irritability, agitation or trigger distress.

  Patho-physiological changes that can cause delirium can be a significant factor and it is appropriate to mention it here 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 characterized by cognitive impairment and inattentiveness (distractibility) or drowsiness. Delusions, hallucinations and emotional

<table>
<thead>
<tr>
<th>Physical</th>
<th>Cognitive</th>
<th>Psychological/social</th>
<th>Environmental/social</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hypoxia</td>
<td>• Memory loss</td>
<td>• Fear</td>
<td>• Noise</td>
</tr>
<tr>
<td>• Hyperglycaemia</td>
<td>• Communication problems</td>
<td>• Anxiety</td>
<td>• Lights</td>
</tr>
<tr>
<td>• Hypoglycaemia</td>
<td>• Difficulty with language/dialect</td>
<td>• Anger</td>
<td>• Temperature</td>
</tr>
<tr>
<td>Electrolyte abnormality</td>
<td>• Inability to express/word finding problems</td>
<td>• Depression</td>
<td>• Overcrowding/busy</td>
</tr>
<tr>
<td>Dehydration</td>
<td>• Reduced spatial awareness</td>
<td>• Social isolation</td>
<td>• Inappropriate signage</td>
</tr>
<tr>
<td>Constipation</td>
<td>• Associated with learning disabilities</td>
<td>• Mania</td>
<td>• Lack of information</td>
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<tr>
<td>Infection</td>
<td>• Reduced understanding/comprehension</td>
<td>• Fixed beliefs</td>
<td>• Long waiting times</td>
</tr>
<tr>
<td>Pain</td>
<td>• Disorientation</td>
<td>• Separation anxiety</td>
<td>• Lack of continuity of staff/care</td>
</tr>
<tr>
<td>Sensory impairment</td>
<td>• Poor executive function</td>
<td>• Loss of self worth</td>
<td>• Loss of routine</td>
</tr>
<tr>
<td>Sleep deprivation</td>
<td>• Loss of insight</td>
<td>• Hallucinations</td>
<td>• Imposed boundaries/routine of the institution</td>
</tr>
<tr>
<td>Medication (effects)</td>
<td>• Disinhibition</td>
<td>• Delusions</td>
<td>• Unfamiliar surroundings</td>
</tr>
<tr>
<td>Illicit drugs/alcohol</td>
<td></td>
<td>• Powerlessness</td>
<td>• Pace of surroundings</td>
</tr>
<tr>
<td>Drug or alcohol withdrawal</td>
<td></td>
<td>• Loss of status/role</td>
<td>• Over-stimulation</td>
</tr>
<tr>
<td>Post-surgery</td>
<td></td>
<td>• Suicidal tendencies</td>
<td>• Under-stimulation</td>
</tr>
<tr>
<td>Hunger, thirst</td>
<td></td>
<td></td>
<td>• Stopping a habit/behaviour (e.g. smoking)</td>
</tr>
<tr>
<td>Incontinence/urgent toilet needs</td>
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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 difficult behaviours if they cannot be communicated.

- Cognitive factors

  The cognitive factors include the inability to remember new information, explanations or instructions, the loss of inhibitions, poor judgment and planning and importantly communication problems manifesting in an ability to articulate needs (understanding and expression) can all lead to distress or difficult behaviours.

- Psychological/emotional factors

  Individuals suffering from delusions, especially paranoid, can feel they are being threatened and lead to defensive and challenging responses. People with personality disorder may have difficulty foreseeing the consequences on others of their actions and may become acutely distressed. Fear is a 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.

- Social/environment factors

  These can be provocative in an individual, especially temperature and noise, more so if they are prolonged or persistent and may also interfere with an 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 of activity they are exposed to.

  A lack of stimulation and inactivity can lead to boredom and frustration in individuals in residential care or those requiring longer lengths of stay. It may be exacerbated by a lack of communication and dialogue between staff and patients/residents, poor care planning, lack of structure of daily activities and lack of planned or meaningful activities themselves.
SECTION TWO: Managing risk and assessing behaviours

PART ONE – Risk situations

In high risk, potentially dangerous situations, prevention, avoidance and de-escalation is the preferred approach. Physical interventions, rapid tranquilisation, seclusion and heightened levels of observation, should only be used where these other approaches proves insufficient. Any intervention should always be used in conjunction with de-escalation focusing on skilled communication techniques and fostering good relationships, activities and diversion to avoid situations from flaring up again [see xyz]

Any intervention must minimise the risk to the person’s health and safety and with minimum interference to their privacy and dignity. It must also be justifiable, appropriate, reasonable and proportionate (to risk of harm) and in line with NICE Clinical Guidelines 25, 42, 82,103, 142.

Assessing risk

Risk assessment is about assessing the likelihood and consequence of challenging behaviour and identifying and implementing appropriate measures to avoid, mitigate or control the risks.

A formal risk assessment will usually not be possible in fast paced emergency departments, admissions units and intensive care, where there is little or no lead up to behaviours; limited or no observation time; where the person does not necessarily have a history of challenging behaviour (or at least one that is readily accessible by staff); where lengths of stays may be short; where 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 would not be feasible. Nonetheless, they should be used selectively for those patients with a propensity for challenging behaviours and it is important for such areas to have policies and procedures in place to minimise the risks.

In these environments it is important that staff are trained and skilled to quickly identify challenging situations, recognise the precursors, dynamically assess the risks and implement immediate de-escalation interventions to reduce the dangers. Staff should still try to ascertain as much background as is possible from the patient, carers and notes before interventions are put in place. It is important that assessments and adjustments to the care plan are documented and shared.

Risk factors

Risk factors are personal, situational or environmental characteristics where the likelihood of challenging behaviour is greater. Risk factors point to a predisposition to challenging behaviour that may require quick management decisions.

Personal risk factors may include previous indicators of someone’s behaviour and current clinical presentations. Historical and current factors may operate independently or interact together and may combine with environmental and situational triggers to heighten the risk of challenging behaviour, see Fig.1

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

Personal
• History of aggressive/violent behaviour
• History of intent to harm others
• History of mental illness/self harm/suicide attempts
• Previously detained under a section of the Mental Health Act
• Forensic, criminal related history (prisoners in hospital, etc)
• History of substance and alcohol abuse or withdrawal
• History of disruption to service delivery and resource (damage to property, equipment, disruption to staffing levels etc)
• Current clinical factors including specific diagnoses, delirium and delusions.

Environment
• Environmental factors – New environments are always difficult for people with dementia, and busy, active, crowded acute wards are over stimulating and overwhelming for many. Other agitated or distressed persons can exacerbate distress.

Situational
• The activities being undertaken – e.g. washing, dressing, giving medications etc
• The services being provided and the client group
• The staff member – attitude, skill levels, training, approach and awareness
• Night time
• Restrictions, denial or confrontation (e.g. a person wanting to leave, cigarette breaks)

Preventing the risk of challenging behaviour

• Preventing risk relies on meeting the individualised care needs of the person:

  ‘Care where the patient is an equal partner with the health care professional and where both parties work together to make an assessment, identify options for and 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)

• This approach is based on positive staff attitudes, compassion and empathy. Dignity is important and requires that the individual is kept comfortable, valued, respected, in control and have choices in their treatment and care. Empathic understanding means seeing problems from the perspective of the patient/resident.

• Delivering individualised care requires good leadership, skilled staff, positive attitudes, confidence, high levels of staff tolerance and adequate resources. It requires training and practice, and often role-modelling by people who know how to do it and can share their expertise.

• Outside of specialist mental health settings, staff are instilled with the mindset that they need to work quickly and be efficient. However the success of this care model relies on staff being able to talk to the patient, to understand their psychological, emotional and physical care needs.

• It means building positive relationships between professionals and the person being cared for. The rewards equally apply to staff delivering the care as well as the person. Staff tend to feel empowered and supported by this approach.

• This includes involving the individual and taking their views into account when planning treatment and care, gathering information, building a ‘personal profile’, working
effectively with family members and listening and incorporating their views on care/support for the individual.

- There also needs to be an initial awareness and understanding of behaviour patterns and triggers that act as precursors to challenging behaviour. This should be gained through liaison with the individual, family and observing what is happening - an ABC analysis may assist where possible [see below…]

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.

- 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, empathy, non-confrontation, minimising threat, and negotiation, compromise, agreeing to any reasonable requests, distraction, ‘time out’ techniques, and changes of staffing which are all key here.

- Doing nothing

The ‘art of doing nothing’, and ‘watch and wait’ are important strategies in high risk situations where it is safe to do so, although they require staff confidence as they may seem counter-intuitive. Challenging behaviour around the time of transition (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 a person, staff and other individual’s 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/resident absolutely needs medical intervention, or another essential intervention e.g. a soiled incontinence pad needs changing, physical intervention 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, and 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 within the confines of the care environment, keep the patient/resident 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 or ‘setting others off’
• Observation

‘Special’ observation that goes beyond therapeutic engagement should be considered for the immediate and long term prevention and management of challenging behaviour. The level of observation required is determined by the level of risk. It must not be intrusive, should respect dignity and privacy and should be conducted safely in accordance with NICE CG 25. Organisations should have an action plan for checking availability of internal staff (e.g. staff bank/agency, central response team, movement of staff from other areas). An observation policy should be in place to clarify observation levels and what is expected of staff (a prior knowledge of the person’s history is desirable) and how to initiate/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 both short term strategies are required (e.g. immediate control of a dangerous situation), and when it is not required (where de-escalation, non-pharmacological means, use of more routine medication (e.g. pain relief), should be attempted first.

In mental health settings, service users can agree ‘Advance Directives’ with clinical staff during care planning to avoid escalating situations, by agreeing how they would like to be managed (including physical interventions) in emergency situations.

Post-incident reviews

Post-incident reviews are invaluable in identifying the lessons learnt. It is good practice to include staff involved in the incident, witnesses, other colleagues, the patient/resident and carer to ascertain the reasons their behaviour. The individual perspective can help identify triggers due to staff attitudes, actions or behaviours. A post incident review will only be effective if the information is documented in care plans and shared with everyone in health and social care involved in delivering care for that individual, see section xyz.

PART TWO - Emergency situations: Some principles around physical intervention

The purpose of physical intervention

*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* (MHA Code of Practice (1983) 2007).

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 used inappropriately

There are inherent dangers to patients and staff through the inappropriate use or poor application of physical intervention in challenging situations. Between January 2009 and March 12, 126 out of 823 physical intervention incidents reported to the NRLS, caused moderate or severe harm and even led to death of the patient in two incidents in the acute healthcare setting. Staff involved in incidents ranged from clinical (nursing and support staff)
and a significant proportion involved security staff and police either in isolation or in combination".6

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

When it may be considered

In a situation of imminent or grave danger, based on a rapid risk assessment, staff may need to take immediate action to prevent harm. Not to act in these circumstances may constitute a breach of their duty of care under common law. Any form of restrictive physical interventions must always be:

- Reasonable, necessary and proportionate
- Conducted by appropriately trained and competent staff
- Combined with strategies to continuously de-escalate
- Use the least restrictive interventions
- Used for the minimum amount of time
- Able to continually monitor the patient for signs of medical/physical distress.

Risk assessment

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

Assessing capacity

Staff must presume the individual has capacity unless there is a good reason to suspect it is lacking. If someone is behaving ‘oddly’, or dangerously, there is prima facie evidence to suspect it is lacking and a need to assess capacity under the MCA.

Under the MCA, physical intervention is acceptable if the person lacks capacity and the decision is made in their best interests. There is judgment involved, but as long as it can be justified that there were grounds to doubt capacity and an action as 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 MCA assessment may be impractical and practitioners should not delay in 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 undertaking physical interventions must understand the law with regards to the use of reasonable force during a physical intervention and how to justify such action to achieve the desired outcome. There is no legal definition of what constitutes reasonable force,

however the main principles are proportionality, necessity and reasonableness. This includes: are there any viable alternatives to using force, is it proportionate and necessary to the situation that presents itself, does it use the least amount of force for the shortest time? Finally, can it use be justified in a court of law, if necessary?

Roles and responsibilities

In acute healthcare settings, clinical staff are generally not trained in physical interventions. If staff have not been appropriately trained they must not be involved in restrictive physical interventions – see section xyz.

All organisations should have a clear and consistent protocol for managing challenging behaviour in an emergency situation, in accordance with NICE CG 25. This must include an emphasis on continuous de-escalation, a clear division of responsibilities, who should take the lead in decision making, who is permitted and not permitted to do what during a situation. It must also clearly identify trigger points for when staff need to seek further assistance from other colleagues, response teams, security and the police.

Organizations should conduct a periodic review of staffing levels to ensure a minimum number of trained and competent staff are available to safely manage a situation and hold centrally held, up-to-date records of those staff that are available in an emergency.

However, there must however be a pragmatic approach to safely manage a situation, for example some escorting/guiding may be permitted in some circumstances (e.g. where an elderly person with dementia is wandering away from a controlled area).

When to call the police

Staff should contact the police only as a last resort, in situations where:

- Where a possible crime has been committed
- Where a serious injury has been sustained
- Where all possible avenues to safely deescalate and manage a situation have been exhausted and have failed
- Where staff, patients and the public remain in imminent and grave danger
Fig. 1 - Risk assessment process

Person

Historical factors
- Violence and aggression
- Intent to harm others
- History mental illness/self harm/suicide attempt
- Previously sectioned
- Forensic/criminal
- Service disruption and damage
- Substance abuse

Current presentation
- A specific diagnosis
- Delirium
- Delusions
- Sensory impairment
- Pain
- Unpleasant symptoms

Triggers
Environmental factors
- Busy, over-crowded, over-stimulating
Situation factors
- Administering medicine, washing, dressing

Precursors
Recognizable cues: tense/angry facial expressions, pacing, vocalizing distress;
Subtle behaviours: posturing, cornering, invasion of personal space

Challenging Behaviour
PART THREE – Understanding behaviours

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

A crucial part of prevention is for staff to be ‘reflective practitioners’ who are able to observe and analyse challenging behaviours, identify triggers/antecedents, understand the reasons for the behaviour and implement simple, immediate or longer term care strategies. This approach has a vital learning and education element.

Prevention through a 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/we as an organisation do differently?’

Culture and habit in dealing with individuals and their carers, for example by being more collaborative, less confrontational, tolerating and diverting 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

Functional assessment is particularly suitable for assessing individuals who are unable to communicate their needs verbally who present challenging behaviours in any health and social care setting.

This approach relies upon identifying the typical context in which the behaviour occurs and the resulting consequences which may well serve to perpetuate the behaviour. It also relies on identifying 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 whereby staff record events that occurred immediately before 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 to record and organise these observations for as long as is needed to identify behaviour triggers, patterns, in order to identify appropriate and effective care strategies. The observation period should be determined on a case-by-case basis. The ABC analysis should be combined with other analysis methods, in particular individual profiling.

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/triggers of the behaviour

The antecedents/triggers may originate from a combination of factors stemming from the person, other persons, or staff delivering the care or the care environment.
Behaviours of the individual at the time of the incident

How did the individual react, their appearance, verbal and physical actions? A detailed description is important to understanding, labelling and generalisations should be avoided: e.g. the individual was 'verbally abusive' or 'physically aggressive' will not provide the level of detail to unpick behaviours.

Consequences of the incident

Staff behaviours, reactions, or interventions can reduce, or provoke, exacerbate or reinforce the behaviour. Does the analysis indicate that the person wants 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? What is also being looked at here are any simple practical strategies. Often simple minor modifications to a care can have dramatic effects e.g. modifying someone’s bathing/washing routines may stop agitation or aggression.

Delivering care

By understanding the reasons for behaviours, including identifying what needs to be done to minimize an individual’s distress, this approach will help healthcare professionals understand the appropriate role and limitations of drug treatments. Instead a thorough understanding of non-pharmacological interventions is needed:

- It is often an individual’s distress that can lead to challenging behaviour, rather than the individual being deliberately challenging;
- It is staff attitudes and skills that may need to change: e.g. not blaming the individual for their behaviour;
- It is not an inevitable consequence for conditions such as dementia/delirium.
- It requires staff to honestly appraise what they can do to make things better and clinical leaders (ward managers, consultants) to enable a culture in which person-centred approaches are promoted and values
- It requires models of the delivery of care and ways of working to be assessed and modified - [see section…]

It is also about designing on-going care and follow up care on discharge for people with mental health or other needs, such as:

- 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.
SECTION THREE: Clinical Assessment

Introduction

This section provides strategies for both the immediate and long term medical assessment of individuals who may be challenging. Whilst aimed specifically at doctors, all health and social care professionals who contribute to care and should adopt a consistent approach.

Diagnosis and drug prescription is mostly specific to doctors, but other aspects and responsibilities, including information gathering, liaising with families and other carers, monitoring and review, and decision making will be shared with multi-professional colleagues.

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 is required.

This section should be applied in conjunction with Section xyz care strategies

Emergency situations

- First make a rapid assessment of the situation and the safety considerations:
  - If there is a threat to your personal physical safety, ensure that where possible you have help of another healthcare professional who is trained how to work in close proximity to the patient, to safe position themselves and apply physical intervention techniques.
  - Is the physical environment safe? (e.g. the risk of 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.

- Make a decision on physical intervention
  - If you need to get immediate control of an emergency situation (i.e. within 30-60 minutes) in which an individual is uncooperative, agitated or physically aggressive, you may elect to deliver rapid tranquilisation and/or safe physical intervention to maintain safety and facilitate a thorough medical assessment or immediate treatment. This must follow a treatment algorithm, and be in accordance with NICE CG 25 Guidelines on emergency control of the acutely disturbed adult patient in inpatient psychiatric settings and emergency departments.
  - Should rapid tranquilisation be required, it must be delivered in accordance with NICE CG25 by appropriately trained and competent staff. 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:
  o Take a history if possible. At 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.
  o 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.
  o Complete any examination not done under ‘ABCDE’, including level of consciousness, temperature, 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, full bladder, and constipation.
  o 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 need be) tests for vitamin B12, folate, MRI, EEG, LP, blood or urine toxicology, CK (for NMS), anti-neuronal antibodies and VGKC Abs (for limbic encephalitis).

• If collateral information was 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 person centred approaches (see section XXX).

• Identify the exact nature of the behaviour, circumstances and possible provoking factors, and if these have changed over time. Consider an ABC chart.

• Assess for delirium: <1 week history of increased confusion, fluctuation, inattention or drowsiness. See NICE CG103 risk factors for delirium (i.e. age over 65, cognitive impairment/dementia, #N.O.F, severe illness).

• If delirium present seek a cause (drugs, drug withdrawal, infection, hypoxia, metabolic, neurological, some combination, something else), and follow a management guideline (NICE CG 103). Assess clinically as for emergency situations.

• Assess for evidence of other serious mental disorder 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:
  o Physical problems: pain, constipation, urinary symptoms, thirst or hunger.
  o Activity-related: boredom, misinterpretation of care tasks.
  o Treatment related: catheters, monitors, infusions, effects of medication.
  o 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 (single room) may be needed.

• Try to involve family or other carers if available.

• Reassure, and repeat this frequently (as often as required) if necessary, 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:
  o Psychosis: delusions or hallucinations (but care over ‘delusions’ due to forgetfulness)
  o Depression, anxiety
  o Emotional liability; distress (e.g. crying, anger) disproportionate to emotional stimulus
  o Apathy
  o Aggression, agitation
  o Sleep disturbance
  o Wandering
  o 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, fluctuation. 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 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 below, guideline for managing behaviour and psychological problems in patients with diagnosed or suspected dementia.
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).7

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7 Harwood R et al, guidelines on the emergency control of the acutely disturbed adult patient – University of Nottingham, (2012)

Harwood R et al, managing behaviour and psychological problems in patients with diagnosed or suspected dementia (2012)
SECTION FOUR: Care strategies

• This section provides strategies for both the immediate and long terms care needs of patients who may be challenging. Whilst specifically directed at nurses, all health and social care professionals who contribute to care should adopt a consistent, team based approach.

• This should be read in conjunction with the case studies provided in Appendix 1.

Care principles for managing emergency situations

• 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 it takes place. In all cases, they should be assessed and managed by multi-disciplinary teams (MDT).

• Good communication should be the overarching strategy to de-escalate, reduce and minimise the levels of distress or anxiety. Communication will help move through the rest of the strategies.

• Move away from a task focused model to a conversation focused model to help gain the individual’s cooperation.

• Avoid trying to ‘control the situation’, focus on talking to the individual to find out what the problem is causing their distress.

• Be compassionate, empathise, reassure and understand distressing situations from an individual’s perspective throughout:
  o What do they perceive is happening?
  o Does the individual understand what is going on, even if they have been told?
  o May they perceive something or someone as a threat?
  o Is their understanding coloured by their cognitive problems?

• Safety should always be paramount. Staff should never put themselves or other patients/residents or visitors in danger. They need to know needs to know how to respond to an escalating situation and when to withdraw.

• Following an incident, there should be the opportunity to reflect what has happened to improve future practice [See debrief]
# A practical approach to de-escalate and manage an individual exhibiting challenging behaviour

## Background

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, 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 verbal and non-verbal communication skills outlined in Fig. 2 below.

5. Approach the individual in a calm, friendly and non-confrontational way. If needed, stand back to give them personal space. Ask: “You seem upset. Can I help you?”

6. Listen to the individual’s concerns and offer reassurance. Can any reasonable requests be incorporated within the delivery of care, wherever possible?

7. Look for any immediate causes of distress and does it have a simple solution. For example is the person deaf, do they understand English, or are they unable to express themselves?

8. Give clear and consistent information. Repeat especially if the individual has a head injury, is intoxicated, or has short-term memory loss.

9. Ensure that the person understands why you are doing certain things (e.g. carrying out examinations).

10. Explain what is going to happen, why it is happening and reach agreement with the person, for example, “Here is your medication, how would you like to take it?” Is a level of compromise needed?

## Consider…

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. Distraction techniques (e.g. chat about hobbies/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 changing staff members if you are unable to defuse a situation.

15. ‘Watch and wait’ or ‘leave and return’ if safe, appropriate and it is judged that the
individual’s behaviour may settle.

16. Getting assistance by continually evaluating the situation and make a judgment about whether it is getting better or worse and needs escalation. If necessary, seek support or help, e.g.:

- From the mental health or learning disability liaison team/contact point
- From a doctor if the individual is acutely unwell or may need rapid tranquillisation
- From security and/or a senior medic or other manager.

17. Special observation to prevent further escalation. Make an assessment first, decide on level of observation required and ensure the safety of staff and patients during the observation.

**Emergency situations**

18. The first responsibility is to ensure that staff, the person, other patients, 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 the behavioural and medical management. These strategies should be thoroughly risk assessed first and fully documented.

22. If the situation becomes dangerous:

- Consider pulling the alarm, or leaving the area
- Call the police as a last resort.

**Situation is under control**

23. Managers should ensure that where necessary, the staff member(s) involved is able to take a break, move to a quiet area or undertake different duties. If this is not immediately possible, clinical supervision may be an alternative.

24. The staff member, the patient and visitors should be given access to immediate medical attention if required. Reassurance should be provided to all.

25. Document the incident via the organisation’s incident reporting system, incident forms, and/or individual notes. Allow for personal notes from those staff involved in the incident.

26. The staff member, in consultation with the ward/unit manager, may want to report the incident to the police (if they have not already been called). Seek advice from the organisation’s nominated security management specialist if required.

27. The ward manager/unit manager should evaluate the event and offer staff the option to be participate in a debrief if necessary.

28. Following an incident review, communicate lessons learned to the rest of the team.
29. Facilitate an in-depth clinical assessment of the patient by a doctor to respond to any physical/organic needs or causes of discomfort (e.g. for dementia, delirium, depression or other mental disorders, acute precipitants or predisposing factors).

30. Plan ongoing care and management strategy for the individual and record this in the care plan. Decide who this care plan needs to be shared with (e.g. security staff).

Sub-acute and long term care strategies⁸

1. Involve family and carers

- Explain the ward/service routine to the family
- Ask for personal profile information on the individual for help in planning care.
- Encourage family contact as often as possible.
- Give family and visitors advice on how to interact with the individual and what to expect
- The family should receive verbal/written information on the effects the individual condition, treatments, expectations, subject to individual confidentiality
- Support 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, ambulance crew, records.
- Learn about the individual’s profile – important chronology and events, family history, previous occupations, interests/hobbies, likes and dislikes (e.g. do they smoke), preferences, normal routines, needs and aspirations, spiritual, cultural and religious needs and practices. For individuals unable to communicate their needs, if they have a carer they will be able to give detailed information about the individual
- Use something equivalent to the ‘This is me’ tool, developed by the Alzheimer’s Society http://alzheimers.org.uk/site/scripts/download_info.php?fileID=849.
- Promote familiarity and routine for the patient/resident.
- Learn about the individual’s functional ability – what are they able, unable to do for themselves, what might provoke distress and what relieves and calms them

- Have they any sensory impairments, physical health problems and retained abilities. Physical health needs must be attended to
- Observe and record any challenging behaviour - use an ABC chart where practical

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⁸ amalgamated from Poole’s Algorithm; includes elements of and Brighton and Sussex Foundation Trust Pathway Pack
3. **Group meeting to plan care (involve person, family members/carers)**

- Discuss all possible causes of behaviour, involve individual, family members and carers (where possible)
- Ensure that all staff are involved in planning care
- Think about the effect of staff interactions, routines and environmental factors
- Discuss overall care aims/objectives, discuss all possible care strategies and delivery

Look to minimise lengths of stay, ensure appropriate discharge planning and follow up care, including the use of community mental health teams.

4. **Initiate care plan**

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

5. **Plan communication strategies**

- Use verbal and non-verbal communication skills outlined in *Fig.2 below*.
- Plan your communication, know the treatment objectives, where the individual is on the care pathway, what it is you want to achieve and get agreement from the person
- Use appropriate language (be aware of cultural practices), seek an interpreter if necessary
- Make sure hearing aid and glasses are on and in working order where needed. Consider portable external hearing aids if necessary
- Is the person in bed? Communicate at eye level. Get low to the bed to aid effective communication.
- If there are barriers to communication consider moving the individual to a quiet area, reducing background noise (TV, radio etc)
- Find creative solutions to aid communication – e.g. label items, use coloured cards and pictures (e.g. angry/sad faces); use communication boards and talking mats
- Consider substituting a staff member as an immediate action where the individual may for no reason taken offence at a particular staff member
- Always keep calm even if the individual starts to become agitated e.g. trying to get out of bed and/or pulling at their lines. Down play angry outbursts, make no direct response, do not shout or argue back, or become upset in front of individual.

6. **Adapt environment**

- Consider adapting or modifying environment (e.g. make it 'home like' and consider personal mementos, changing the lighting, reducing noise avoiding temperature fluctuations)
- Have reminders of the date, time and location if appropriate
- Have photographs and notes from family/friends, reminders of when visitors will return
- Address any disorientation and way-finding problems (e.g. the way to the toilet)
- Excessive noise can be irritating, provocative and over-stimulating. Switch off radios and TVs if needed. Consider the impact of noise caused by 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 such as a single room if possible (although not appropriate if the person’s behaviour suggests a need for social contact, or if a falls risk is deemed unacceptably high). Avoid excessive bed moves.
- For individuals in need of stimulation, consider environmental adaptations to engage and reduce boredom.
- Nurse on low beds for individuals assessed at risk of falling/climbing out of bed.
- Encourage day/night routine. Keep bed area well lit during the day and dark and quiet at night if safety of individuals allows.
- Allow individual to move around the ward/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, volunteers, students, family members and any other staff in the planning and delivery of the activity programmes
- Avoid boredom and loneliness
- Plan appropriate activities on a daily/weekly/monthly basis as appropriate
- Consider building activities into the weekend
- Consider discussions, reminiscences, music, games, exercises, creative activities, involve visitors
- Match activities to a person’s interests/former occupations.

8. **Independence and mobility**

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

9. **Normalise sleep-wake cycles**

- Allow for 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 and provide reassurance and gentle activities.

10. Nutrition

• Make sure that the individual has 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 to feed themselves? e.g. consider different coloured meal trays for individuals who require assistance.

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
• Consult with relevant local care teams
  ▪ Monitor for pain management requirements, and any new symptom presentation.

Fig. 2 - A communication tool for delivering individualised care

<table>
<thead>
<tr>
<th>An approach for talking AND listening</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Engage.</strong> Establish a personal connection, e.g. introduce yourself, make eye-contact, smile, ask how the individual wants to be addressed. Try to find out information about the individual through general chatting. Talk to the family member and carer.</td>
</tr>
<tr>
<td><strong>Conversation.</strong> Speak clearly and calmly and try to initiate a conversation. Do not be afraid to talk to the person.</td>
</tr>
<tr>
<td><strong>Empathise.</strong> To aid communication with the individual ‘step into their world.’ How would you feel in their situation? Acknowledge their concerns and feelings and show compassion.</td>
</tr>
<tr>
<td><strong>Listen.</strong> Actively listen, accept and validate feelings and ideas expressed by the person. Try to be open-minded and not judgemental.</td>
</tr>
<tr>
<td><strong>Understand.</strong> You may need to speak slowly, keep information simple, allow time to understand and respond to questions. Avoid sounding patronising here.</td>
</tr>
<tr>
<td><strong>Question.</strong> Consider alternatives to multiple questions, e.g. make statements (‘you look unwell today’), use ‘we’ (we must do something about that), ask questions with a yes/no answers, ask questions and offer a number of choices.</td>
</tr>
<tr>
<td><strong>Transparent.</strong> Be open and honest and transparent when communicating with the person about what needs to be done.</td>
</tr>
</tbody>
</table>
| **Negotiate.** Work out a compromise between what you need to do and what the individual wants or will accept; as a rule look to give two options. 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, even if there is no real information to convey, e.g. 'now we are going to sit down here' etc. Explain all procedures and medical 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**. Asking the individual 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 and avoid punitive behaviours: avoid embarrassment, humiliation and allow face saving in front of peers.

- **Non-verbal communication**. Remember that non-verbal communication (including voice tone) is sometimes more important than verbal communication!

So always consider:
- Approach/communicate in view
- Friendly voice tone
- Make eye contact
- Facial expression (smile)
- Acknowledge (nodding)
- Non threatening stance and posture (open posture)
- Body movement (avoid sudden movements)
- Give personal space
- Appropriate use of touch (reassurance, affection).
De-briefs

Debriefs should be part of the support offered to staff following an incident of challenging behaviour. Debriefs should be conducted as a conversation among peers, to:

- Allow 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.

Regardless of which of the above objectives are being addressed during the meeting, the experience is best for everyone when it is a purely supportive meeting.

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 useful where the incident was serious enough or of a nature that it is likely to cause stress, trauma or distress to those who were involved.

Alternatively staff may request the opportunity to have an open conversation about an incident, or arrange one informally among themselves. This approach may be particularly appropriate for less serious, low level incidents. In some cases staff may not wish to take part in a 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 emotional or educational objectives. Unless conducted by a trained and experienced manager, trying to address both objectives in one meeting runs the risk of blurring the focus of the meeting and may even make what should be a supportive atmosphere feel punitive. These objectives should therefore normally be dealt with in two separate meetings. 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.

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.⁹

The timings for debriefs should be determined by the circumstances. For low level incidents, debriefs may be held soon after the incident. However for a more serious incident, if the debrief is held too soon, it may not allow enough time for the stress or trauma symptoms to fully manifest itself to enable people to talk about them. The patient/resident (and family) should also be given the opportunity to debrief.

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

⁹ See Christopher John’s ‘Model of Structured Reflection’ as an example.
SECTION FIVE: Training [see Annex 1]

Introduction

All staff in direct contact with patients/residents 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 assessment tools, 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 preventing challenging behaviour, fundamental to which is attentive person centred treatment 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 will benefit from understanding more about challenging behaviour and specific tools and strategies that will aid its identification, prevention and management.

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

In communicating this guidance organisations have an opportunity to reinforce key policy messages and guidance, including that in directly related areas such as Safeguarding.

It may help to consider training at three levels:

1. **Core learning needs**: A base level of awareness of challenging behaviour for all staff that interact with patients including non-clinical ward based staff, plus existing Conflict Resolution Training (CRT) requirements and dementia awareness.

2. **Role Specific input**: Guidance and training relevant to specific job roles performed and in particular where there are defined responsibilities in terms of the prevention and management of challenging behaviour such as clinical assessments, care planning and carrying our special observations.

3. **Targeted training and support**: Additional risk based inputs that can be planned, for example in an environment where challenging behaviour and injuries are generally more prevalent or reactive i.e. responding to quickly changing needs.

These are described in more detail below:

1. **Core Learning Needs**

It is important that all staff whether performing direct care, or in a support role have a basic awareness of challenging behaviour and a common language. For many this will be sufficient for them to recognise and reduce risks, whereas for others this will simply be a foundation.

This Core Learning can be delivered in various ways and should include:
Challenging Behaviour Awareness

To support the delivery of training for the prevention and management of challenging behaviour, each section of this guidance has a set of core learning outcomes which are applicable for all patient facing staff – See Appendix 2

Conflict Resolution Training (CRT)

Front line staff working in health and social care 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 also choose to include Challenging Behaviour Awareness as part of a combined course with CRT or incorporate it as part of other training initiatives such as those addressing staff training needs around dementia\(^\text{10}\).

It is important therefore that all staff interacting directly with patients receive both CRT and the Challenging Behaviour Core Learning Needs outlined above.

2. Role Specific Input

This guidance provides a range of tools and strategies for preventing and managing challenging behaviour which includes role specific responsibilities. Certain roles will require additional focused input to the Core Learning outlined above in order to equip individuals to fulfil their responsibilities.

Most of 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 has in its prevention and management.

The following list, whilst not exhaustive provides examples:

- **Managers** need to be aware of their responsibilities for implementing and monitoring compliance with this guidance, risk assessment, encouraging reporting, reviewing of incidents and identifying additional training and support needs.

- **Doctors** require input on medical assessment, diagnosis and treatment protocols and tools for challenging behaviour.

- **All staff (doctors, nurses, HCAs, allied healthcare professionals)** require input on developing person centred care strategies and plans for preventing and managing challenging behaviour.

- **Security and/or Emergency Response Team members** need to have a full understanding of powers, rights and responsibilities including relevant procedures such as clinical holding, detention, removal and special observation. They need training in how to prevent, calm and manage challenging behaviour in a way that best protects individuals and staff and may need training in the medical risks associated with the use of physical intervention in individuals who may be acutely unwell.

\(^{10}\) Common core principles for supporting people with dementia: a guide to training the social care and health workforce, DH 2012
• **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 physical intervention of an individual, which can involve substantial risk.

3. **Targeted Training and Support** (Planned and Reactive)

In addition to the 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 a range of variables including the environment, individual group 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 more such individuals for longer periods than others. Similarly, drug and alcohol complications can impact in 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 surrounding for example, a procedure, 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 inform this and 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, there will however be situations that occur with little warning requiring 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 Fig.2
**Fig. 2 ‘Targeted’ Training Needs Assessment: A risk based approach**

<table>
<thead>
<tr>
<th>Service/Patient Considerations</th>
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<tbody>
<tr>
<td>Incident Analysis</td>
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<tr>
<td>Risk Behaviours &amp; Scenarios</td>
</tr>
<tr>
<td>Risk Activities Performed</td>
</tr>
<tr>
<td>Policy &amp; Guidance</td>
</tr>
<tr>
<td>Role Expectations</td>
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<tr>
<td>Existing Knowledge &amp; Skills</td>
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</tbody>
</table>

**Delivering learning**

**Core Learning** is focused mainly on raising of awareness of challenging behaviour and simple steps everyone can take to help prevent it. This could 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. Ward based ‘drop-in training’ may assist here.

NHS Protect stipulates CRT must include face to face training. Whichever methods are used it is important that organisations can evidence that key messages are received and understood. 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 plans are competent to do so, as are those engaged in behaviour management and response roles. Staff involved in ‘specialing’ patients must have their training needs identified.

Consideration should be given to including key learning within induction and refresher training and threading into existing pre and post registration training.
**Targeted training** may need to include practically based input for staff most vulnerable to assaults and to those that respond to risk behaviours. For nursing, clinical, support and medical staff in areas of heightened risk of clinically related assaults may need practical input on how to position and work safely in close proximity to an individual who may be confused, unpredictable and vulnerable. This may include assault 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.

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

The strategies and skills used to physically manage a confused person 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.

All such training should place emphasis on prevention and CRT and include relevant law and reference NICE, CQC and DOLS guidance.

**Transfer to practice and maintenance**

Challenging behaviour and clinical related assaults are a significant problem and it is important that organisations ensure this guidance and accompanying training is adopted. Organisations should also take every opportunity to refresh and reinforce key messages in the prevention and management of challenging behaviour and embed these in core inductions and update training.

Monitoring of compliance and evaluation of transfer and impact of training are vital and a reduction in injuries and restrictive practices targeted.
SECTION SIX: Communication and information sharing

Principles to communication and information sharing

Sharing patient identifiable information within health and social care services to safeguard patients and protect staff is not a breach of confidentiality.

Patient confidentiality

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

The Department of Health’s Confidentiality: Code of Practice and Supplementary guidance for the NHS should be read in conjunction with this section. This guidance will aid the decision making process for sharing patient confidential information where it is necessary to do so. The supplementary guidance specifies that disclosure is permissible where it is 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 members and carers from the outset.

• Transfer

The maintenance of meticulous medical records, care plans, and the collating and sharing of sources of information on what causes a person’s distress are vital when an individual is transferred from one care setting to the next.

Professionals have the responsibility for relaying information on challenging behaviour and management strategies on 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). This will be important in ‘settling down’ an individual as they are transferred from one care setting to the next.

Information exchange also needs to take place where an individual have been sent for diagnostics tests and return to their original 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 and be discussed with family or other carers if not. It should incorporate findings from other

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11 Confidentiality: NHS Code of Practice, DH, 2003
12 Confidentiality: NHS Code of Practice - supplementary guidance: public interest disclosures
sources, including profile work, health and social needs, risk assessments, ABC charts, incident analysis and general observations.

Care plans will describe the specific interventions that have been discussed with and agreed by the person, family and carer and staff and should include all strategies that 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 necessary in order to aid their understanding. Where an individual is cognitively impaired, care plans should be discussed and agreed with their family or other involved carer/advocate.

Regular review meetings should be held to ensure that the identifiable behaviours have been resolved, or to commence 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, based on observations from previous shifts to inform oncoming shifts. Although it is acknowledged that there may be time constraints, the nurse in charge to make sure that sufficient time is allocated during handovers for communication on changes in the individual’s behaviour, and solutions for staff taking over care. Any changes to the individual management should be included in the care plan.

  Handovers may be one suitable forum to enable staff to debrief low level incidents that have occurred.

- **Passport/profile**

  Individual profiles/passports which form an important part of their records are one vehicle for care information to be transferred along with the individual, for example when they move from a care home onto the ward and back again. This should be completed by the primary nurse, family and carers and will then become a valuable running document for staff to add any additional information as the individual is moved between care settings.

- **Post incident reviews**

  Thorough post incident reviews are vital to learn lessons from an individual and staff safety perspective, to update the care plan and share information with all those responsible for delivering care. At a wider department and organizational level, a review of incidents may help to identify short falls in the delivery of care (e.g. where a disproportionately high levels of intervention has been used) and may require the dissemination of best practice to staff, the updating of policies and training programmes.

- **Markers and alerts**

  All individuals deserve equal treatment and care on presentation/admission. The 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 and they should never be used punitively.

  A marker/alert can refer staff to the care plan for care interventions or highlight simple behaviours and suggested care interventions. They are widespread in mental health,
learning disability and ambulance settings (address flagging) as an integrated part of a risk assessment process. They have the potential benefit of being able to alert staff from care-to-care settings to the needs, risks and interventions needed at any time (including out of hours) where compatible systems are in place.

Organisation must have clear criteria for notifying a person, their family and carers before adding a marker (if there is an immediate threat it should be done retrospectively), proper audit and review procedures (e.g. every 3 months) and procedures to delete/remove a marker when it is no longer applicable – i.e. when behaviour no longer poses a risk.

The following descriptors may be considered for a challenging behaviour marker:

- **Compliance** – individual does what is requested
- **Verbal resistance** – “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 abuse, e.g. pinching, scratching, biting, slapping, grabbing etc
- **Serious or aggravated resistance** – throw objects, objects as weapons, attacking etc

For further information on markers, please see NHS Protect guidance:


External Information Sharing

**Information sharing protocols**

Any organisation looking to share confidential information with external organisations about a person’s challenging behaviour should take advice from their Caldicott Guardian, a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing between the health and social care organisations, local authorities, social services and partner organisations which satisfy the highest standards.

The DH 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 all organisations specifically develop an information sharing protocol to provide a legal gateway for sharing patient identifiable information to prevent and manage challenging behaviour, in accordance with the following legal framework:

- **Common Law**

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

- **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 information sharing principles are in accordance with S.29 of the Data Protection Act.

- **European Convention of 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 well-being 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.

The public authorities’ duty to share confidential information around challenging behaviours may be considered in the interests of public’s 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 enforcing the Data Protection Act 1998 (DPA) in relation to the sharing of confidential information which is based around eight principles of “good information handling”


- **Caldicott Principles**

Information sharing protocols governing the sharing of information between organisations should adhere to the following Caldicott 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.

The NHS Information Policy Unit and NHS Information Authority (NHSIA) can provide further information around information sharing principles and patient confidentiality.

http://www.doh.gov.uk/ipu/confiden/index.htm
http://www.nhsia.nhs.uk/caldicott/pages/default.asp
SECTION SEVEN: Organisational responsibilities

Boards

Chief Executives and Boards should demonstrate strong leadership and good governance by implementing the recommendations in this guidance, in order to effect the delivery of high quality and safe person centred care. This should form a central strand of clinical governance and effectiveness.

Boards must link with commissioners to optimise the positive individual experience and protect them from harm (see Domain 4 and 5), of the DH NHS Outcomes Framework domains for commissioning health services from 2012-13.


A Board strategy to prevent challenging behaviour must require:

- The delivery of the highest quality, planned person centred care, where the individual experience is of equal importance to any other organisational goal
- A commitment to the safety needs of patients/residents and staff
- A commitment to prevention strategies and an acknowledgement of the risks in using interventions
- An emphasis on compassionate person centred care delivered by a skilled workforce\(^{13}\)
- Availability of adequate resources, training and a highly skilled workforce
- Strong leadership from senior clinicians, directors of nursing, general and clinical managers and ward managers, who must oversee the care delivered by ward staff.
- Ratifying and implementation of effective policies, systems and procedures which are strongly weighted towards prevention
- Gaining assurance that these priorities are being met through regular feedback, outcomes and incident analysis.

Organisational culture

Challenging behaviour should be managed with the same level of commitment and resource in any clinical setting from emergency settings to elderly care.

Changing the organisational culture is a key part of preventing challenging behaviour. Cultural changes take time, resources and continuous effort, however all staff need to be aware of the benefits of preventing challenging behaviour can bring to the organisations reputation, individual care, staff and patient/resident safety and satisfaction.

Staff should be encouraged to provide regular feedback on their concerns about the delivery of care and should feel supported to raise issues without a fear of recrimination. Regular ‘clinical supervision’ may assist sharing concerns here.

Costs of challenging behaviour

There is a lack of evidence of the true financial cost of challenging behaviour, especially as many incidents particularly of a clinical and, or less serious nature can go underreported.

\(^{13}\) DH, Compassion in Practice, nursing, midwifery and care staff, our vision and strategy, 2012.
Managing those who are challenging is generally agreed to be extremely resource intensive.

NHS Protect provided a global figure which suggests that the financial cost of physical violence to the NHS was an estimated £60.5 million during 2007-08. 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 in 2009-10, reported 759 physical assaults and 1427 non-physical assaults. As a result, the number of staff days lost through absence immediately following an incident as a result of physical assaults, non-physical assaults and threatening behaviour, was 872 days. When replacement costs were added, the overall loss to the NHS was £122,000.

In another ‘typical’ large acute trust in 2012, its 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% was linked to challenging behaviour. They also responded to 263 calls for assistance with confused patients, conducted 87 clinically related restraints and attended 209 calls to assist relating to patients with mental health issues and dealing with patients leaving wards/A&E against medical advice. Directly attributable costs include £63,000 spent on security officer ‘bed watches’ and £50,000 on CRT and physical intervention training.

**Benefits of prevention**

Having an effective strategy to prevent challenging behaviour has numerous benefits:

- **Financial savings**: reduced lengths of stay, lower re-admission rates, reduced staff absence due to sickness and stress, lower staff turnover, reduced enhanced observations, lower stocks of items, safety equipment, medication
- **More efficient, effective and productive delivery of healthcare and better outcomes**
- **Delivery of important national priorities around better quality of care, reinstating compassion into healthcare, person centred care, dignity and respect**
- **Increased staff confidence, satisfaction, motivation and retention**
- **Increased individual 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 (CQC) outcomes*

Provider organisations must comply with the Care Quality Commission’s (CQC) regulatory framework underpinned by 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.

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14 some studies have found links between the increased costs of providing services for instance for those with learning disabilities and challenging behaviour (Knapp et al 2005)
15 Cost of violence against NHS staff – A report summarising the economic cost to the NHS of violence against staff 2007-08
Preventing challenging behaviour is essential to be able to demonstrate compliance with CQC outcomes around Involvement and information; Personalised care, treatment and support; Safeguarding and safety; Staffing; and Quality and management.


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.

Under this 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.

A number of the Regulations exist under this Act which must be considered when managing the risks from challenging behaviour, these include:

- The Management of Health and Safety at Work Regulations 1999. In particular, it requires employers to assess risks to employees and non-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), The Regulations put duties on employers to report serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses). This includes any act of non-consensual physical violence to a person at work, which results in sickness of 7 days or more.

www.hse.gov.uk

Organisational strategy for preventing and managing challenging behaviour

Nominated security management specialist

In accordance with NHS Protect standards for providers, organisations should employ or contract a qualified person who has been trained and approved by NHS Protect and accredited by the professional accreditation board to undertake security management work. This nominated security management specialist should work to ensure the safety and security of staff, patients and service users. Related roles and responsibilities might 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 management and advising on appropriate security provisions and technologies to protect staff
- When an incident necessitates further action, to liaise and assist the police with their investigations
• Assist clinical staff where necessary in a post-incident review to identify lessons learnt and implement appropriate remedial measures

**Reporting**

The 2012 NHS staff survey highlighted that just under two-thirds of incidents of physical violence and 44% of bullying, harassment and abuse cases were reported.\(^\text{16}\) Some of the main reasons for staff underreporting include:

• Stoical acceptance and tolerance of staff in the face of adversity
• Staff empathising with the ill person and not blaming them
• Staff concern that it may reflect poorly on their ability to manage an incident
• Reporting being too complicated, time consuming or not suitable for lower level behaviours
• 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:

• A high reporting regime is an indication of good organisational governance, a commitment to ever improving care, recognition of person’s needs and the need to support victims.

• Good incident reporting assists risk departments in identifying trends, patterns and ‘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.

• Good reporting has an inherent value to improved care by:
  - Enabling immediate changes to the care plan and the better delivery of care
  - Enabling overall improvements be made to the delivery of care: e.g. environment changes and redesign, changes to models of care to be needs focused etc
  - Providing a mechanism for staff to receive support and feedback
  - Providing a learning opportunity for staff to problem solve solutions.

• Organisations should 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 when completing incident forms with other risk and care planning documentation.

• For low level incidents, wards may find it impractical to complete a detailed incident form for each event and may consider incorporating a less detailed incident form into existing systems.

• Wards may consider implementing an incident tally. This gives staff a sense of ownership by implementing local strategies to prevent future incidents, and gives them confidence and control over their working environment.

\(^\text{16}\) http://www.nhsstaffsurveys.com/cms/
**Risk assessment**

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

- Individual risk assessments on admission or post incident to feed into their care plan
- Unit/ward-level 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/committee and Board senior management level response.

Where risk departments identify serious risks of challenging behaviour, this should feed into areas such as:

- 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
- The better protection of lone working staff (see below)

**Specific risk: Protection of lone workers**

Lone workers are particularly at risk from challenging behaviour. Organisations need to be able to accurately categorise ‘lone workers’, conduct risk assessments and put in place prevention measures, such as personal safety training, access to technology (backed up by a call support centre), an escalation process and support from colleagues - see NHS Protect guidance for further details [insert link…]

**Training**

Good training needs analysis and the delivery of bespoke training is essential as a ‘broad brush’ approach to training does not meet the needs of staff to prevent challenging behaviour, leads to low levels of compliance and satisfaction with the training programmes and is a poor use of resources. A tailored training programme should include:

- Core skills (Challenging behaviour awareness and CRT)
- Role specific (Individual clinical assessment and care planning)
- Targeted (risk based assault reduction and physical intervention)

Role specific training, such as delivering individualised care should be a key part of continuous professional development. This must be available to all healthcare professionals at both pre- and post-registration levels, and to health care assistants and assistant practitioners appropriate to their role, see section xyz.

**Staffing levels**

Even if staffing levels may not be considered low in relation to the normal nursing template for a particular individual group, it only takes one or two individuals exhibiting challenging behaviour to skew the allocation of resources on a ward and create a situation where it is
impossible for ward staff to deliver good quality care. When planning care to preventing challenging behaviour, organisations need to consider:

- Optimum staffing levels (see below)
- Mapping of staff skills levels and mix to the provision of care
- Recognition of the positive contribution that continuity of care makes to prevent distress
- Decisions on the best use of agency staff/HCA when planning care to prevent distress.
- Central register of those with physical intervention training.

The RCN recommends mandatory nurse staffing levels and links prescribed minimum staffing levels to better outcomes for patients, better quality of care, better individual experience, more efficient and effective working and fulfilling CQC’s inspection requirements to safeguard the health, welfare and safety of service users.

http://www.rcn.org.uk/__data/assets/pdf_file/0009/439578/03.12_Mandatory_nurse_staffing_ levels_v2_FINAL.pdf

**Personalised care**

This should be at the heart of any strategy to prevent challenging behaviour. *The Dementia: Understanding the risks and preventing violence – Work safe British Columbia* is an excellent guide which is freely available, published in Canada and explains how clinical care approaches and interventions, based around person centred care, can prevent or minimize the risk of injury to staff when caring for people with dementia.

**Ward environment**

According to the NHS Institute, ward nurses in acute settings spend an average of just 40% of their time on direct individual care. The Productive Ward scheme aims to improve this situation by releasing up time to provide more direct patient care. It is a systematic and inclusive approach to improving the reliability, safety and efficiency of the care that staff deliver.

The programme aims to enable healthcare professionals to evaluate the processes of care within their ward/unit settings and increase the proportion of time staff spend providing direct care, improve the experience of both staff and individuals and by organising the ward space so that the delivery of care is more efficient.

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

[Insert link]

**Care environment**

A well designed, maintained and managed care environment can minimise a person’s agitation and distress, reduce staff stress and can help achieve a calm environment.

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 the well-being of people with dementia, as well as improve staff morale and reduce overall costs. Early audits from EHE projects in
mental health settings have shown a reduction in falls, incidents of violent and aggressive behaviours and in the use of anti-psychotic medication.

See the overarching design principles and an environmental audit tool - link

**Service delivery**

Those who use health and social care services are entitled to expect a high quality service, delivered in a courteous and professional way. The breakdown in good customer service can exacerbate and escalate a situation to the extent where it is out of control.

The Design Council’s ‘Reducing Violence and Aggression at A&E’ recognised that violent and aggressive behaviour against A&E staff 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 waiting times viewed as unreasonably long
- Inhospitable environments
- Dehumanising environments
- Intense emotions in a practical space
- Unsafe environments
- Perceived inefficiency
- Inconsistent response to ‘undesirable behaviour’
- Staff fatigue.

The project produced three solutions including better information and communication to reduce a patient’s anxiety levels; a staff centred programme to enable staff to engage directly with issues of violence and aggression; and a design toolkit, including environmental layout and atmospheric recommendations.

Link
## ANNEX 1 - Clinically related challenging behaviour - Prevention and management training

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>CORE</th>
<th>ROLE SPECIFIC</th>
<th>TARGETED: Risk Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODULE</td>
<td>CLINICALLY RELATED CHALLENGING BEHAVIOUR AWARENESS</td>
<td>CONFLICT RESOLUTION TRAINING (CRT)</td>
<td>CLINICALLY RELATED CHALLENGING BEHAVIOUR ASSESSMENT &amp; PLANNING</td>
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<tr>
<td>AUDIENCE</td>
<td>All staff with direct individual contact (Can be a combined course)</td>
<td>As appropriate for Doctor, Nurses &amp; Managers</td>
<td>As appropriate for Doctors, Nurses working in Heightened Risk Environments</td>
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<tr>
<td>LINKS</td>
<td>Integrate with: Violence Reduction Policy, NICE, CQC, DOLS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDICES

- **Appendix 1 - Case studies**
  - Case study 1 - Imperial College Hospital Foundation Trust [Learning Disabilities]
  - Case study 2 – Sussex Partnership Hospital Foundation Trust - [Learning Disabilities]
  - Case study 3 - King’s College Hospital Foundation Trust – [Dementia]
  - Case study 4 – South London and Maudsley Hospital Foundation Trust- [Dementia]
  - Case study 5 – Cambridge University Hospitals NHS Foundation Trust;– [Mental health]
  - Case study 6 – South London and Maudsley Hospital Foundation Trust – [Mental health]

- **Appendix 2 - Core learning outcomes**

- **Appendix 3 - Glossary**

- **Appendix 4 - Expert Group**
APPENDIX 1 - Case studies

CASE STUDY 1 – Imperial College Hospital 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 in the department, 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.

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 over hearing staff discussing her condition. All well-intentioned efforts to calm and reassure her were met with great resistance on her part. The staff observed that she appeared very frightened and anxious and the initial impression was that this woman had a severe neurological or psychiatric condition. Mindful of her safety and that of the emergency staff, 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 all she wanted to do was to walk. The nurse spent the next hour or so walking round and round 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 she walked, the more her mobility improved and she then began to talk. It transpired that she had a learning disability and suffered with 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 mobilizing. Once the woman had gained her equilibrium she was quite happy to sit down and be formally assessed.

Key messages for treatment

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 be creative and adaptive 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, this woman needed time, understanding and a period of one-to-one attention in order to be able to communicate effectively and recover. In the competing demands of a busy emergency department it is essential that staff recognise the importance of such interventions and that they are given the priority that they deserve.

Source: Julia Gamston - Senior Nurse, Emergency Department, Imperial College Hospital Trust
CASE STUDY 2 – Sussex Partnership Hospital Foundation Trust

Background

Gary is a thirty seven 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 causes 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 nineteen 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 in turn failed to provide appropriate care and support for him. There were a range of factors to account for this sorry state of affairs including inadequate planning, poor management, low levels of unskilled and inexperienced staffing, 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 in order that the service is very much 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 concerned, for example, with 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 form.

Outcome

Gary has now lived alone, with staff support, for twelve 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, attends health appointments when necessary, has holidays and follows other leisure pursuits, eats out in pubs and restaurants and so on. Importantly, he now sleeps well at night – previously a long established 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 that has demonstrated the potential for change to occur, even in the most unpromisingly extreme circumstances.

Source:
CASE STUDY 3 – King’s College Hospital NHS Foundation Trust

Background

Marjory Warren 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 an overwhelming experience for patients with dementia. Environmental factors can trigger behavioural changes in this patient group whereby patients often wander due to under-stimulation or because signage is inadequate and they are looking for something. It is recognised that a lack of stimulation and boredom 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 Friend’s 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. The project team identified four main areas for improvement:

- Entrance to the ward
- Day room
- Nurse’s station
- General orientation and clinical ‘feel’ to ward

What was done

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 and the clinical atmosphere 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 was improved to aid orientation and day/night clocks were put up to help aid orientation.
The overall ward environment was ‘de-cluttered' through innovative use of storage. Seating and artwork was 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 to admire the views of London.

The existing dayroom was transformed into a multi-sensory space. The room needed to be flexible enough to be used for agitated patients who might require a low stimulus environment but which could be changed into a space where structured/unstructured activity could also take place. Lighting, imagery and sounds can also be adjusted to suit mood in
addition to provision of reminiscence materials and atomisers. Portable sensory equipment is also provided to encourage stimulating 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 covers areas such as the environment. Patients feel more confident when mobilising. Anecdotally when patients are transferred to Marjory Warren from the Medical Assessment Unit with one-to-one nursing, this is not required 24 hours after admission to the ward. We are still evaluating the data but the overall impression from patients, staff and visitors is that the environmental improvements have had a significant positive impact on patient well-being 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/mobilise without the fear of falling. Sensory Room - Very relaxing and calming environment for patients/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 Foundation Trust
CASE STUDY 4 – South London and Maudsley Hospital Foundation Trust

Background

Mr J has been admitted to an acute older person’s 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 keep 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 tool “This is me” 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 time of distress. Mr J really enjoys a clean shave and his wife demonstrated how he likes this. 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 Mr J is distressed the following has been helpful:

- Speak clearly, slowly, using his preferred name and ensuring he has time to respond in every interaction
- Answer any of Mr J’s question honestly and as succinctly as possible
- In any interaction ensure that Mr J is orientated to the environment
- Increase staff one-to-one times at these times
- Show Mr J familiar objects that he likes
- Provide an activity that he enjoys as 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, talk about past positive memories, use of therapeutic touch and offer 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 have 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 and as a result of team approach that delivers responsive care incident are resolved quickly
- Staff feel supported and enabled to provide responsive care
- The family state that they feel involved in his 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 for practice

- The critical dimension of **ALL** care is to be kind, compassionate, respectful and 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
• 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 (Kitwood 1997)
• Family and informal carers are crucial to understand the needs of the person and full involvement in care will lead to better outcomes.

CASE STUDY 5 – Cambridge University Hospitals NHS Foundation Trust

Background

The individual is a 38 year old female. She has a personality disorder of the antisocial and impulsive type and a heavy substance misuse problem. She has some forensic history, having been detained on section 38 and has also been in prison for burglary. She has been treated under the Mental Health Act 3 times in the last 8 years and has one admission on to a Psychiatric Intensive Care Unit (PICU).

Her mother died of an 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. 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, called “stupid” and worse. Her poor reading and writing abilities indicates 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 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 on 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 pain killers. Because of this, the nurses found it difficult to care for her as she was very intimidating. The nurses found developing a rapport difficult. 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, i.e. one-to-one care.

A nurse specialist was called in after a weekend where security had been with her 6 times on the Sunday. The patient has an intimidating manner.

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 the wish if at all possible, or else gave a clear explanation as to why not.

In this patient’s case she wanted to go out for a cigarette, which they did. This was an opportunity to begin engaging the patient by asking them 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. Aims of care
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 the gains for herself. The aim of the plan was to ensure her needs were met so she did not have to present with 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 and ask if she wanted anything and to 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, trips for a cigarette etc.

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

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, 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 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; Addenbrookes*
Adult Mental Health Nursing Care Plan

(To be completed by mental health nurse for nursing care to be carried out by the nursing team).

**Issue(s) to be worked with:-**

X finds it very difficult being confined in hospital in a single room, also if staff are confrontational as it reminds her of very difficult incidents of abuse in her childhood.

**Agreed way of caring:-**

1. X is on a Positive Behavioural Programme this means that:
   - Please can her allocated nurse go into her room every hour to see if she wants anything, also to ask her how she is and have a chat.
   - Record in her room-on the chart on the wall, when you have been in so she knows when the next visit is.
   - Tick on the chart on her door to remind you when the next interaction is.

2. X can go down for a cigarette 4 times a day about 8,12,5 and 10 but we are not rigid about this. She knows that staff may be too busy and is OK with this as long as she is told rather than left.

3. If you think X is becoming agitated ask her what the problem is and try and help, remind her that we are doing our best and that things have been going really well recently.

**Review:-**

Daily review.
CASE STUDY 6 – South London and Maudsley Hospital Foundation Trust

Background

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

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

In terms of his experiences, he spoke of the variations of communication in the various wards. He has also found that even in the forensic service, there are variations in staff approach, from those staff enforcing the rules to those whom 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 staff members and other patients alike.

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, in particular those who 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 are responsible for target setting, achieving targets and are accountable for things not being done, including the primary and associate nurse. It also had the benefit of giving him direction and some idea of what he had to achieve and what this would mean for him.
### 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/guidelines for himself as reference to pursue the 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 - M and A, 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, to ask for hospital grounds leave.

- Mentioned about KGV assessment sessions with the Associate Nurse P and to think about whether he is interested in attending; the session would be taped to discuss in the future.
These are some of the statements made by X, it often shows poor reflection on the part of the nurse. In some cases a move away from controlling the patient towards exploring and accepting decisions made by X appears essential in facilitating greater engagement.

It is noticeable that the Primary Patient Pathway is of greater benefit because without meaningful engagement we have nothing.

Source: Jim Tighe, Team Leader, Cane Hill, South London and Maudsley Hospital
## APPENDIX 2 - Training core learning outcomes

<table>
<thead>
<tr>
<th>CORE LEARNING</th>
<th>ALL DIRECT PATIENT FACING STAFF ABLE TO:</th>
<th>SUPERVISING ROLES CAN IDENTIFY THEIR RESPONSIBILITIES TO:</th>
</tr>
</thead>
</table>
| **Introducing and Understanding Clinically Related Challenging Behaviour** (Chapters 1 & 2) | 1. Identify where to access policies and guidance relating to clinically related challenging behaviour  
2. Explain why it is important to be proactive in addressing challenging behaviour  
3. State the key principles of dignity in care  
4. Identify key legal requirements relevant to clinically related challenging behaviour and an individual’s rights  
5. Define challenging behaviour and common characteristics of individuals who manifest such behaviour  
6. Provide examples of the types of challenging behaviours most relevant to their role and setting  
7. Identify patterns of challenging behaviour  
8. Identify common environmental, situational and physical factors which may trigger challenging behaviour  
9. Identify behaviours that may be precursors to challenging behaviour  
10. State the four main categories of reasons for challenging behaviour | • Ensure guidance and information is readily available locally on clinically related challenging behaviour  
• Maintain staff awareness of the signs/precursors and triggers of clinically related challenging behaviour |
| **Managing Risk and Assessing Behaviour** | 1. Explain why physical interventions, rapid tranquilisation and seclusion should only be used as a last resort  
2. Explain how patients can be vulnerable due to their condition and behaviours  
3. Describe risks to staff supporting individuals with displaying clinically related challenging behaviour  
4. Explain how risks can be reduced through positive staff attitudes and behaviours and by recognising and responding to the needs of each individual patient  
5. Describe key principles for managing the risks with challenging behaviour  
6. Describe actions to be taken to reduce risks to patients and staff in an emergency situation | • Monitor risks to both patients and staff relating to challenging behaviour  
• Advise staff on how they can help prevent the challenging behaviours and reduce associated risks to themselves, the patient and others  
• Ensure an individual’s capacity is assessed in accordance with the MCA and policy  
• Ensure physical intervention is only used lawfully and as a last resort by appropriately trained staff  
• Ensure staff focus on understanding and responding to the specific needs of the individual patient |
| Understanding Behaviours | 1. Describe how challenging behaviour can result from a communication issue and/or unmet need  
2. Give examples of functions of challenging behaviours relevant to their setting  
3. Recognise that challenging behaviour can often be prevented through delivery of good care | • Advise and support with functional assessment of challenging behaviour and use of ABC charts (where practical) |
|---|---|---|
| Care Strategies | 1. State the key care principles for managing emergency situations  
2. Describe a practical approach to de-escalate and manage an individual displaying challenging behaviour  
3. Identify practical strategies for individualised sub-acute and long term care  
4. Describe the elements of a communication tool for delivering individualised care; an approach to talking and listening | • Monitor for signs of clinically related challenging behaviour  
• Ensure staff know what is required of them in an emergency and respond accordingly  
• Support and advise on individualised care and sub-acute and long term care strategies  
• Supervise consistency of care provision for the patient in accordance with agreed strategies  
• Provide good role models for positive communication and individualised care  
• Inform and involve families and carers  
• Ensure debriefs and handovers take place |
| Information Sharing and Learning | 1. Identify requirements on staff in identifying and reporting incidents and risks  
2. Explain why it is important to pass on relevant information to colleagues in notes and at handover (whilst respecting patient confidentiality)  
3. State key Safeguarding messages and what to do if there are concerns over an individual’s treatment or care, including whistle-blowing procedures  
4. Identify sources of further guidance, advice and support available within the organisation in the prevention and management of challenging behaviour | • Review care plans and ensure information sharing and involvement of stakeholders  
• Supervise the reporting and follow up of incidents  
• Provide leadership and effective supervision to ensure professional patient centred care and to identify and act quickly on safeguarding concerns  
• Identify any further staff learning needs and inform the relevant persons who can support these |

**ROLE SPECIFIC LEARNING**

**Doctors**  
Additional knowledge required by Doctors involved with immediate care

*In addition to the Core Learning outcomes Doctors should be able to:*

- Explain the benefits of a person centred approach for patients with clinically related challenging behaviour
- Explain the benefits of actively involving multi-professional colleagues, families and other carers to inform assessment, treatment and care
| Long term medical assessment of individuals with clinically related challenging behaviour | **In emergency situations:**  
- Describe how to undertake a rapid assessment in an emergency situation of the safety of oneself, the patient, staff and others  
- Identify NICE CG 25 requirements on use of physical intervention to gain immediate control of an emergency situation, including those relating to safe holding and rapid tranquilisation  
- Identify the key stages involved in making a clinical assessment where an individual is exhibiting clinically related challenging behaviour and the investigations involved  

**In sub-acute or longer term situations**  
- Explain why it is important to use person centred approaches and observation tools when assessing behaviours, their underlying causes and the needs they may be communicating  
- Describe how to assess for delirium and its common causes  
- Describe how to assess for evidence of other serious mental disorders, with appropriate specialist advice where needed  
- Explain how provoking or exacerbating factors are identified, documented and addressed  
- Explain how to make a formulation or diagnosis for the problem behaviour  

**Non-pharmacological approaches:**  
- Identify approaches based on the care needs of the individual  
- Explain how to develop a care plan with nursing and other multi-professional colleagues  
- Identify if a low stimulus environment is needed and any extra reassurance, support and care  

**Drug treatments:**  
- Identify symptoms related to clinically related challenging behaviour  
- Identify potential for Dementia with Lewy Bodies or Parkinson’s Disease, and relevant treatment guidelines  
- Identify when drug treatment may be appropriate to reduce distress and risks of harm to patient and others  
- Describe how to assess a patients capacity to give or withhold consent to treatment  
- Explain the key legal requirements to comply with and protect the patients best interests  
- Identify best locations for care if initial management is unsuccessful, or behaviours cannot be contained  
- Identify when further senior advice is needed and when urgent referral to mental health services is required  

**Follow up**  
- Identify follow up steps to review progress and treatments  
- Identify when it is necessary to communicate changes with GPs and relevant mental health services, community mental health or learning disability teams  

| Conflict Resolution Training (CRT) | **Core CRT Requirement**  
Front line staff in the NHS 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 also choose to include Challenging Behaviour Awareness as part of a combined course with CRT or incorporate it as part of other training initiatives such as those addressing staff training needs around dementia |
It is important therefore that all staff interacting directly with patients receive both CRT and the Challenging Behaviour Core Learning Needs outlined above.

**Additional Needs for Higher Risk Settings**

- **Responding to physical challenges presented by patients**
  - In addition to the Core learning outcomes and CRT, staff that have increased exposure to clinically related challenging behaviour and associated risks of injury to staff and patients, may also need to be able to:
  - Identify situations and activities within their setting that present increased risk of harm to staff and patients
  - Demonstrate practical strategies to reduce risk of injury when in close proximity to patients providing treatment and care
  - Demonstrate how to protect against imminent threats and disengage safely
  - Explain how risks to patients can be reduced where physical strategies are necessary
  - Demonstrate low arousal methods for guiding & re-directing confused patients
  - Demonstrate respect and duty of care for patients

**Additional Needs to the above for Incident Response Functions**

- **Incident Response**
  - In addition to the Core learning outcomes, CRT, and the additional outcomes for Higher Risk Settings individuals performing an incident response function as part of their roles as security officers, porters, doctors and nurses, may also need to be able to:
  - Demonstrate safe methods for holding a patient to prevent them harming themselves or others
  - Demonstrate safe methods of clinical holding to allow essential treatment or care at the direction of a doctor
  - Demonstrate how to work effectively as part of a team in an emergency situation
  - Demonstrate how to verbally and physically de-escalate interventions
  - Demonstrate a duty of care and respect for the patient
  - Describe how to report and account for actions
APPENDIX 3 - Glossary

**ABCDE**
An approach used for resuscitation in emergency situations: A=airways; B=Breathing; C=Circulation; D=Disability; E=Exposure.

**Challenging behaviour**
Any non-verbal, verbal or physical distress 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 include loss of memory, mood changes, and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases, including Alzheimer's disease and damage caused by a series of small strokes. Dementia is progressive, which means the symptoms will gradually get worse.

**Information sharing protocol**
An agreement for the secure sharing of personal confidential information across organizations, to facilitate the necessary, appropriate and lawful sharing of information to meet the public interest while protecting their individual rights.

**Personality disorder**
A type of mental illness in which the person has difficulty perceiving, feeling and relating to situations and to people. There are many specific types of personality disorders.

**Physical intervention**
Any physical contact between persons using reasonable force to restrict movement or mobility and is intended to prevent serious harm to the patient or staff member.
APPENDIX 4 - Expert Group responsible for development of the guidance

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