Document Title:	Policy for managing medically challenging behaviours in acutely ill patients and using restrictive practices
Document Purpose:	Providing guidance for staff
Document Application:	Trust wide
Responsible for Implementation:	Director of Nursing, Senior Managers, Senior Nurses

Main imperatives of this document are that:

- staff must make themselves aware of this policy
- staff will understand decisions regarding restrictive practices must balance: need for treatment; independence and safety in the least restrictive manner whilst doing as little harm as possible

Document Classification:	Corporate	**Document Reference:**	CO/ PO/00152
Version Number:	2	**Secondary Reference:**	
Issued by:	Director of Nursing	**Effective Date:**	March 2015
Author:	Interim Head of Safeguarding	**Review Date:**	March 2019

Expiry Date: March 2025

Associated Documents

1. Safeguarding and Protecting Vulnerable Adults
2. Learning Disability and Autistic Spectrum Condition Policy

APPROVAL RECORD		
Validated by Facilitator:	Risk and Document Control Manager	**Date:** April 2016
Agreed by Specialist Group:	Senior Manager Group	**Date:** March 2016

DOCUMENT HISTORY

Revision History

Revision Date	Summary of Changes
March 2015	New document
March 2016	Extensive review of policy

CONTENTS

1. INTRODUCTION

This policy discusses: the management of medically challenging behaviours in acutely ill patients, meeting patient needs for treatment and reducing/minimising any distress they may experience. Basildon and Thurrock University Hospital NHS Foundation Trust (BTUH) recognises and accepts its responsibility for promoting safe therapeutic services; acknowledging that care should always be managed in accordance with relevant legislation and national best practice guidance.

The importance of positive engagement and communication within care services cannot be overemphasised; all staff must be committed to meeting patient/service user needs and reducing distress and they must recognize that any complex behaviours impeding treatment may result from a physical illness.

BTUH will:

- encourage reflective practice
- have systems for the review of incidents and authorise staff to make practice changes as a result of these reviews.
- make initial training and refresher courses for conflict resolution available to staff.
- adhere to relevant legislation.
- carry out risk assessments and act upon the findings.
- provide systems that allow adequate staffing to prevent or manage incidents.
- provide support for patients/service users, staff and others who have been involved in conflict.

2. ROLES AND RESPONSIBILTIES

Chief Executive:

The Chief Executive as the Accounting Officer has overall responsibility for the quality and safety of services provided by the Trust. In this respect, he/she is responsible for ensuring that the infrastructure required to support the delivery and implementation of this document is available. He/she will delegate the full implementation of this document to a relevant Executive Director.

Medical Director:

The Medical Director is responsible for ensuring that the necessary systems, processes, training and competency assessment (where appropriate) are available to ensure that all medical and dental staff are able to comply with the contents of this document. In addition, he/she is responsible for ensuring that the monitoring and audit of this document is undertaken and reported in the appropriate forum as indicated in the document.

Director of Nursing:

The Director of Nursing is responsible for ensuring that the necessary systems, processes, training and competency assessment (where appropriate) are available to ensure that all non-medical staff (nurses, midwives and allied health professionals) are able to comply with the contents of this document.

Director of Operations:

The Director of Operations is responsible for ensuring that there are systems and processes in place to communicate and implement this document in the clinical areas.

Divisional Clinical Directors:

The Divisional Clinical Directors are responsible for ensuring that systems and processes are in place throughout the Divisions to ensure that this document is disseminated appropriately and that monitoring of compliance is undertaken, with remedial action implemented as appropriate.

In addition, the Divisional Clinical Directors are responsible for ensuring that all medical and dental staff comply with the contents of the document.

Divisional General Managers
The Divisional General Managers are responsible for implementing the systems and processes required throughout the Divisions to ensure that this document is disseminated appropriately and that monitoring of compliance is undertaken, with remedial action implemented as appropriate.

Heads of Nursing and Quality (HoNQ):
The HoNQs are responsible for ensuring that the policy is disseminated throughout the Division and that the required monitoring and audit are undertaken, with the resources provided to support this.

Clinical Service Unit Clinical Leads/ Unit Managers:
Clinical Service Unit Clinical Leads and Unit Managers are responsible for implementing this document in the Clinical Service Unit and for monitoring the impact on the service and reporting compliance with the document. They are accountable to the Divisional Clinical Director and General Manager in this respect.

Head of Therapies:
The Head of Therapies (HoT) is responsible for ensuring that this document is fully implemented at department level. This will include making sure all relevant and necessary training is given and received, that the introduction of the document is monitored and therefore assessing the impact this is having on service delivery. In addition, the HoT is responsible for ensuring that the required monitoring and audit are undertaken within the Therapy CSU and reported through the relevant governance system.

Supervisors of Midwives:
The SoM is statutorily responsible for document development, implementation and compliance monitoring across the midwifery spectrum. They are accountable to the LSMO for all elements of midwifery professional performance.

Lead Nurses:
Lead Nurses are responsible for ensuring that all nursing staff (including Nurse Specialists, Practitioners/Advisors) within the Clinical Service Unit comply with the contents of this document and for taking action when this is not the case. The Lead Nurse will make sure that all necessary training is provided.

Medical Staff
The Consultant holds ultimate responsibility for ensuring that all members of the medical team follow this document.

Senior Sisters/Nursing Staff
The Senior Sister/nurse in charge is accountable for the safe care and management of patient on the ward. They are therefore responsible for ensuring that all staff within the ward comply with this document and for implementing a system to provide assurance that this is the case.

3. COMMON PATIENT DIAGNOSES LINKED WITH MEDICALLY CHALLENGING BEHAVIOURS

Individuals manifesting medically challenging behaviours often have a cognitive impairment either chronic and permanent (dementia or a learning disability) or acute (head or brain injury, drug/alcohol intoxication, withdrawal or side-effects). The types of behaviours exhibited by both groups can include non-verbal, verbal and/or physical behaviours which impede or prevent required treatments from being delivered.

These can sometimes be associated between behaviours, with specific patterns such as 'sun-downing' with dementia patients (behaviours more prevalent in the afternoon/evenings or during times of heightened activity such as mealtimes). Table 1 provides examples of behaviours which may be observed.

Table 1 Types of behaviours

Non verbal	Verbal	Physical
Agitation	Shouting	Scratching
Pacing	Swearing	Biting
Staring	Crying	Grabbing
Interference with property	Repetitive questions/statements	Spitting
Invading personal space		Kicking
		Removing lines/catheters
		Self harming behaviours

3.1 Examples of medically challenging behaviours

Medically challenging behaviours present difficulties for all clinicians involved in trying to meet urgent/essential physical health and treatment requirements. Behaviours such as inadvertently removing feeding tubes and other essential lines mean that necessary treatments cannot be delivered in a timely or effective manner.

Clinically related medically challenging behaviours are often a manifestation of a patient/service user's distress, and represent them attempting to communicate their unmet needs. These behaviours can occur in any health environment; however, prevalence is complex. In the acute hospital sector most incidents necessitating interventions occur not in A&E as expected, but on acute medical wards (NHS Protect, 2013:4).

4. MANAGING MEDICALLY CHALLENGING BEHAVIOURS

Many patients in the acute phases of an illness become restless, confused or unable to understand what is happening to them. There are a range of reasons including: medical conditions, a cognitive impairment or pre-existing mental illness. Some patients will also experience a worsening of any pre-existing cognitive impairment or mental illness because of the change in their environment, moving from home into a busy hospital setting where there is lots of noise and activity. Thus any required treatments may be more complex to deliver; however, and most critically these treatments may also be life-saving and thus must be delivered/administered.

Medically challenging behaviours focus on two key areas:

- deleterious or harmful to self
- deleterious or harmful to others including: patients, staff or visitors

The former may include: pulling out essential lines; refusing tests; increased falls risk etc.; the latter may include: walking round the ward and banging into other patients; trying to go home, removing other patients' lines and or aggression towards others. Clearly, both areas present difficulties to teams caring for them; staff are duty bound to safeguard and protect both the patient himself/herself and those others around them.

4.1 Managing patients in an acute phases of illness with medically challenging behaviours – without capacity due to their illness e.g. Sepsis or UTI

Sometimes patients manifest behaviours such as: pulling lines, catheters etc. out because they are medically unwell; this may result in the need to treat them because they are acutely unwell but also unable to consent for treatment. This group of patients will probably recover within five days, having received the requisite antibiotics. In such cases short term risk assessed and planned restrictive interventions such as the use of mittens is appropriate.

4.2 Documenting care and restrictive interventions delivered to patients lacking capacity for a short five day period

All clinical staff should be familiar with taking a history from the patient/service user or another; particularly important where the patient/service user may present with complex or unusual behaviours linked to an acute illness. Records should contain information on:

- medication taken within the last 48 hours, in order to prevent overdose
- beneficial or adverse effects of previous medication
- influence of illicit substances, legal highs or alcohol consume

Mental state and capacity should be clearly documented, and any physical examinations must state which, if any, of the following apply:

- acute confusional state
- general condition and weight
- previous history of falls
- state of hydration
- presence of infections
- evidence of pre-existing cardiac or pulmonary conditions or pregnancy
- baseline pulse, blood pressure, temperature and respiratory rate if at all possible
- previous head injury and seizures
- physical disabilities

These discussions provide supporting evidence identifying the need for the deployment of a restrictive practice in the person's best interests in the short term.

4.3 Understanding reasons for medically challenging behaviours – key points for staff

The need for staff to understand behaviours in order to manage these effectively is critical; staff must always remember that:

- distress and the context of care can cause medically challenging behaviours
- behaviours are not an inevitable consequence of conditions such as dementia
- the individual is not to blame
- staff must be reflective and honest to develop a culture which promotes personalised care
- models of care and pathways may require modification to minimize distress

5. CONTRASTING WITH RESTRAINT - USING A RESTRICTIVE PRACTICE APPROPRIATELY

The act of restraint involves taking deliberate actions taken to stop a person from doing what they wish to do. There are five well recognised forms of restraint:

- physical restraint – holding the person, blocking their movement to stop them leaving
- mechanical restraint – the use of equipment such as chairs with lap belts or specially designed mittens
- technological surveillance such as tagging; pressure pads; CCTV
- chemical restraint – using medication to sedate or reduce movement
- psychological restraint – constantly telling someone not to do something

Whilst the malicious and abusive use of restraint can occur, the vast majority of clinicians are conscientious and caring.

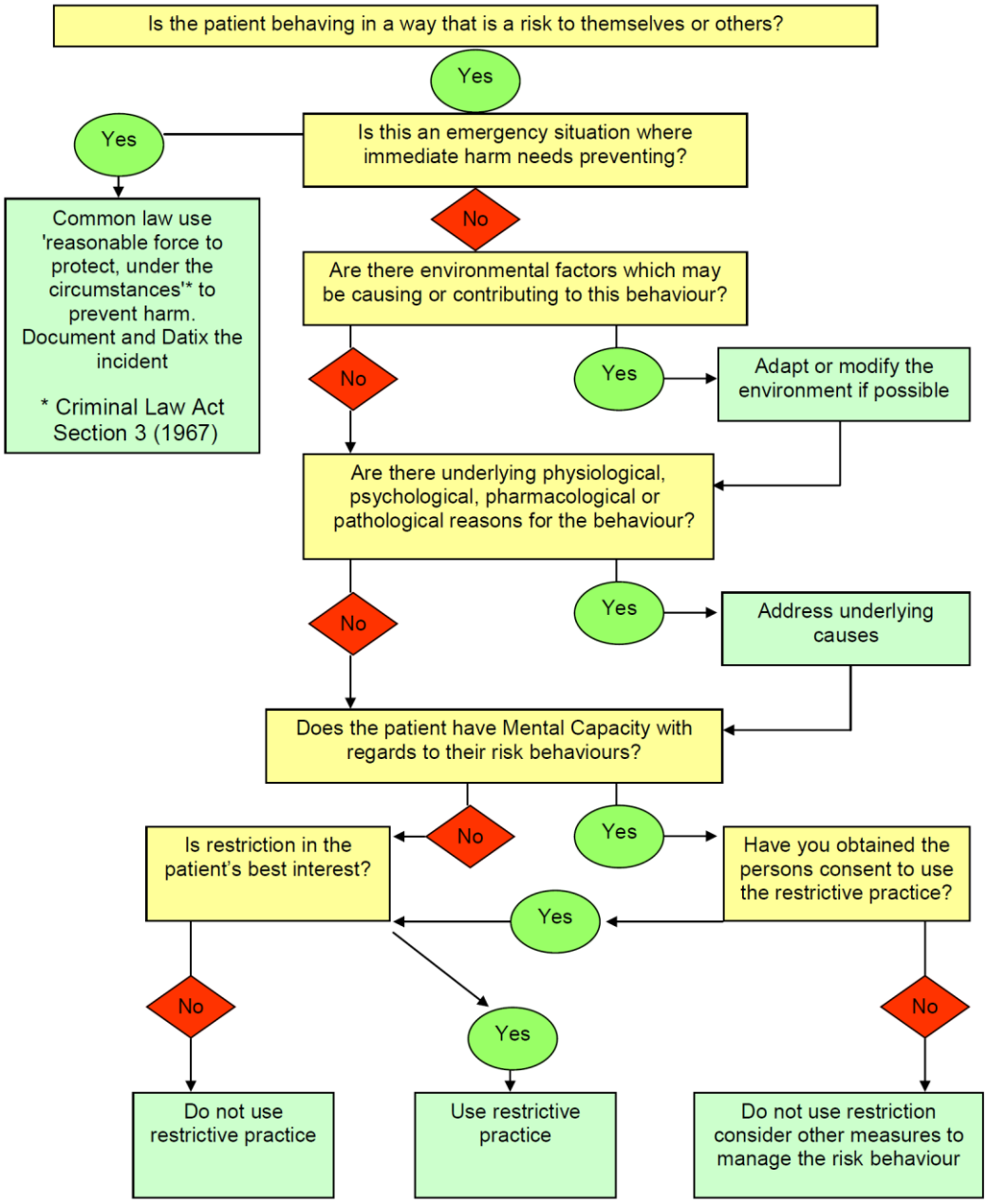
Equally, decisions about the use of restrictive practices are ethically sensitive and challenging; however, there are circumstances where the use of a restrictive practice is justified and positively required. A restrictive practice will, in such cases, be positively employed to ensure the person's safety and enable their treatment.

Table 2 shows the key differences between restraint and restrictive practices. For example, the use of mittens may be considered a form of restraint. However, there will be circumstances when the use of mittens is clinically justified, such as to prevent removal of tracheostomies or lines essential to maintaining life. Table 2 shows that the use of bed rails to stop a person getting out of bed when they wish to would be considered as a form of restraint. Conversely, using bed rails to prevent someone from falling out of bed would not, and would be a decision made about the person's personal safety and injury prevention. Similarly, the use of mittens would not be considered first line least restrictive choice for a patient wishing to take of their clothes; however, these may be used as part of a care plan designed to prevent the removal of a tracheostomy or other lines which may be in place to preserve life. Therefore, the situation is complex, and Figure 1 shows considerations linked to making a decision to use a restrictive practice.

Table 2 Examples of restraint/restrictive practices vis-à-vis ensuring safety

Control behaviour/prevent person doing something - restraint	**Ensuring safety – restrictive practice**
Use of bed rails to stop someone getting out of bed	Use of bedrails to prevent someone falling out of bed
Physically holding a person down	Physically stopping someone walking out in front of a car by holding their arm
Forcing treatment without consent	Treating someone in their best interests
Use of baffle locks or key pads	
Use of mittens as a first line	Risk assessed and care planned use of mittens to safeguard treatments or prevent harm
Use of low seats/bucket seats	Care planned use of a low chair for clinical reason
Inappropriate use of wheelchair straps	Risk assessed and care planned use of wheelchair straps to prevent a person falling out of a chair
	1:1 or 2:1 observations/diversionary entertainment

Figure 1 Flow chart guidance for restrictive practices



5.1 Making reasonable adjustments to reduce behaviours

A range of strategies can be employed to manage behaviours and alleviate medically challenging behaviours. For example, careful observation strategies may reveal the person wants to walk around more in the afternoon, but that they settle after dinner; thus serving dinner at an earlier time may be an effective way of managing the person in a non-restrictive manner. Ensuring blood and other tests are taken at a time of day when the person is functioning well, rather than at a time when they are clearly anxious or upset is another strategy which may be useful. Sometimes, in a non-emergency situation waiting half an hour may reduce the problem; or asking a different professional to approach the patient.

6. THE ROLE OF MEDICATION

The following are important considerations for staff involved in using medications to support them in their patient management strategies:

- ensure that you and key members of your team are familiar with the medications that you are using and the related possible side effects
- discontinue any potentially unhelpful medications
- simplify the medication regime
- agree a suitable therapeutic goal with the team
- note previous medicines and response
- note total medications in the last 24 hours (including illicit substances/alcohol)
- time limit prescriptions to ensure review
- use the algorithm for treatment as appropriate to the client group

6.1 The use of IM and IV medications – related considerations and NICE recommendations

Care must be by taken when giving intra-muscular/intra-venous injections, particularly to highly aroused or elderly patients. The inadvertent risks of injections such as: bolus dosing; nerve damage; bruising; needles breaking etc. are increased when patients/service users are resistive. There is also a higher than expected absorption rate of all medications due to the increased blood flow to the muscles in highly aroused patients/service users.

Intravenous injections can lead to a high concentration of the drug in the heart muscles and should always be avoided in older patients.

Given that medication may be required in an emergency it would be normal practice to record this on the PRN area of the medication chart.

6.2 Medications and contra-indications

Benzodiazepines when used in the elderly often have a paradoxical effect and also increase the risks of falls. However, Benzodiazepines are commonly used, and have important advantages over antipsychotics in terms of side effects and toxicity. Increasingly, benzodiazepines are a recommended choice; atypical antipsychotics may also produce effective calming and are tolerated better than older antipsychotics. However, the use of such medications is largely to be avoided with the elderly or those with dementia.

Suitable drugs needs to have a rapid onset of action; frequent small doses are safer and more effective than single larger doses, but may lead to a risk of accumulation. Therefore, the medications used should have a short duration of action and the prescriber should bear in mind the pharmacokinetics of the preparations used.

Advice may be sought from BTUH Pharmacists, senior clinicians or on-call mental health services.

6.3 Risks and complications associated with benzodiazepines and antipsychotics

There are specific risks associated with the different classes of medications that are used; the specific properties of the individual drug used should be taken into consideration. When combinations of medications are used, risks may be compounded; staff will need to be aware of the following complications associated with benzodiazepines:

- loss of consciousness
- respiratory depression or arrest
- cardiovascular collapse (in patients receiving both Clozapine and benzodiazepines)

Similarly, staff will also be aware of the following for antipsychotics:

- loss of consciousness
- cardiovascular and respiratory complications and collapse

- seizures
- subjective experience of restlessness (akathisia)
- acute muscular rigidity (Dystonia)
- involuntary movements (Dyskinesia)
- neuroleptic malignant syndrome (NMS)
- excessive sedation

7. TRAINING REQUIREMENTS

BTUH has a policy for training employees and staff in relation to the management of medically challenging behaviours. This training specifies who will receive: which level of training (based on risk assessment); the training frequency; the techniques in which they will be trained.

7.1 Specific staff training needs

Clinical staff should have access to training related to the following:

- the 'Bournewood Ruling' (especially in respect of restriction and deprivation of liberty).
- the Mental Capacity Act (especially in respect of the best interests and least restrictive principles).
- carrying out risk assessments for the prevention and management of clinical risks of medically challenging behaviours.
- racial, cultural, spiritual, social and special needs issues to ensure that staff are aware of and know how to work with diverse populations and do not perpetuate stereotypes.
- competency training to recognise anger, potential aggression, antecedents and
- risk factors of disturbed/violent behaviour and to monitor their own verbal and non-verbal behaviour.
- methods of anticipating, de-escalating or coping with disturbed/violent behaviour.
- competency training in observation so that they are equipped with the skills and confidence to engage with patients/service users.

7.2 Core learning needs – for managing medically challenging behaviours

All staff, whether in a caring or support role, should have a basic understanding/awareness of medically challenging behaviours and use a common language to describe and manage this. There will be three basic strands to training:

1. medically challenging behaviour awareness
2. resolution and treatment requirements (capacity assessments/DoLS etc)
3. promoting safe and therapeutic services

8. MONITORING AND AUDIT

Compliance with this policy will be monitored by the Head of Safeguarding on a biannual basis or following changes in national guidance.

9. APPROVAL AND IMPLEMENTATION

Approval

Approval of the document will be through the Senior Manager Group

Implementation

This document will be available electronically on the Trust intranet and staff will be informed of any updates via the Hub. Hard copies of the policy will be available via designated hard copy libraries in accordance with the Controlled Documents policy.

10. AUTHOR AND CONTENT CONTRIBUTORS

Interim Head of Safeguarding -
Named Nurse safeguarding -
Learning Disability Advisor -
Senior Manager Group

11. REFERENCES

The Blofeld Inquiry into the death of David Bennet (2004)

Department of Health (2000). Zero Tolerance Pack. Department of Health. Leeds.

Health and Safety Commission Violence and Aggression to Staff in Health Services: Guidance on Assessment and Management, (HSE 1997).

Department of Health (1999a) Addressing Acute Concerns: Report by the Standing Nursing and Midwifery Advisory Committee. London, HMSO

Department of Health (1999b) Effective Care Coordination in Mental Health Services: Modernising the Care Programme Approach. London, DoH.

Department of Health (2000) Safety, Privacy and Dignity in Mental Health Units. London, DoH.

Department of Health (2003) Inside Outside: Improving Mental Health

Department of Health (2002) Guidance on Restrictive Physical Interventions for people with learning disability and autistic spectrum disorder, in health, education and social care settings.

Gournay K., Ward M., Johnson S., Thornicroft and Wright S (1998) Crisis in the Capital; Inpatient Care in Inner London Mental Health Practice 1, 5, 10-18.

National Audit of Violence
ww.rcpsych.ac.uk/.../centreforqualityimprovement/nationalauditofviolence/navnationalreports.aspx - 32k

National Confidential Inquiry

http://www.medicine.manchester.ac.uk/suicideprevention/nci/

The National Institute for Mental Health in England (2004) - Interim guidance 'Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health Inpatient Settings: Mental Health Policy Implementation Guide'

National Institute of Clinical Excellence (2005) Short-term Management of Violent (Disturbed) Behavior in Adult Psychiatric In-patient Settings Guideline 25

NHS SMS strategy document (2003) "A Professional Approach to Managing Security in the NHS"

Royal College of Psychiatrists (1998). Management of Imminent Violence. Royal College of Psychiatrists. London.

Royal College of Nursing (1998) Dealing with Violence Against Nursing Staff Royal College of Nursing. London.

Royal College of Nursing (2013) Guidance on the minimisation of and alternatives to restrictive practices in health and adult social care, and special schools Royal College of Nursing London

Wessley S., Rose S., Bisson J (1989) A systematic review of brief psychological interventions ("debriefing") for the treatment of immediate trauma related symptoms and the prevention of post-traumatic stress disorder. Cochrane.