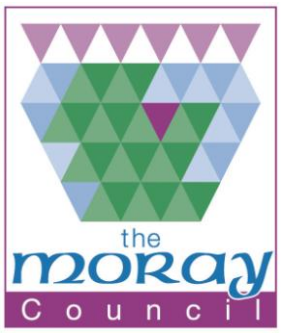

EDUCATION AND SOCIAL CARE SERVICES

Learning Disability Services

Behaviour Which Challenges Services, Restraint, and Physical Interventions

POLICY

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1.0 Introduction

Moray Council supports a wide range of people within its services, many of whom have complex needs arising from a range of social, emotional, physical, cognitive and physical factors. Service users can be supported by a diverse range of social, educational and health services including services for children and young people, services for adults with cognitive impairments (e.g. Learning difficulties/disabilities, services for older adults, family services etc.). Service users can also receive significant support from family and informal carers whose contribution must be recognised.

In a small number of cases the interaction between the individual's complex needs and their social and physical environment can cause the person to present a range of behaviours that can be described as challenging. These can include aggression and/or violence directed towards self or others. The existence of these behaviours carries implications, for the person's quality of life and the safety of others. Whilst regrettable, the exposure of staff to such behaviours is therefore a foreseeable and sometimes unavoidable aspect of care services. The risk of exposure to behaviour which challenges services can never be completely eliminated.

Moray Council carries a range of statutory responsibilities for the welfare of staff and service users. We are committed to supporting vulnerable people in a manner, which seeks to balance and promotes the welfare and safety of all individuals. This involves the promotion of a positive service culture in which we seek to understand the reasons behind behaviour which challenges services and acceptable responses to behaviour(s) are clearly defined and consistently implemented.

Maintaining and promoting the rights and welfare of all service stakeholders is a fundamental goal of this policy. Although the causes and solutions to behaviour which challenges services are complex, a key aspect is ensuring that service delivery is based on a model of practice, consistent with best practice and the Council's legal obligations. This policy is therefore based on the Positive Behavioural Support model

(see Joint report of the Royal College Psychiatrists, British Psychological Society and the Royal College of Speech and Language Therapists (RCP et al. 2008). Positive behavioural support is based on research, which concluded that although complex in their origins, established patterns of behaviour which challenges services are often the result of the interaction between distress, impairment and the social environment that have resulted in such behaviours becoming learned means of fulfilling the individuals needs. Developing a workforce of "reflective practitioners" (RCP et al. 2008) able to look beyond the immediate presenting behaviour and understand and address the underlying needs is therefore a key aspect of this approach.

2.0 Aims, Objectives and Scope of the Policy

- To make clear to service users, staff and the public the approach to behaviour which challenges services, restraint and physical intervention required by Moray Council.

- To promote the safety of staff, service users and public who may be at risk from aggressive or violent behaviour. Wherever possible such behaviour should be minimised. The aim is to promote safe working conditions, and practices within which such behaviour can be positively addressed.

- To safeguard the welfare of staff, service users and members of the public who may be at risk from aggressive or violent behaviour.

- To promote a shared vision within which staff can seek to harmonise practice.

- To respond to individualised service user needs through careful assessment and individual care planning in partnership with other professionals, agencies, parents, carers and service users/young person (as appropriate).

- To develop and maintain professional attitudes and responses to behaviour which challenges services and through the appropriate use of training, support and

supervision to enable staff to gain knowledge of good working practices and gain insights into their own practice.

- To provide a statement of the shared responsibilities of Moray Council and its employees in regard to the safety of service user, staff, members of the public and all those affected by its operations.

- To ensure that Moray Council meets its legal obligations when dealing with Behaviour which challenges services, Restraint, and Physical Intervention?

- To minimise the use of restraint and restrictive interventions and to maximise the independence of service users.

3.0 Definitions

The misuse of language and terminology can wrongly label a service user. The promotion of a common set of values reflected in shared definitions is therefore important in ensuring safe, effective practice and conformance with the expectations outlined in the underpinning framework of law, guidance and Care Standards. Various definitions appear in the statutory framework. For the purpose of this policy the following definitions apply:-

Behaviour:- Any thing the person does that can be observed. So 'Colin nipped Rachel on the left arm with his right hand', is a behaviour. 'Colin was annoyed with Rachel' is not a behaviour it is an inference drawn from the observation of his behaviour and involves a judgment which by implication may be subjective.

Chemical Restraint:- A medication used to control behaviour or to restrict a service users freedom, which is not a recognised treatment for an underlying disease (US Health Care Finance Administration 1999).

Behaviour which challenges services:- Behaviour can be described as challenging when it is of such an intensity , frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion (RCP et al. 2008).

Dilemma – A risk situation where:

- There are no harm free options
- A decision may need to be taken soon, as delay will be harmful.

Functional Analysis - Aims to understand behaviour through systematic observation and analysis of the relationship between the behaviour, its antecedents and consequences. This will include comprehensive assessment, risk-benefit assessment, functional analysis and formulation.

Hazard: - anything that can cause harm.

Holding:- A direct physical contact used with the intention of discouraging a behaviour (DoH 1993). This might, for instance, include holding someone's hand, placing an arm around the shoulder, guiding someone away from danger, etc.

Mechanical restraint:- The restriction of movement by the use of some form of mechanical device. This may include limb splints, cot sides, restrictive chairs, secure sleeping bags but also locked doors, etc.

Physical Intervention:- A manual intervention involving physical contact between two people with the aim of preventing harm or preserving the welfare of a vulnerable person. This might involve redirecting the person, which would not constitute a restraint or physically restraining a person see below.

Physical Restraint:- A direct physical intervention used with the intention of preventing a behaviour (DoH 1993). This usually involves force exerted by the staff

member against resistance by the service user in order to restrict or control their freedom of movement in some way although it can sometimes be used proactively.

Restraint: - There are two definitions of restraint, which impact on the work of the Care Commission.

The National Care Standards (NCS) define restraint as:
'Control to prevent a person from harming themselves or other people by the use of …
• physical means (actual or threatened laying of hands on a person to stop them carrying out a particular action);
• mechanical means (for example, wrapping someone in a sleeping bag or strapping them to a chair);
• environmental means (for example, using cot sides to prevent someone getting out of bed);or
• medication (using sedative or tranquillising drugs for the symptomatic treatment of restlessness or agitated behaviour)'.

The Mental Welfare Commission defines restraint, in its broadest sense, within their best practice guidance document "Rights, Risks and Limits to Freedom (2006)
'…restraint is taking place when the planned or unplanned, conscious or unconscious actions of care staff prevent a resident or patient from doing what he or she wishes to do and as a result is placing limits on his or her freedom'.

The Mental Welfare Commission further defines the following means of restraint:
• Direct physical restraint (holding someone).
• Direct mechanical restraint (lap belts or bedrails).
• Locking doors.
• Video surveillance.
• Passive alarms.
• Medication.

There are also indirect limits to freedom such as:

• taking away walking aids;
• control by staff; and
• financial controls.

Risk: – The likelihood of potential harm from the hazard.

Risk-benefit assessment*:-

When a provider is using restraint either as a direct intervention or a safety measure, they will need to have undertaken a comprehensive risk-benefit assessment and documented outcomes and actions. Any actions should make clear that they are the only practicable means of securing welfare and detail the exceptional circumstances - SSI 114/2002 Regulation 4(1) (c).

The documented risk-benefit assessment should include details of the following in the care plan:

• the involvement of the person and/or their relative or main carer/representative
• the behaviour or situation that is seen as causing the risk. Assessment should include factors such as physical illness, pain, side effects of drugs, psychological issues and consideration of a medical assessment
• the potential and/or actual risks to the service user and others eg if bed rails were being considered as an option, was the person's ability to climb up and fall from a greater height assessed
• the options that have been considered and the reasons why each has been discounted
• what action is being considered and/or implemented – this should start with the least intrusive response and should include the benefits to the individual, whose interests should be paramount
• What action is being considered and/or implemented where restraint is needed to safeguard other individuals
• what outcome is expected, including the costs/benefits to the service user as a result of the action being taken
• how all staff will be made aware of the action being taken

• the training that has been made available to staff to ensure that they can manage the intervention and take the any appropriate action needed
• the system for monitoring the appropriateness of the intervention, evaluating its effectiveness and taking any further action as required
• Recording when the response will be reviewed.

***Risk-benefit assessment" replaces the term "risk assessment"** taking account of recommendations from the Nuffield Council. "Regulators should require care providers to consider risks not in isolation, but in the context of a risk-benefit assessment and should replace the term 'risk-benefit assessment' with the term 'risk-benefit assessment'."

Risk Policy – An approved statement of when and how risks should be assessed, taken and managed.

Risk Management – Manipulating the assessed level of risk through the use of available resources.

Risk strategy – A method of implementing, reviewing and monitoring risk decisions.

Touching:- An appropriate direct physical contact as would be expected between a responsible parent and their child used to comfort, encourage, praise, coach or comfort a distressed person.

4.0 Related Policies/Procedures/Legislation

The Moray Council's responsibilities are set out in the following legislation:

- The Social Work (Scotland) Act 1968
- Health and Safety at Work Act 1974
- The NHS and Community Care Act 1990
- Community Care and Health (Scotland) Act 2002
- Chronically Sick and Disabled Persons Act 1970

- Disabled Persons (Service, Consultation and Representation) Act 1986
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Mental Health (Scotland) Act 1984
- Community Care (Scotland) Act 1990
- Health and Social Services and Social Security Adjudication's Act 1983
- Adults with Incapacity (Scotland) Act 2000
- The Regulation of Care (Scotland) Act 2001
- Children (Scotland) Act 1995
- Adult Support and Protection Act (Scotland) 2002
- Data Protection Act 1998
- Freedom of Information (Scotland) Act 2002
- Offences Against the Person Act 1861
- The Human Rights Act 1998
- Equality Act 2010
- Criminal Law
- Civil Law
- SSI 114 / 2002 Regulation 4(1) (b) and (c) state that providers shall:
  - '…provide services in a manner which respects the privacy and dignity of service users…'
  - '…ensure that no service user is subject to restraint unless it is the only practicable means of securing the welfare of that or any other service user and there are exceptional circumstances …'
- SSI 114/2002 Regulation 4(1) (c).

Policies/Procedures

- The Moray Council's Lone Working Procedure
- The Moray Council's Bullying Policy
- The Moray Council's Harassment at Work Policy
- The Moray Council's Incident Reporting Procedure
- The Moray Council's Community Care Incident Reporting Procedure
- The Moray Council Learning Disability Services Policy

Other Related Documents

- The Moray Council's Dealing with work related violence guidelines
- The Moray Council's Single Shared Assessment Form
- The Moray Council's Joint Service User and Carer Review Form
- Standards for Assessment and Care Planning for Adults
- National Community Care Outcomes Framework
- Mental Welfare Commission Guidance around reflective practice
- Mental Welfare Commission Publication 'Rights, Risks and Limits to Freedom' and 'Safe to Wander'
- National Care Standards – The Scottish Commission for the Regulation of Care
- SSC Codes of Practice
- Issues of Capacity especially when involving Service Users in discussions

Duty of Care:- Is *"A legal obligation imposed on an individual requiring that they exercise a reasonable standard of care while performing any acts that could be foresee ably harmful to others*." (Lyons 2004). It is an obligation on the part of an individual, or organisation, to avoid causing harm to the person towards whom the duty is owed, either by acts of Commission (i.e. doing something), or Omission (i.e. not doing something). Where breaches occur remedies may exist through the Civil Law.

"*Individuals who are considered professionals within society are often held to a higher standard of care than those who are not*". (Lyons 2004) Some forms of behaviour which challenge services can be experienced as frightening or threatening. Targeted staff can develop unhelpful attitudes and responses which may further encourage the behaviour. These may include the wish to punish or, conversely, to avoid or minimize contact with the person which may compromise their duty to protect the service user from harm. In some situations the event of injury to the service user person through acts or omissions such responses may be deemed to contravene the Duty of Care owed to the person. Compliance with policy will enhance protection.

5.0 The causes of behaviour which challenges services

Behaviour which challenges services is not a medical diagnosis. Given its potential to label and stereotype an individual it should be applied with caution, preferably based on multi disciplinary agreement. Behaviour which challenges services results from a series of interactions over the course of the person's life between the individual and environmental factors. Individual factors are those characteristics, which people bring with them – their genetic makeup, the severity of their learning disability, the presence of sensory impairments, trauma or dementia together with the presence of additional sensory or physical disabilities and their personal history of relationships, attachment problems and experiences and so on. Environmental factors are the characteristics of the services they use – the number, training, attitude experience and disposition of staff, how they work with the people they serve and with each other, the quality of the material environment and the appropriateness of the range opportunities it presents. The behaviour(s) are employed to meet a need arising from the interaction **that is not otherwise being met**.

The experience of people who present behaviour which challenges services can include a range of factors that can increase the risk of developing behaviour which challenges services.

- Trauma. Resulting from active abuse or passive abuse i.e. neglect.
- Attachment difficulties.
- Interrupted development / acquired or progressive cognitive impairment e.g. dementia.
- Limited social networks.
- Limited opportunities to develop adaptive social skills.
- Working and living environments which prevent reciprocal relationships from developing.
- Lack of meaningful and rewarding activities.
- Communication difficulties - inability to express pain, frustration, needs, etc.

- Cultural Factors.
- Lack of sleep/ disturbed sleep pattern.
- Physical / mental ill health.
- Medication.
- Substance abuse.
- Domestic violence.
- Inconsistent responses from carers that can inadvertently promote the acquisition and worsening of behaviour which challenges services.

The starting assumption is generally that whatever the person gains as the outcome of problem behaviour is a legitimate want or need. For example it does not matter if staff feel that one person gets "*more than their fair share of attention, the fact that the individual has shown problem behaviour (which usually incurs at least some penalties) shows that, for them at this time in their life, attention is desperately important. The goal is not immediately to insist that they get by with as little attention as anyone else but to provide as much affection and interest as they need without their having to resort their problem behaviour to get it*" (Mansell et al. 1987: 226).

6.0 Primary Prevention (Before a Critical Incident)

It is now widely recognised that good practice in supporting people with a learning disability is based on the principles of Positive Behavioural Support (PBS). This approach is encapsulated in the Public Health Model advocated by the Commission for Social Care Inspection CSCI (2007a), which stresses that services must approach the prevention of Behaviour which challenges services on 3 levels:-

- **Primary** (before);
- **Secondary** (during);
- **Tertiary** (after).

Primary prevention is concerned with trying to avoid, by positive and pro-active practice, the behaviours arising in the first place. Participating in a varied and stimulating social life and relationships is an important vehicle for meeting social needs. People who present behaviour which challenges services have the same right of access and inclusion into a valued lifestyle as everyone else. This principle of means making available to all people with disabilities patterns of life and conditions of everyday living, which are as close as possible to the regular circumstances and ways of life or society (Nirje 1992) is called Normalisation. In practice it can involve:-

- Establishing a positive and caring professional relationship that supports the service user recognises the role played by attachment and provides a vehicle for understanding the whole person and their needs in terms of growth and development. Behaviour which challenges services can best be understood sometimes as a failure of relationships.
- Identifying the individuals' receptive and expressive communicative repertoire and working to promote the acquisition and use of communication skills / aids in the context of a total communicative environment.
- Understanding the person's feelings, abilities and difficulties, including awareness of the person's past experiences, losses and significant life events.
- Encouraging and supporting participation in education, social events, networks and activities of interest (e.g. hobbies).
- Advocacy, supporting and promoting the persons legitimate interests and rights.
- Teaching and encouraging the social skills which form the basis for relationships.
- Reviewing and addressing the service delivery factors which promote or trigger behaviour which challenges services.
- Promoting access to specialist support where appropriate.

7.0 Staff Behaviour

The behaviour of staff can actively influence the emergence and/or reduction of *Behaviour which challenges services* in a variety of ways. Authoritarian, or conversely

over protective staff attitudes, may inhibit the individuals ability to develop helpful coping skills and behaviours, and can constitute a form of abuse. There is a powerful dilemma for staff and unpaid carers between the independence of the person presenting challenging behaviours and the duty of care (Hart, Sense Scotland, 2007).

Given the aversive impact of their behaviour challenging individuals may experience the reaction of others as cold, distancing or rejecting. They may therefore try even harder to meet their social needs by exhibiting more extreme behaviours. Packages of care must therefore be based on thoroughly knowing and understanding the individual and their experience. Taking account of the fact that most behaviours are the result not of extraordinary circumstances but of the same circumstances that would affect most people (Sense, 2007) This is done through assessment which can have different elements but should always include a functional assessment (see below). Sometimes more detailed assessments of communication may be required. Staff need however above all to get to know the individual and their background well. The current framework for doing this is person-centred planning. It is therefore vital that all staff read and follow individualised care plans and risk-benefit assessments.

It is important to understand that all behaviour which challenges services is *multiply determined*. There are many contributing variables. Characteristically the person may use behaviour which challenges services to exert some degree of control over an immediate situation. They may lack the skills to manage the emotions evoked by a particular set of circumstances or not have the skills to convey their need in a more socially appropriate manner. The underlying functions of behaviour which challenges services can be numerous but can often fall under four broad categories:-

- **Approach Goals: -** Underlying needs may include attention, status, control, etc. Such behaviours may be used to convey the message “come here **"**.
- **Avoidance / Escape Goals: -** Underlying needs may include the avoidance or escape from demanding or non-favoured tasks, unpleasant situations etc. The

underlying message is “go away". Sometimes the person may not want an activity they have been enjoying to end.

- **Tangibles: -** The behaviour may be used to achieve a tangible goal, e.g. access to food, desired activities etc.
- **Sensory: -** The behaviour is a response to a sensory imbalance or inability to cope with environmental factors (e.g. noise, smell, stimulation, temperature, taste, touch etc). Individuals with more severe learning difficulties and those with severe atypical autism may exhibit such behaviour but anybody including ourselves can show strong sensory preferences.

The determination of the causal factors underlying specific behaviour which challenges services can often be achieved by systematic analysis of a specific behaviour(s), using information from a range of relevant sources. A key aspect of such assessments is the process of Functional Assessment. Functional assessment involves the systematic collation and interpretation of data about the service user often over several weeks or months. The intention is to identify a pattern to the persons behaviour from which the function(s) of the behaviour can be determined. The process is designed to complement existing care planning arrangements but is critically dependant on the provision of reliable information from direct care staff. See Appendix 1.

Functional Assessment should identify

- **The Setting Conditions: -** The circumstances in which the challenging behaviour is likely to occur.
- **Triggers: -** The factors most likely to initiate the behaviour in the short term.
- **The Function(s):-** What does the behaviour achieve for the person? NB for someone with a limited behavioural repertoire they may use the same behaviour e.g. self injury for a different purpose in different settings in response to different setting conditions and triggers.

- **Behavioural support: -** The activity plan, communication strategy, environmental changes required to reduce, support and/or diminish the persons need for the behaviour over time.
- **Behavioural Management: -** The measures required to address the immediate risk posed by the behaviour.

8.0 Responsibilities and Accountability

The ability to support service users with complex needs and behaviour which challenges services requires a consistent and coherent approach in which the responsibilities and obligations carried by staff at all levels of the organisation are understood and implemented.

All Staff

In the event of any incident of violence or aggression as defined above, all staff involved should take appropriate action, as laid out in this policy, and use approved measures to protect themselves and others. The employees' obligation to observe the "Control Measures" put in place by the Council is imposed by the Health and Safety at Work legislation (1974/1999). The safe non physical de escalation of any incident will always constitute the main priority. Staff responsibilities include:-

- To report and record incidents of violence as required under the Councils Violence in the Workplace policy.
- To familiarise themselves with and follow the relevant policies, procedures and guidelines of Moray Council in relation to the safe management of Behaviour which challenges services.
- To report observed breaches of the Councils policy and reporting requirements by others.
- To inform management of any perceived shortcomings in the Councils arrangements for the management of challenging behavior and to suggest improvements.

- To assist in the development of care and plans and to follow agreed plans.
- To inform management of any factor which could potentially impair their ability to work safely with people who challenge.
- To wear appropriate clothing when on duty for example, no jewellery, long sleeve tops, etc. Implicit responsibility on the authority is to ensure that this is promoted during induction of staff and ongoing training.

Senior Managers

Senior managers carry the ultimate responsibility for establishing and maintaining a safe system of work. They hold the accountability in the event of post incident litigation. Senior management leadership is pivotal to ensuring that all staff are supported and that practice is based on a clear and well understood conceptual approach. This policy is a fundamental element of ensuring a common practice model.

Subject to appropriate delegation arrangements the Senior Managers responsibilities will include:

- To assess and continually monitor the ability of the Council to provide an appropriate service to individuals with Behaviour which challenges services.
- To monitor the arrangements for the assessment and management of risk.
- Ensure staff compliance with all policy requirements.
- Ensure that there are adequate resources available to operate this policy and to report any problems to the Council.
- Monitor the frequency and pattern of incidents and report as necessary to the Council.
- Ensure adequate arrangements for staff support.
- Monitor the implementation of this policy.
- Ensure compliance with other relevant policies including safeguarding.

Line Managers

Subject to delegated arrangements it is the responsibility of line managers to: -

- Monitor compliance with this policy.
- Arrange for the completion and review of Risk-benefit assessments.
- Debrief all staff and service users involved in significant incidents of behaviour which challenges services as soon as practicable.
- Monitor incidents of Behaviour which challenges services to ensure:-
  a) accurate organisational awareness.
  b) development of appropriate planning.
- Identify and address individual and team training needs in -
  - Person-centred planning and active support including intensive interaction
  - Positive behaviour support.
  - Total communication approaches.
  - Recognising and responding to mental health problems.
  - Non-restrictive and restrictive physical interventions.
- Report incidents involving violent or aggressive behaviour to the relevant authority, in line with Council policies.
- Devise in conjunction with other agencies strategies for working with individuals with Behaviour which challenges services.
- Ensure an awareness of, and compliance with, the policies of the Council
- To ensure that all staff in direct contact with challenging service users are appropriately informed of care and educational plans, risk-benefit assessments and the required Control Measures.
- Take all reasonable steps to ensure that the workplace is safe and to review and update arrangements as necessary.
- To ensure that all staff working with behaviour which challenges services are competent and fit to do so.
- To provide leadership in the promotion of positive and safe work cultures.
- To support staff who follow Council policies and procedures.

- To offer appropriate opportunities for personal supervision and mentorship aimed at promoting and maintaining competence in working with behaviour which challenges services.

Front Line Staff

Subject to delegated arrangements it is the responsibility of front line staff to:

- Contribute to the completion and review of risk-benefit assessments.
- Obtain and supply information about any previous history of behaviour which challenges services.
- Monitor incident reports concerning service users with whom they have an active involvement.
- Liaise with staff, service users, parents and carers and other relevant professionals following significant incidents of behaviour which challenges services.
- Where appropriate, provide support to service users involved in significant critical incidents involving behaviour which challenges services.
- Facilitate and implement the development of care, positive behaviour management plans based on functional assessment.
- Seek advice as appropriate and in line with the objectives of this guidance.

9.0 Reporting and Monitoring Restraint

Aggressive and violent behaviour is often the focus of concern. However the term “Behaviour which challenges services” encompasses a broader range of behaviours, and is not simply synonymous with violence and aggression. Whilst there is some inevitable overlap, the specific issues which arise from staff exposure to violence and aggression are addressed in the Councils “Dealing with Work Related Violence” guidelines, to which reference should be made.

It is important to ensure that incidents involving behaviour which challenges services are accurately recorded. The accurate recording of targeted behaviour is also essential to the analyses of underlying patterns and motivations and the development of effective care and educational plans. All staff must record specified behaviours using appropriate procedures and on the **internal Incident Reporting database**. Similarly, behaviour involving aggressive and/or violent behaviour should be reported under the Incident Reporting Policy. This should also act as a trigger for constructive action to support people exposed to behaviour with a potential for physical and psychological injury. Under-recording effectively makes the behaviour invisible to those with the responsibility for the well being of both service users and staff.

Hence, dependent on the circumstances it may be necessary to record incidents in various formats under a variety of procedures. These may include:-

- Verbal reports to line manager.
- Recording under Functional Analysis procedures (Appendix 3).
- Care plans (detailed record).
- Risk-benefit assessments.
- Work-Related Violence/Challenging Behaviour Incident Report (Appendix 1).
- The Physical Intervention protocol for individual service users which has been discussed with and agreed by carer, service user where appropriate and all involved professionals. This should be reviewed regularly.

10.0 Procedure for Dealing with Risk Behaviour

Risk-benefit assessment

*The Council has an obligation under Regulation 3 of The Management of Health and Safety at Work Regulations 1999 to assess and minimise the risk imposed by all "*foreseeable*" hazards in the working environment, "*so far as is reasonably practicable*."*

Each service user should have in place a risk-benefit assessment screening and if appropriate a risk management plan should be in situ. In the event on an incident occurring, the risk management plan should be reviewed and amended if required. In relation to behaviour which challenges services this will involve assessment of factors such as the following:-

- Specification of hazardous behaviour(s).
- Assessment of possible adverse outcomes.
- Assessment of consequences if no action were taken.
- Identification of who might be harmed and how in so far as possible.
- Specification of required action(s) (i.e. control measures).

Any significant control measures identified through the risk-benefit assessment process must be incorporated within care and educational plans. Risk-benefit assessments should be monitored and reviewed on a regular basis.

Pro active Planning

Effective planning is the cornerstone of safe practice. Priority should be given to the development of contingency plans for service users with an established pattern of behaviour which challenges services. These should involve the development of written plans, which should cover the following issues: -

- Specification of target behaviour(s).
- The assessment of the possible underlying function(s).
- The circumstance under which it is likely to emerge (*Setting Conditions*).
- The *Triggers* likely to promote the behaviour (which should be avoided).
- The *Warning Signs* which can denote impending loss of control or increasing arousal.
- Care planning and the specification of longer term approaches for behavioural change.

- Crisis management and the actions to be taken in the event of situations which place the person and/or others at risk of injury.
- Where the physical restraint of the service user is anticipated the techniques to be used should be specified, as far as is reasonably practicable.

All staff in contact with the service user must familiarise themselves with the care plan, which should be monitored and reviewed on a regular basis.

Risk taking: - Some degree of personal risk taking is an implicit part of learning and maintaining the life skills essential to independent living. Each service should have an explicit policy which determines the balance between service users personal autonomy and staff's duty of care. These should emphasise the necessity of some degree of risk taking and respect for autonomy, privacy and the dignity of the individual. The principal aim of this policy should be to avoid restraint wherever possible. These should be subject to consultation with stakeholders and publicised in the form of leaflets etc.

Supporting individuals whose behaviours may present a risk to themselves or others can generate a range of conflicting pressures on staff and services. Fear of harm, publicity and/or litigation may promote over protective approaches. Conversely, ad hoc, or laissez faire approaches to risk management may expose the individual to unnecessary harm. Staff and services supporting vulnerable service users often encounter situations which constitute a “dilemma” in which all the protective options carry some degree of risk. Hence “risk avoidance” approaches, which attempt to remove all risks may be unhelpful or impractical. Effective protective action may involve a risk management approach based on “hazard reduction”, in which risks are systematically assessed and action taken to eliminate or reduce foreseeable hazards, or factors which increase harm, wherever possible.

Risk-benefit assessment

Assessment of risk should be an integral part of care planning for each service user and should include strategies for anticipating and managing future risks.

Service users should expect that services accommodate his or her normal level of physical activity.

Where any form of restraint is contemplated the initial focus of assessment should attempt to establish the underlying reasons for the behaviour(s). These may include:-

- Learned, functional patterns of behaviour.
- Potential medical factors (psychiatric illness, epilepsy, illness, drug side effects, diet etc).
- Life stressors (loss and bereavement, worries etc).
- Relationships (poor relationships/incompatibility with staff, peers etc).

It is a key condition of the Moray Council commissioning process that all services supporting service users, for whom the Council carry responsibility, have enacted policies on Behaviour which challenges services and have training strategies for all staff in behavioural; management and physical intervention models, comparable to that used by the Council.

Policies relating to the use of restraint and behavioural management should be considered by commissioners of services as part of the process of contracting for services.

Resources:- No form of restraint should be used to cover deficiencies of service, lack of professional skill or defects in the environment.

Ethnicity & Culture:- Consideration should be given to any factors arising from the culture and/or the ethnicity of the service user including the ability to communicate. Where necessary staff should have training in the delivery of culturally appropriate care.

Risk and psychological distress:- Where restraint measures are contemplated attention must be given to the degree of psychological distress which may result and any additional hazards which may arise from the control measures contemplated. This should be balanced with an assessment of any potential benefits to the person and/or other service users which may arise from the restraint measures.

Any restraint measures should not cause greater distress than the original problem. For instance whilst some people with a learning disability may require removal from distressing or over stimulating environments, this should involve removal and be distinguished from " time out" which forms part of a applied behavioural analysis guided intervention, which should only be instituted with multi disciplinary approval and monitoring.

Acceptable Risk:- If no remediable cause is found the next step is to assess the degree of risk inherent in the service user being unrestrained. Only if that risk is unacceptable should further discussion of restraint proceed.

Risk-benefit assessments should involve all relevant members of staff on a multi disciplinary basis and include the service user (as appropriate), significant relatives, carers, advocates, welfare attorneys or guardians or other representatives.

Alternatives: - Before any form of restraint is considered alternative interventions should always be contemplated first. These may include medical, psychological, interventions and/or modifications of observation, service regimes, activities, or even buildings. The assessment should consider any existing intervention or aspect of the service environment that may be a cause of the behaviour for which restraint is being considered.

11.0 Restraint

Restraint in its widest sense implies preventing a person from doing what they wish to do. In terms of the management of behaviour which challenges services 'restraint' would imply the restriction of free movement or mobility as a means of controlling the behaviour. This could involve:-

Devices: - the use of devices such as cot sides, low chairs, straps, duvets or over tight bed sheets etc.

Environmental restraint:- such as limiting access to specific areas of a building, the building exit , locking doors etc. Turning up the heating a degree or two to promote drowsiness etc. This would have to be carefully managed in line with the service users' medical conditions, etc.

Normal security measures, such as locking doors to ensure safety from intruders is a normal and acceptable practice. Similarly, if faced with an emergency situation involving the prospect of imminent injury, temporarily locking someone in a room, may be permissible, as a last resort response only. However, such responses are not acceptable when they are used on a regular or routine basis to control behaviour.

Removal of items: - such as shoes, shoelaces, outdoor clothing etc. Service users should be encouraged to wear night attire, or special clothing prior to normal bedtimes etc.

The right to restrict mobility will vary dependent on setting and staff role. Consideration must be given to age, status and capacity of the individual service user. Legislation and guidance outlines the ability of staff to restrict free movement under specific circumstances and balances human rights with safe practice. The welfare of the child and the concept of the autonomous adult are central legal themes. Key obligations include:

Rights: - People who present behaviour which challenges services including individuals with additional support needs and learning disabilities retain their full human rights unless these have been restricted by a legal process, and only then to the extent allowed by the law.

Involvement:- *Subject to the age of consent self determination and freedom of choice and movement should be paramount unless there are compelling reasons why this should not be so. However in the event of a need to pro actively address "foreseeable" behaviour which challenges services the use of any form of restraint should be subject to consultation. To the extent where it is possible and reasonable service users should be consulted on any restraining action and consent obtained. Any relatives, carers, welfare attorneys, guardians and relevant professionals should be involved in the discussions. In all cases some explanation should be given, at a level the person can understand. In appropriate circumstances consideration should be given to the involvement of a Speech and Language therapist to facilitate communication.*

12.0 Secondary Prevention - Crisis Management

Effective support to people who present behaviour that challenges must always place the emphasis on prevention and wherever possible reducing behaviour which challenges services through the constructive exploration of causal factors and the teaching of alternative coping skills. However, regardless of the rigour of such preventative measures critical incidents involving risk behaviours may still occur. Consequently it is important to manage such behaviour safely, and to avoid recurring practice errors wherever possible through post incident learning.

The belief that all behaviour can be controlled safely, regardless of its severity, is a common assumption. Staff involved in critical incidents often look back afterwards and feel that the situation would have been different, “if only” they had done something different. The published evidence base indicates that the reactions and opinions of other people not directly involved in the incident often increase such “Performance Guilt”. Moray Council is committed to ensuring an approach to risk management which

avoids stereotypes and the development of a "Blame Culture" in which incidents are automatically attributed to the ineffectiveness of staff. Such an approach recognises the need to balance staff support with accountability and to ensure that all those involved are helped to reflect on and learn from incidents of *Behaviour which challenges services.*

Although successful diffusion / de-escalation usually involves certain practice principles, the appropriate actions required in a given situation will be determined by the professional judgement of intervening staff and it is both difficult and often unhelpful to specify too precisely the steps which staff should follow. Staff actions should be informed by a knowledge of the service user, their motivation, abilities and the intervention plan, undertaken in the context of professional relationships.

Effective responses may include: -

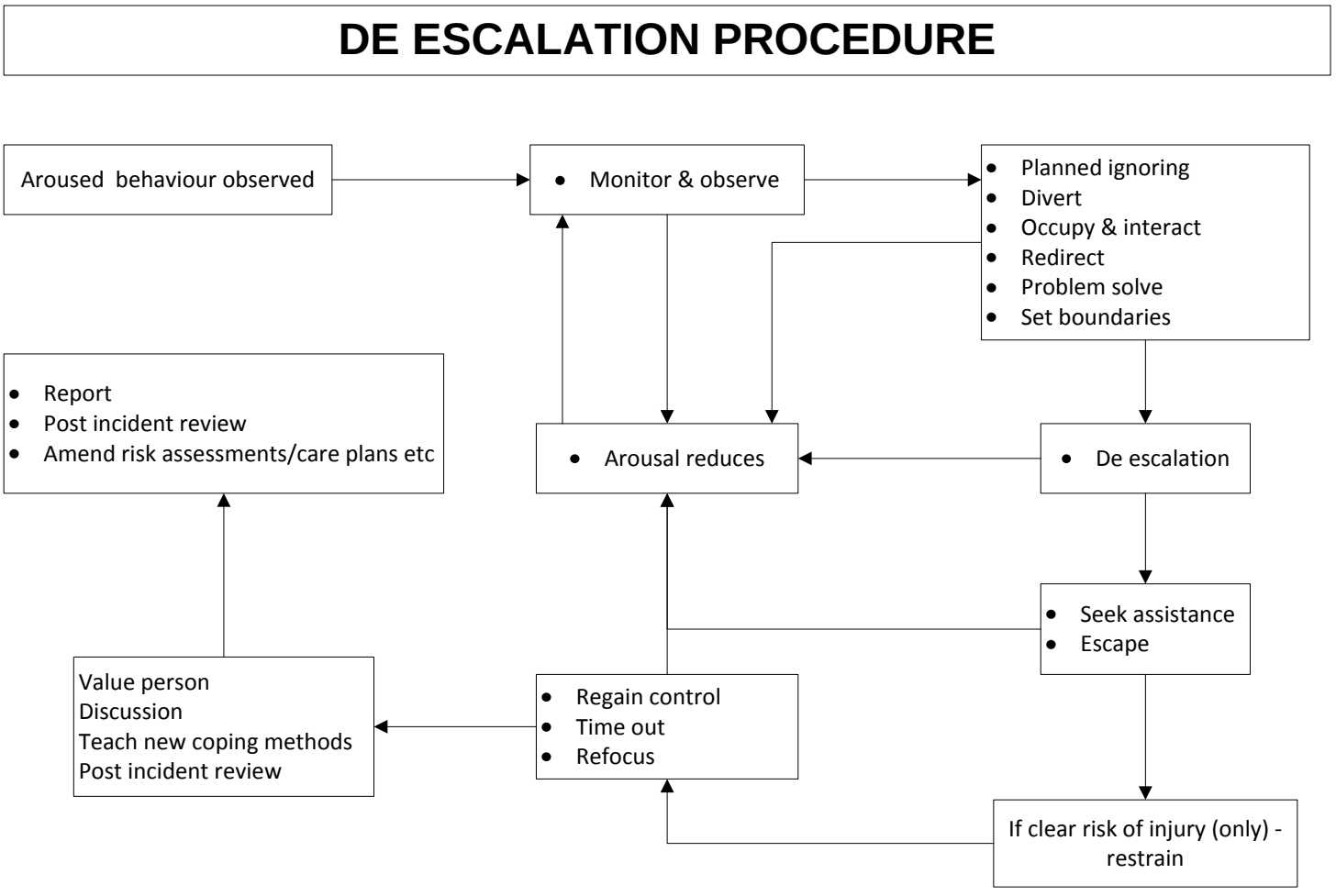
- Staff should attempt to spot the warnings signs that often precede critical incidents by monitoring the service user's behaviour for any significant departure from normal behaviour. These should be specified in Risk-benefit assessments and Care and/or Education Plans. It is usually not helpful to ignore these. Staff should attempt to intervene early in developing situations, to divert the service user's attention into safe and/or interesting activities.
- Try to offer help and support and "listen" to the message being communicated, both in what the person says and through their non-verbal behaviour. Try to resolve any specific problems/difficulties and re assure them and talk to them about their concerns.
- Make options available, avoid confrontations and " cornering " the person either physically or psychologically. Try not to argue or issue threats or ultimatums.
- Reduce the level of demand, in terms of the task being undertaken, surrounding activities or events etc. Developing a system for `time out` or allowing the person to withdraw temporarily from the situation may be helpful.

- Manage the immediate environment. Perhaps changing the people involved or removing objects which could be used as 'weapons` or which may be causing the person distress.
- Be aware of and use space constructively. Touch may act to re-assure an agitated person. Equally, the person may feel crowded. Touch may therefore act as a ` trigger` for a person who is angry, frightened or confused.
- Distract the person from their focus or course of action, if this is not insensitive. (N.B. If we distract people by offering alternatives the person likes we should ensure that these alternatives are not only available at times when there are problems).
- Redirect the person onto something s/he likes or feels less anxious about, or possibly create a disruption which breaks the cycle of behaviour. Humour can sometimes help, although this should not be at the person's expense.
- Restate rules and boundaries and remind the person of possible consequences. Suggest delayed compliance giving the person time to process the information.
- Try to remain calm. Breathe deeply and be aware of and control your own emotional reactions. Always try to avoid conveying a sense of threat to the challenging person. Maintain a re assuring, controlled tone of voice.
- Do not invade the person's space, attempt to " win" or have the last word.
- Avoid words and topics which are known to be provocative. Communicate at the level of the persons understanding, using "core messages" and avoiding complex statements, figures of speech. Insults, threats and ultimatums *must* be avoided.
- If attempts at de-escalation are successful, do not remove the support too quickly or there may be re escalation. Continue to monitor, re assure and value the person, this may be necessary over a prolonged period , dependent on the needs and coping strategies of the individual.

In summary, where possible the process of de-escalation should involve:-

1. Defuse the situation.
2. Regain control.
3. Refocus the person.
4. Value the person.

13.0 De escalation procedure - summary (defusing, regaining, refocusing and valuing):



14.0 Physical intervention

Whilst the de escalation of aggressive behaviour must always remain the first priority, in specific, albeit infrequent, circumstances it may be necessary to use physical intervention to prevent injury.

Within the broader concept of restraint, physical intervention implies a physical contact between staff and service users. By choice, no responsible person would choose to employ any form of physical intervention. In the context of the Councils' "duty of care" negligence and consequent legal liability can arise through acts of both commission (what staff do) and omission (what staff don't do). Moray Council will therefore equip and support identified staff to employ physical interventions in defined circumstances to achieve specific aims. The protection of the service user and/or others, in situations of significant potential risk, as a last resort response only, is the sole circumstance in which physical restraint is legitimate.

Historically, many high profile national examples of poor practice have resulted from situations where staff were unclear about the permitted uses of physical interventions or where physical interventions were employed outside permitted circumstances. Clarity about the circumstances in which physical interventions are permitted is crucial to safe practice which balances the rights of all parties and ensures that the provisions of the jointly agreed care plan form the basis of practice; thus safeguarding the welfare of the service user.

Any physical contact must be minimal and socially appropriate. All physical interventions should be viewed as an intervention hierarchy. Staff should employ the lowest level of contact appropriate to the situation. In ascending order this will involve:-

Touching: - Some roles, for instance caring for a vulnerable person, may involve close proximity and the performance of tasks involving intimate contact. Touch may also have a legitimate role in skills coaching and conveying comfort or re assurance in

situations of distress as would be expected between a responsible parent and their child.

Holding:- Involves a direct physical contact used to discourage rather than prevent a behaviour. Examples might include supporting a frail person to prevent falling or a gentle touch on the arm to discourage excessive movement.

Restrictive physical restraint: - Involves a direct physical intervention used with the intention of preventing a behaviour, usually against resistance.

The difference between these categories of contact involves the aim of the contact and the degree of force employed.

Legal perspectives: - The use of force must always be justified; otherwise it may be deemed unlawful. It is generally accepted that responsible staff have the same rights as any other citizen in using minimum restraint necessary to prevent someone from hurt. However the law requires that where restraint is justified t*he force used must be the minimum required to achieve its purpose and no more*. For instance the Mental Health Act, Code of Practice (1993; page 77) states that a physical intervention should only be used:-

"*As a last resort and never as a matter of course". "When there seems to be a real possibility that significant harm would occur if intervention is withheld"*.

"*Any restraint must be reasonable in the circumstances. It must be the minimum necessary to deal with the harm that needs to be prevented*."

Restraint can take place in the context of an unplanned emergency or in a scenario in which the behaviour of a service user is highly predictable such that we can plan how we will to avert the situation but also how we might best manage it. For some service users in some situations this may involve restraint forming part of their care plan.

The general circumstances in which restrictive physical intervention may be appropriate are outlined in various national documents. For adult services these are primarily dealt with in the;

- Guidance on the regulation and use of restraint (http://www.scswis.com/index.php?option=com_docman&task=doc_download&gid=357&Itemid=378)
- Commission for Social Care Inspection (2007) *Rights, Risks and Restraints* (http://www.mwcscot.org.uk/web/FILES/Publications/Rights_Risks_web.pdf).
- Commission for Social Care Inspection (2007a) *Guidance for Inspectors: How to Move Towards Restraint Free Care* (Available from www.csci.org.uk)
- Mental Health (Care and Treatment) (Scotland) Act 2003, Code of Practice (Sept 2005) (available from http://home.scotland.gov.uk/home).
- Adults with Incapacity (Scotland) Act 2000.
- Human Rights Act 1998.
- Offences Against the Person Act 1861.

15.0 Circumstances of use

Moray Council will support staff who use physical interventions appropriately. It is, however, impossible to specify exactly the range of circumstances in which restrictive physical intervention or restraint may be legitimately applied. Again the professional judgements of intervening staff are crucial. Such situations will, however, conform to the legal principal of "the *prevention of a greater and significant harm" .*

Restraint *may be* legitimate in situations in which: -

The staff member believes that:-

- The individual will cause harm to themselves or another person if they do not intervene.
- A vulnerable adult (in terms of the Councils Safeguarding policy) will run away and will put themselves or others at serious risk of harm .
- A person will cause significant property damage, which is likely to have a serious emotional effect on themselves or others or create a physical danger to themselves or others.

Restraint *should not* be used when:-

- It is judged that staff cannot control the person safely through the use of restraint techniques.
- Other methods of restoring a safe situation are likely to be successful.
- There would be no change in the final outcome.
- To gain compliance with staff instructions where no significant risk is present.

Only staff who have received the approved training should take the lead role in physical interventions, unless there is no other option.

There will be particular circumstances that will need to be taken into account in considering when and how certain people may be restrained. Pro-active assessments will consider a number of factors. These will include:

- The persons medical condition (e.g. asthma, obesity, etc).
- The persons motivation in seeking restraint.
- Any history of physical or sexual abuse.
- The severity of any presenting pattern of behaviour and the consequent risk to staff.
- The physical environment.

During restraint the senior or most experienced member of staff must take responsibility for continually assessing the person's response to the intervention and consider factors such as:-

- Respiration difficulties.
- Fits or seizures.
- Vomiting.
- Blue colouration of hands, feet, or other body parts (indicative of reduced blood circulation).
- Mottling (paleness/yellowing of skin due to restricted blood circulation).
- Bone fractures.
- Compliance of all staff with the training provided.

Staff should seek to avoid any technique or hold which replicates a previously abusive situation.

Managers should regularly audit patterns of physical intervention and other relevant incidents or accidents including near misses. Such audits should be recorded by the designated senior manager in conjunction with the health and safety manager and will be used to inform any subsequent review of this policy.

16.0 Methods of Physical Intervention

Only staff who have received the approved training should take the lead role, or be involved in physical restraint, unless there is no other option.

Unless in an emergency, where there is a clear and immediate risk of the person incurring or inflicting a significant injury, restraint by a single person should be avoided wherever possible. **Staff should only attempt to physically intervene when sufficient staff are available.**

17.0 Recording of Restrictive Physical Interventions

The use of all restrictive physical interventions must be recorded within 2 hours of the incident using the forms in Appendix A. A carer should be appropriately trained in the use of physical interventions. Service managers must however regularly audit patterns of restraint, as per the Violence at Work procedures and relevant incidents or accidents. Such audits should be recorded and will be used to inform any subsequent review of this policy. A review of the use of restraint in the context of a broader review into the effectiveness of arrangements for managing the risk of violence, led by the consultant practitioner challenging behaviour in conjunction with the service manager provider services, and health and safety advisor. This should be reported to the Governance Board on an annual basis.

The use of physical interventions will be monitored and adult services will collate this data on an annual basis. This will contribute to the monitoring and review of the effectiveness of current arrangements and to provide performance and other relevant information as necessary. This will include the provision of data to CALM as part of their audit of the safety and effectiveness of the CALM system.

18.0 Procedure for implementing restrictive physical restraint

Pre Incident

Subject to Training Needs Analysis and risk-benefit assessment managers should ensure that an adequate pool of staff, trained and currently accredited in CALM restraint techniques are available.

Where the use of restraint is a foreseeable likelihood, teams should rehearse the implementation of restraint, identifying and addressing identified hazards. Staff should be offered opportunities to practice restraint in a safe controlled setting. A record of such practice sessions should be kept in the appropriate training folder. It is a legal requirement for employers (Health and Safety at Work Regulations 1999, Reg 11) to

assess and maintain staff competence in control measures required to safely manage risk. Consequently the Council require staff to participate in *a minimum* of four recorded practice sessions per year, in line with the Councils to avoid skill decay, and consequent enhanced risk. Service managers will monitor compliance with this provision.

Critical Incidents and restraint events

Critical situations which give rise to the use of restrictive physical restraint can be stressful, confusing and require staff to exercise a high degree of professional judgement. As a general principle restraint should be implemented for the shortest possible duration, employing the lowest level of effective intervention. Such judgements should be balanced with the risks of releasing the restraint prematurely. In the event that restrictive physical restraint is deemed necessary and justified, staff should attempt to observe the following procedure:-

A) Solo intervention

It is unwise for staff to attempt to implement restraint without assistance. It is anticipated that where necessary, such situations will require the use of low level intervention only.

Lone working presents specific implications for behaviour which challenges services management and the use of restraint. In some group settings, one person restrictive restraints may, on occasion may be necessary preferably temporarily to uphold the Councils' Duty of Care. In some lone working situations the priority for staff is likely to be that of escape and/or self defence. The risks of individual situations and the potential need for training in escape and/or restraint methods should be subject to discussion with managers, risk-benefit assessment and training needs analysis.

B) Team Restraints

- One staff member should assume the lead role, and clearly communicate this to assisting staff who should follow the instructions of the lead person. Participating staff should be delegated a clear role (e.g. which arm to take, clearing away obstacles, removing bystanders etc) ,

  - The role of the lead person is to give clear instructions to the staff team.
  - To continue to verbally de escalate through clear communication with the subject.
  - To constantly monitor the welfare of the person to whom the restraint is applied. Subject to a judgement of risk, in the event of a substantive indication that the subject is experiencing physical or psychological harm consideration should be given to disengagement. If required the restraint can be re applied, should the person continue to present physical aggression.
  - Non involved staff should vacate the vicinity to ensure that their observation does not further inflame the behaviour. No verbal comments should be made.
  - Once the person is seated, the team leader (designated number 1) should continue attempts to de escalate and re assure the person, using positive, constructive and minimal language. Assisting staff should remain silent.

Once the person begins to exercise self control the holds should be gradually relaxed, as per the taught procedure. i.e.,

- touching rather than holding the person.
- shadowing the person at an appropriate distance.
- reducing the number of staff involved.
- When the person is judged to have regained self control excess staff should move to a safe distance, leaving a designated colleague only to continue verbal re assurance, whilst continuing to monitor the situation and provide assistance, if instructed.

- Once the person has regained their composure, they should be allowed to withdraw to a safe space (e.g. their own room etc.).

Post Incident

The restraint leader should confirm with the person that they are not injured. This should be clearly recorded in the incident report form and in the persons support plan.

Where there are grounds for judging that an actual or potential injury may have been sustained, any injured party should be escorted to an appropriate medical facility (e.g. GP or Casualty Department). The outcome of the visit should be clearly recorded. In the event of staff injury staff should complete an injury report).

Post incident de briefings should be undertaken with individual staff and teams and the service user, as per paragraph 11.

19.0 Training in physical intervention

Within the context of the wider training strategy the Council is committed to providing appropriate training for all staff working with people who present with behaviour that challenges services. This will be determined on the basis of a systematic training needs analysis undertaken by line managers and supported by risk-benefit assessments.

Staff who are unsure of their capacity to undertake such training, or to employ physical interventions in the workplace on medical grounds will be offered an occupational health assessment.

20.0 Tertiary prevention - after an incident

Incidents of *Behaviour which challenges services* may have an emotional impact on all parties directly and indirectly involved in critical incidents. This can be a normal reaction and should not be automatically viewed as indicative of incompetence. Staff may feel upset and de skilled. Equally service users may feel frightened of their own behaviour and the potential consequences. Critical incidents also carry a clear potential to erode professional relationships. They also have the potential to undermine, or conversely increase the ability of all parties to cope effectively with similar situations in the future. The failure of individuals and organisations to learn from incidents and increase their abilities to manage future similar incidents safely is a recognised consequence of behaviour which challenges services. It is the aim of Moray Council to ensure that it operates as a “Learning Organisation” which adapts and improves its practices.

Conceptually, crises pose both problems (to be solved) and opportunities (to be grasped) for staff, service users and the organisation. Dependent on the individuals abilities and needs it may be possible to help involved parties to explore their emotions, attitudes and thinking processes and behaviour, with the aim of to promoting insight and enhancing coping behaviours which avoid future behaviour which challenges services or unsafe practices.

Enabling involved parties to explore and learn from incidents is a crucial element in safe practice. This is done through the process of Post Incident Review. The skilled exploration of incidents conducted in a non-blaming manner at a suitable point after the incident. It may also be necessary to support the person through any adverse consequences of the incident, which could include ill feeling from peers and, in extreme cases, formal sanctions.

The involvement in a physical intervention should always be discussed at routine clinical supervision.

21.0 Post incident reviews

a) Service users

After an incident a number of immediate responses may help to get things back to normal:-

- The person may require space and time to collect himself or herself, or alternatively they may need people around and a lot of re assurance.
- The person may wish to apologise. It is usually helpful if this is accepted with good grace. It is however, usually unhelpful to try to extract an apology.
- It may be appropriate for staff to offer an apology (i.e." I didn't mean to upset you.").

Once the situation has been stabilised consideration should be given to undertaking a **Post Incident Review (PIR)** . The aims of a PIR are to:-

Aims :-

- To restore relationships.
- To promote learning and the development of alternative coping skills.
- To promote insight into the impact of the behaviour on others.
- To support the service user with the therapeutic exploration of the emotions and/or memories generated by the incident.
- To promote an understanding of the link between behaviour and consequences.

Timing :-

The increased emotional arousal generated by incidents can negatively impact on thinking recollection and self control. Post Incident Reviews should be conducted as within 72 hours of the incident, rather than immediately after an incident, once it is

clearly judged that the service user has regained emotional control, and the exploration of the incident will not act to re-trigger aggressive behaviour.

Requirements:-

Post Incident Reviews should be conducted:-

- By a competent, impartial staff remember.
- In private.
- Without interruption.
- With sufficient time available.
- With adequate consideration of staff safety (i.e. risk-benefit assessment).
- Conducted on a no blame basis, avoiding judgemental and punitive responses.
- Conclusions should be incorporated in individualised care plans and risk-benefit assessments.

Process:-

Established patterns of behaviour which challenges services in individuals may be affected by learning, dysfunctional thoughts patterns, the impact of previous trauma or the inability to understand or control emotions. Skilful post incident reviews may offer a positive opportunity to gain insight and to understand and rehearse alternative coping skills. The needs of individuals are however a matter of judgement, based on knowledge of the service user. However, a typical PIR is likely to involve exploration of:

- The service users' perception of the factors contributing to the incident.
- Available potential alternative perceptions (e.g. other involved parties).
- The impact of the incident on significant relationships.
- The emotions and/or memories generated by the incident.
- Teaching (where required) of alternative coping skills.
- The available staff support to exercise alternative behaviours.

- How progress is to be monitored.

Where required:-

- Facilitate access by the service user access to the complaints procedure.
- Adapt care plans and risk-benefit assessments.

b) The Staff Group

In many services the prevailing ethos may view the risk of trauma and/or injury as just ` part of the job`. This is rarely helpful as it tends to de sensitise staff and may promote an acceptance of extreme behaviour and promote authoritarian attitudes. Emergent research (e.g. RCP et al. 2009 op cit; Richards 2003; Bloom 2008) suggests that the support offered by the employing agency will be a significant factor in the recovery process. Moray Council is committed to the provision of appropriate levels of staff support.

In its common usage the term “de briefing” covers a wide range of practices. One previously common model (Critical Incident Stress De briefing) is specifically aimed at reducing emotional trauma, and is now not generally recommended (e.g. HSE 1998) Whilst a principal aim of any post incident review process is to offer staff a sympathetic and supportive forum to explore the incident it is not intended as a clinical intervention. Access to occupational health and/or independent counselling will be arranged where necessary.

Fear of blame can often impede the ability of individuals and organisations to learn from incidents, leading to defensive practice and the repetition of ineffective or unsafe practices. It is important to review the actions and procedures used to manage significant critical incidents in a constructive manner. Current best practice suggests that staff involved in critical incidents should be offered two forms of de briefing, which can be colloquially termed:-

a) **Informal de briefing** – brief exchange of facts immediately after an incident with the aim of allowing appropriate action to ensure safety and welfare. This should be offered by whoever is available ie manager on duty, on-call manager. However, this is not a substitute for formal, reflective debriefing which should be a learning process as well as a supportive process.

b) **Operational de briefing** (or Post Incident Review) – A more systematic exploration of the incident , once equilibrium and calm have been restored. This must be carried out by the manager on duty/call. These should be carried out within 72 hours of the incident.

Participants may experience a range of emotional reactions after a significant incident. While some staff may feel able to resume their duties immediately, others may need some personal space to recover. Referral / Self Referral to Occupational Health may need to be considered for some staff.

In the event of physical injury access to medical assistance may be required and should be sought.

It is important to review the actions and procedures used to manage significant critical incidents in a constructive manner. All staff involved in a significant incident, especially those involving physical injury or emotional distress, should participate in a group and/or individual de briefing, or Post Incident Review, (also known in the literature as management de briefing (Richards 2003) conducted on a “no blame” basis, as soon as possible, and preferably within 72 hours of the incident. An appropriate member of staff should facilitate this. The aim will be to discuss the management of the incident with a view to improving staff response and the effectiveness of Council policy, procedures and systems. Where conducted appropriately it will also offer involved staff appropriate support. The overall aim is to promote a “Learning Organisation” approach in which critical incidents are routinely explored in a positive manner. Conclusions can then be incorporated into practice leading to an enhanced ability to address future similar

situations safely. Learning can involve the development of the practice skills of individual and teams and serve to audit and improve the systems and responses of the organisation. It should also promote the use of existing support mechanisms and sources of practice advice which staff may have been reluctant to consult.

Conclusions from such debriefings must be formulated into an action plan and any changes should be incorporated into individual care plans and risks assessments and should be used to audit the overall safety of specific service settings. The effectiveness of the de briefing process and its administrative arrangements will be monitored by appropriate managers.

It is important for managers to address their responsibilities for both staff support and accountability where questions arise about the appropriateness of the employees actions. Where staff malpractice is a potential issue, any investigation will be handled by a different manager.

22.0 Guidelines on Police Involvement

As per The Moray Council's dealing with work related violence guidelines section 1.8.1. (http://intranet.moray.gov.uk/PersonnelServices/HealthandSafety/H%20&%20S%20for%20intranet/7%20Guidance/SMS7.20%20WRV%20070408.doc).

23.0 Legal Assistance

As per The Moray Council's dealing with work related violence guidelines section 2.4.3. (http://intranet.moray.gov.uk/PersonnelServices/HealthandSafety/H%20&%20S%20for%20intranet/7%20Guidance/SMS7.20%20WRV%20070408.doc).

24.0 Equalities Statement

24.1 The Moray Council will not and does not discriminate on any grounds. The Council advocates and is committed to equalities and recognises its responsibilities in this

connection. The Council will ensure the fair treatment of all individuals and where any individual feels that they have been unfairly discriminated relating to, that individual shall have recourse against the Council in line with the Council's grievance and harassment procedures.

In relation to equality of information provision, the Council will ensure that all communications with individuals are in plain English, and shall publish all information and documentation in a variety of formats and languages. Where required, the Council will use the services of its translation team to enable effective communication between the Council and the individual. Where an individual has sight, hearing or other difficulties, the Council will arrange for information to be provided in the most appropriate format to meet that individual's needs. The Council will also ensure that there are no physical barriers that could prohibit face to face communications.

If there is a complaint against discrimination, click on the link below for reporting form and procedure: http://www.moray.gov.uk/downloads/file62366.pdf.

25.0 Data Protection

25.1 The Data Protection Act 1998 governs the way information is obtained, recorded, stored, used and destroyed. The Council complies with all the requirements of the Act and ensures that personal data is processed fairly and lawfully, that it is used for the purpose it was intended and that only relevant information is used. The Council will ensure that information held is accurate, and where necessary kept up to date and that appropriate measures are taken that would prevent the unauthorised or unlawful use of any "personal information".

26.0 Freedom of Information

26.1 The purpose of the Freedom of Information (Scotland) Act 2002 is to "provide a right of access by the public to information held by public authorities". In terms of section 1 of the Act, the general entitlement is that a "person who requests information from a

Scottish public authority which holds it is entitled to be given it by the authority". Information which a person is entitled to is the information held by the public authority at the time that the request is made. This is a complex area of the law that can overlap with the Data Protection Act and other legislation.

All Freedom of Information requests are to be sent to the Information Co-ordinator in the Chief Executives Department.

27.0 Human Rights Act

27.1 In October 2007 the three equalities commissions: Racial Equality, Disability Rights and Equal Opportunities were merged to form one Commission: **The Equality & Human Rights Commission (Scotland).**

The main aspects covered in the **Human Rights Act 1998** are:
Right to life; protection from torture; protection from slavery and forced labour; right to liberty and security; right to a fair trial; no punishment without law; right to respect for private and family life; freedom of thought, belief and religion; freedom of expression; freedom of assembly and association; right to marry; protection from discrimination; protection of property; right to education and right to free elections.

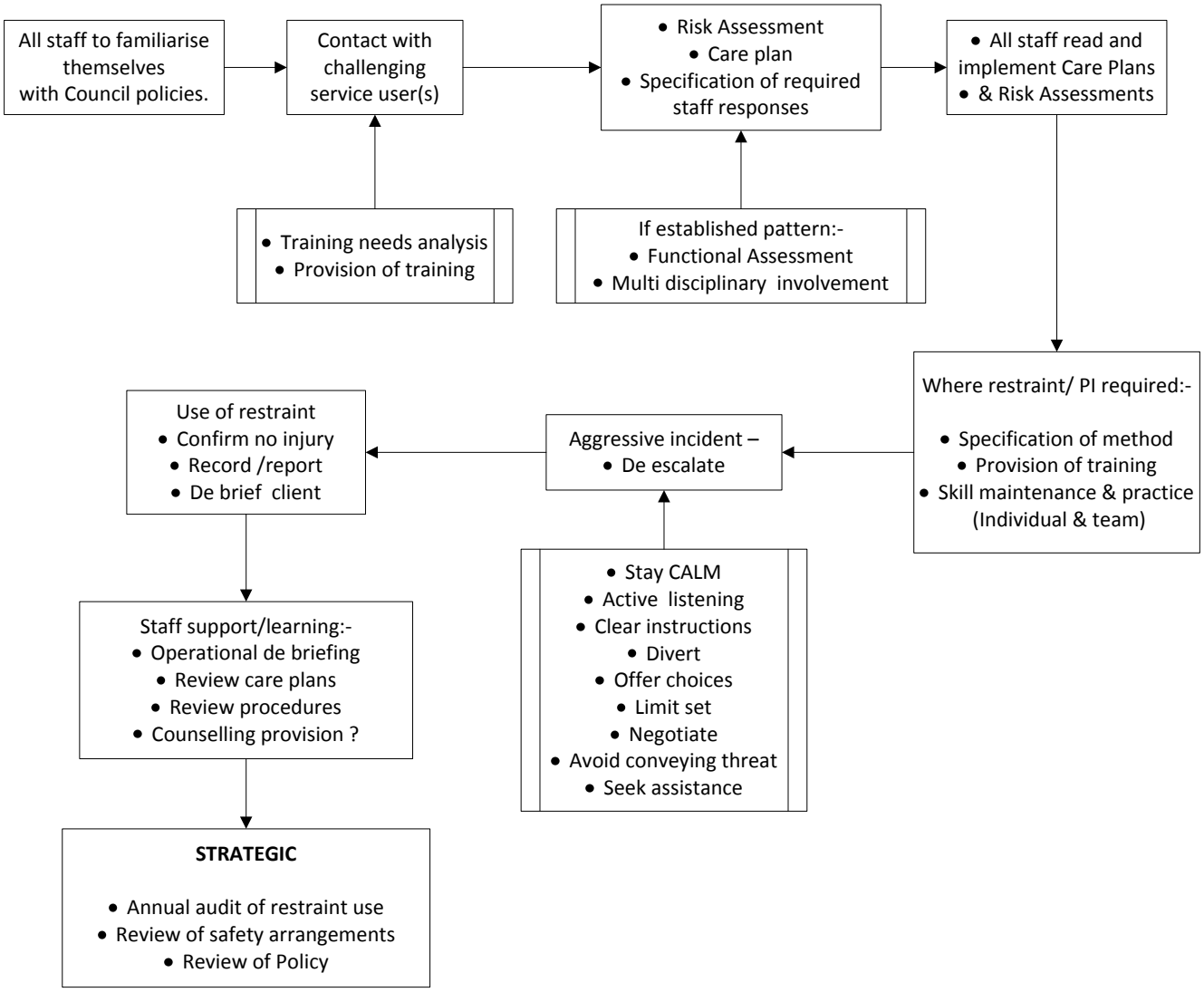
The Human Rights Act can overlap with many areas of the Council's policies, any doubts or queries regarding its effect or implications must be referred to the Legal Services Manager (Litigation and Licensing).

28.0 Review and Feedback

The implementation and effectiveness of this policy will be reviewed after 3 months and annually thereafter.

Appendix 1 - Summary of Procedures

SUMMARY OF PROCEDURES



Appendix 2: Work-Related Violence/Challenging Behaviour Incident Reporting form – amended from Incident Reporting Procedure

WORK-RELATED VIOLENCE / CHALLENGING BEHAVIOUR INCIDENT REPORT

ALL incidents must be reported as soon as possible - Copy to the relevant Line Manager, and a **copy of each report must be sent to the Performance and Quality Team, Spynie Hospital, Duffus Road, Elgin, IV30 1BX, who will then forward the completed report to the Corporate Health and Safety Team**.

Persons Details

Incident No		**Event type**			
Person Reporting		**Employer Name**	**The Moray Council**		
Details of affected person (if known) Employee ☐ Service User ☐ Member of Public ☐ Other ☐ (please specify)					
Affected Persons Name		**Employee Payroll No**			
Affected Persons Name		**Employee Payroll No**			
Affected Persons Name		**Employee Payroll No**			
Affected Persons Name		**Employer**			
Affected Service Users Name					
DOB		**Gender**		**Age**	
Are there any adult protection/capacity issues?		YES ☐ NO ☐ If yes – please specify			

Incident Details

Date/Time of the Event		**Date/Time Reported**	
Time into shift (Hrs/ Mins)		**Service**	**Maybank Service**

Specific Location	

Details of actual job being done at the time	

What happened leading up to the incident	
Description of the incident	
What happened immediately after the incident	

Immediate remedial action	
Names of witnesses (first name/last name)	

De-briefing (has a post incident de- briefing of involved staff taken place/been scheduled?) - please detail	

Has the person a history of such behaviour? YES ☐ NO ☐ DON'T KNOW ☐

Frequency? Regular ☐ Intermittent ☐ Rare ☐

Injury details

Was injuries sustained YES ☐ NO ☐

Details of injuries

Challenging Behaviour	YES ☐ NO ☐	**Duration of the challenge** (Hrs/ Mins)	
Kind of event	Challenging Behaviour ☐ Illness/seizure ☐ Falls/trips ☐ Medication Error ☐ Physical Assault (with intent to injure) ☐ Verbal abuse ☐ Breach of Security ☐ Malicious Calls/Letters ☐ Physical Assault (no intent to injure) ☐ Vandalism ☐ Menacing Behaviour ☐ Disruptive Behaviour ☐ Weapon/improvised weapon involved ☐ (please specify)		

Investigation Findings	
Lessons Learned details	
Event subtype	

Outcome

Distress ☐	Has counselling been offered? YES ☐ NO ☐	
Physical Injury ☐	Time Off Work ☐	Number of days off (if known)
Damaged Property / Equipment ☐ (please specify)		

Is the incident RIDDOR reportable? YES ☐ NO ☐ If YES give ICC Ref:

Investigators details

Investigators Name		**Position**	
Investigators Name		**Position**	

Investigation signed off	YES ☐ NO ☐	**Date**	

Investigators Signature		**Date**	
Investigators Signature		**Date**	

Any other comments/ additional information	

Appendix 3: Functional Assessment Template

The broad- Assessments in the context of behaviour which challenges services are sometimes focused excessively on the behaviour which challenges services to the exclusion of consideration of other aspects of the person's life that may have been significantly affected by the behaviour. John O'Brien (1987) introduced the model of five accomplishments as a statement about what we want services to achieve for people no matter how severe their learning disability or behaviour which challenges services. We can use this to reflect on the role played by the behaviour(s) in their lives and others and to think about what the behaviour is preventing them doing and where services might be failing the individual.

The functional assessment should therefore start by considering:

What does the person need or want and how do we know this?

How is the person presently telling us what they want?

How can we change things so they don't need to use challenging behaviour to tell us what they want or in order to get what they want?

Think!

Is this behaviour new? - has it been happening for a long time? Has it got worse recently?

Could there be an underlying mental health problem. Have you checked this?

Could there be an underlying physical health problem. Have you checked this?

Have any significant life events have happened recently - (death of a member of the family, moving to a new unit or house, departure of favourite staff member).

Assessment should ultimately help us to understand:

When a behaviour is more likely to happen and why?

When it is less likely to happen and why?

The function(s) of that behaviour for the individual?

How we can try to work with the person to reduce their need for the behaviours that are seen as challenging?

The specifics of Functional Assessment

1 Define in conjunction with other staff and/or carers (including the family where appropriate carers) and any other agencies involved the behaviour(s) considered challenging that you want to find out more about.

2 Establish an initial estimate of its frequency and severity from existing incident reports (where this is possible).

3 Establish as much as you can of a 'Problem History' for each behaviour.

When did it start and what was happening at that time in the person's life?

Have there been any recent changes in the behaviours frequency or severity recently?

Are there any factors identified or suggested as contributing to any recent increase such as changes in staff, medication, ill health, social activities etc.

4 Construct a 'treatment' history.

Identify from records, interviews with person, carers, relatives and involved professionals what *formal* and *informal* approaches have been used in the past or are being used at the moment. Parent and staff will *always* have had some form of management strategy and sometimes different staff in the same service will be using a range of different approaches.

Try to find out if any strategies used were successful in the past?

5 Carry out an Environmental Assessment

Consider and try to describe what the person's perceptions and expectations are of the environments they live and work in.

Consider and describe the expectations of others are of the person in those environments (what is he expected to do or learn?)

Outline the type of materials and objects available to the person and the nature of the activities the person is engaged or meant to be engaged upon in terms of range of activities, level of difficulty, etc.

Outline the physical and social environment of the person including:
size, temperature, layout space, noise (not just volume but number of separate voices, noise from electrical equipment, lights, etc) the presence of other people with behaviour which challenges services.

Describe whether the day is predictable for the individual i.e. he knows what is likely to happen next for example on a typical day or whether he may not be able to predict what is about to happen.

Note the textures and patterns on furnishings, wall coverings and floors (Some people with severe atypical autism may find certain combinations of stimuli overwhelming).

Identify details of any recent changes in persons environment, staff etc.

6 Use structured observation(s) (ABC) to find out more about the behaviour

ABC (Antecedent - Behaviour - Consequence) Charts. The person's behaviour is observed (as discreetly as possible) and a log of what was happening is kept. The log can be used to note the range of settings, timing and appropriateness of activities, etc as well as the occurrence of behaviour which challenges services

Antecedents are simply events that seem to precede or trigger behaviour a behaviour may be caused by events which happened minutes ago (proximal) or months ago (distal). A behaviour may be triggered by a re-experienced memory prompted by random recollection or a prompted memory (e.g., a bad experience on a previous visit to the dentist which is reawakened when we smell something that reminds us of the dentists) or it may simply be the result of a series of events. Sometimes a behaviour may be prompted by a combination of events that have happened in the days or hours before the incident which *seems* to trigger it. Sometimes particular times of year such as Christmas may be very difficult for certain service users.

A useful exercise is always to work out when the behaviour which challenges services **does not occur** and think about what is different. This can give you clues as to what the possible triggers might be.

Antecedents should be identified in terms of –

- Times (when is the behaviour occurring most frequently and least frequently?)
- Location (where is the behaviour occurring most frequently?)
- Task (does the behaviour appear to be related to any particular task?)

- Expectation (does the behaviour occur in relation to any particular expectation?) Expectations can sometimes include that the person is meant to be doing nothing except waiting….
- People present - who was in the room or other area? Who was absent?

Behaviours should be identified via a simple description of what the person did. Avoid judging or interpreting the behaviour(s). He is 'attention seeking', 'aggressive' or 'manipulative' are not behaviours but judgements about behaviour.

'Consequences'.

What happened after a behaviour (the consequences) will affect its likelihood of occurring again. Describe what happened after the behaviour. E.g. "Colin spat at service user X. X tried to punch Colin and staff had to intervene. X was asked to leave the sitting room but refused. In order to reduce the risk of further violence which seemed imminent Colin was removed from the sitting room".

Plotting the data from a series of completed ABC and using a spreadsheet we can start to look for patterns in the behaviour of the service user. The plotted data should tell us:

-when the behaviour is more (and less) likely to occur (days of the week and times)
-where the behaviour is more (and less) likely to occur (places, rooms, settings)
-what the environment is like when the behaviour is more and less likely to occur
-what expectations appear to trigger or prevent the behaviour
-what tends to happen when the individual presents the behaviour.

This can indicate the *function* of the behaviour. Amongst the more common functions are:

- *Attention* (this may be of a very specific type from a specific person)

- *Avoid / Escape* (so behaviour may be triggered by trying to avoid the end of an activity the service user likes and/or avoid the start of an acitivity they don't!)

- *Tangible* (if we're passing an ice cream shop and the service users asks and you say no and the service user sits down on the road and screams and starts hitting their face whilst crying for an ice cream, then it's a pretty good bet they want an ice cream….!). Sometimes however it's not quite so obvious.

- *Sensory stimulation* (this may involve the person self injuring or using sensory stimulation which they induce such as rocking or repetitive hand movements. These are often self soothing rituals)

***Because** we're going to interpret the information from the ABC charts in order to determine function the reliability of the information you collect is **really** important. You need to be sure the data is accurate. If staff don't fill in forms or make them up at the end of a shift then we might end up planning an intervention based on an assumption of the function of the behaviour, which is wrong. This could make a bad situation much, much worse. You could try role playing any potential assessment situation in order to ensure staff tasked with collecting information can identify the behaviour and record the setting conditions and consequences consistently.*

Using the information from the functional assessment to inform the individual programme plan.

Just to complicate things it's important to remember that the same behaviour can sometimes serve different functions in different situations. If the ABC does not seem to indicate a clear function try plotting the data for separate settings e.g. the FE College and the respite care house. Use risk-benefit assessment to prioritize behaviour(s) requiring intervention.

If the results of the functional analysis are still unclear consider using a Motivation Assessment Scale (Durand and Crimmins 1988) or Questions About Behavioural Function Scale (Matson et al 1999). These instruments are subject to copyright and this should be respected. A further option is an Analogue assessment. This consists of a series of tests in which artificial situations are created where the forms of reinforcement available are systematically manipulated. The situations created must be individually tailored to the service user and the process can sometimes be used to identify function more accurately. Analogue assessment **should only ever be undertaken under the direct supervision of a clinical or educational psychologist, a qualified behavioural analyst, a clinical nurse specialist or equivalent.**

If the ABC does indicates a likely function;

Remember we don't want simply to stop the person doing the things that we consider challenging. Even if we could simply stop the person exhibiting the behaviour that we perceive as challenging, if we accept the idea that the behaviour had a function and therefore served a purpose then eliminating without replacing it mean that the person still has the need that that the behaviour which challenges services fulfilled. If we take it away they are likely to experiment and may find another means of fulfilling the need that could be much worse!

Our intervention then should aim to make appropriate behaviour more likely**.** The focus is on improving skills and quality of life. Reduction of behaviour which challenges services is an important side effect. Interventions should be carried out on a long term basis because the main focus is on maintaining an increase in positive behaviour. We can avoid exposure to known triggers, actively teach new skills, promote involvement in activities that diminish the persons need for behaviour which challenges services and change the environment, all of which in combination may serve to make the persons behaviour which challenges services redundant.