CHALLENGING BEHAVIOUR, VIOLENCE AND AGGRESSION

VERSION No	**4**
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1. **Policy Statement**
   a) The term 'challenging behaviour' is now outdated and not quite accurate. In this home, we do not consider that the people have 'challenging behaviour' but that there are some people who may have behaviour that may present challenge to staff. With the appropriate assessment, care planning, training and supervision such behaviour may be managed better and not present great challenge.
   b) From time to time residents may present behaviour that challenges staff, even some violent or aggressive tendencies which need to be fully documented in the assessment of need and the care plan.
   c) For the purposes of this particular policy, challenging behaviours includes:
      i. Self-harm
      ii. Self-neglect
      iii. Self-abuse
      iv. harm to others
   d) If challenging behaviour, violent or aggressive tendencies are present then a full and robust risk assessment must be undertaken in order to protect not just the resident, but the staff. This needs to include the use of any restraint techniques where appropriate.

2. **The Policy**
   This document outlines the policy of this organisation in relation to dealing with challenging behaviour, violence and aggression among residents.
   a) Principles
   ✓ ***This organisation seeks to demonstrate respect for the lifestyles and human rights of its residents.***
   ✓ ***We recognise, nevertheless that exceptional circumstances may arise when our workers might be called upon to place limitations on a resident's behaviour, either for their interest or for the protection of others.***
   ✓ ***We will attempt to anticipate these possibilities and to follow precise procedures designed to ensure that the limitation to a resident's lifestyle or human rights is kept to a minimum.***
   b) Resident's Plan of care
   In all instances where our workers are likely to encounter challenging behaviour, violence or aggression to an extent that might limit a resident's lifestyle or human rights, we will seek, when the care plan is drawn up or revised, ***to discuss the facts with all concerned and record the decision and the proposed action in detail. We will seek to understand the reasons for the possible action, and to initiate action which will tackle the problem more positively.***
   c) Risk Assessment
   In the course of considering the care plan we will carry out and fully record a risk assessment in order to make a thoughtful calculation of the possible danger which is faced, and the balance of benefits and disadvantages of the proposed course of action.
   d) Resident's Consent
      i. ***We will make every effort to involve a resident at risk of limitation to their lifestyle or human rights in the discussion about possible physical intervention, and to obtain their agreement that such an intervention might be necessary***.

ii. For residents who are permanently unable to understand the situation or to give informed consent, we will seek agreement from someone close to them and knowledgeable about the situation that can genuinely represent their interests.

e) The Use of Restraint

i. The circumstances in which we regard as justified an intervention by a worker of this organisation which would have the effect of limiting a resident's lifestyle or human rights are:

- **To prevent self-harm or self-neglect by the resident**
- **To prevent abuse or harm to others.**

ii. We class intervention as the use of:

- **Chemical (such as medicines)**
- **Physical**
- **mechanical methods of restraint.**

iii. The intervention used must be:

- **the least that is able to contain the risk**
- **last for as short a time as possible**
- **be administered only by appropriately trained and competent staff and**
- **neither intervention, nor the threat of intervention, should ever be used as a form of punishment.**

f) Reporting

Any instance of the use of any intervention methods should immediately be recorded. The worker involved should report what happened to their manager or deputy manager as soon as possible and the manager should review the position and initiate any possible action to avert a recurrence.

g) Inappropriate Use of Intervention by Others

If a member of staff observes any physical, chemical, mechanical intervention they believe to be inappropriate they must report to the RGN in charge, the deputy manager or manager immediately.

3. Training Statement

All staff will have training in prevention of and managing people with challenging behaviour. They will also be supported in understanding the meaning of physical intervention and their responsibilities.

Related Policies

Assessment of Need and Eligibility
Adult Safeguarding
Care and Support Planning
Consent
Dignity and Respect
Mental Capacity Act 2005
Restraint

Guidance

NICE Quality Statement 154 published June 2017 - Violent and aggressive behaviours in people with mental health problems (extracts' / summary)

STATEMENT 1: ***People in contact with mental health services who have been violent or aggressive are supported to identify triggers and early warning signs for these behaviours***:

Personal, social, institutional or environmental factors can trigger violent or aggressive behaviours in people with mental health problems who receive support in mental health, health or community settings. Identifying these triggers can help people using mental health services, care staff and carers to understand what prompts violent or aggressive behaviour when people are using these services. This knowledge can prevent violent or aggressive behaviours from escalating by alerting people to

early warning signs of distress and enabling them to start immediate de-escalation or remove the triggers causing the violent or aggressive behaviour. Identifying triggers and early warning signs can also help services to improve organisational practice.

STATEMENT 2: ***People in contact with mental health services who have been violent or aggressive are supported to identify successful de-escalation techniques and make advance statements about the use of restrictive interventions:*** Identifying de-escalation techniques that have worked in the past increases the likelihood that de-escalation will be effective and restraint won't be necessary. De-escalation should start when the first signs of agitation, irritation, anger or aggression are recognised. Should a situation escalate to a point at which restrictive intervention is needed, de-escalation should still be attempted. Making advance statements for circumstances when restrictive interventions need to be used allows the person to express their wishes about the most acceptable types of restrictive intervention and can minimise potential harm or discomfort.

STATEMENT 3: ***People with a mental health problem who are manually restrained have their physical health monitored during and after restraint:*** Restrictive interventions are most likely to be used in inpatient psychiatric settings and should only be used if other preventive strategies have failed. They should be used for no longer than necessary and de-escalation should continuously be attempted. Monitoring physical health during and after manual restraint is paramount for the person's safety. There is a risk of death from obstructing airways during manual restraint, but harm can also occur after the event. People with mental health problems are at increased risk of coronary heart disease, cerebrovascular disease, diabetes, epilepsy and respiratory disease; all of which can be exacerbated by the effects of manual restraint.

STATEMENT 4: ***People with a mental health problem who are given rapid tranquillisation have side effects, vital signs, hydration level and consciousness monitored after the intervention:*** Restrictive interventions are most likely to be used in inpatient psychiatric settings and should only be used if de-escalation and other preventive strategies have failed, and there is potential for harm to the person or other people if no action is taken. Rapid tranquillisation is a potentially high-risk intervention that can result in a range of side effects linked to the medication and dose. People given rapid tranquillisation need to be monitored at least every hour until there are no further concerns about their physical status. If rapid tranquilisation is used while the person is in seclusion, additional measures may be needed to ensure safety. People with mental health problems are at increased risk of coronary heart disease, cerebrovascular disease, diabetes, epilepsy and respiratory disease; all of which can be exacerbated by the effects of rapid tranquillisation

STATEMENT 5: ***People with a mental health problem who experience restraint, rapid tranquillisation or seclusion are involved in an immediate post-incident debrief:*** Restrictive interventions are most likely to be used in inpatient psychiatric settings. Conducting a post-incident debrief helps the organisation to identify and address any physical harm to service users or staff, ongoing risks, and the emotional impact on service users and staff. The person with a mental health problem who was involved in the incident should be offered the opportunity to contribute to the immediate debrief and discuss the incident with a member or staff, an advocate or a carer. This debrief should take place as soon as possible after the person has recovered their composure. This gives them the opportunity to give their perspective of the event and understand what happened.

Diversity, equality and language: For all statements, good communication between health and social care practitioners and people with mental health problems and their carers (if appropriate) is essential. Treatment, care and information should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with mental health problems and their carers (if appropriate) should have access to an interpreter or advocate if needed. Carers should be involved in decision-making for people with a mental health problem who lack mental capacity, in accordance with the Mental Capacity Act 2005.