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Policy name:	Safe and therapeutic management of violent, aggressive and dangerous Behaviour (Domiciliary Care)		
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INTRODUCTION

Who should read this policy and who does it apply to?
This Policy has been written primarily to support staff working in the Domiciliary Care Service who may find themselves confronted with actual or potential aggression or dangerous behaviour. It outlines the approach that all staff must use to recognize, prevent and respond to aggressive, violent or dangerous behavior, and to keep service users, themselves and others as safe as possible.

Emphasis is primarily placed on the prevention and de-escalation of incidents, including the skills, knowledge and techniques required to do so effectively. Restrictive physical intervention should not generally be undertaken by domiciliary care staff as a minimum number of staff are needed to physically restrict (restrain) someone safely and in addition it could be considered as inappropriate in the service user's own home. However, there are exceptions to this (described in 'Physical Intervention Techniques' below).

National Guidance
This Policy supports the principles and points of guidance as set out in the following national documents:

- 'Guidance for Restrictive Physical Interventions - How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder' (DOH, 2002)
- 'Physical Interventions and the Law' (BILD, 2004)
- 'BILD Code of Practice for the use and reduction of restrictive physical interventions' (BILD, 2010)
- 'Let's talk about restraint' (RCN, 2008)
- 'The recognition, prevention and therapeutic management of violence in mental health care' (NMC, 2002)
- 'The short term management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments' (NICE, 2005)
- 'Training careers in physical interventions' (BILD,2001)
- 'Mental Capacity Act 2005 – Code of Practice' (TSO, 2007)
- 'Independent Healthcare - National Minimum Standards' (DOH, 2002)
- The Human Rights Act, 1998
- 'Standards of conduct, performance and ethics for nurses and midwives' (NMC, 2008)
- The Health and Safety at Work Act. 1974
- The Mental Health Act Code of Practice
- 'Use of Mechanical Devices: restrictive physical intervention' (BILD, 2008)
- The Criminal Law Act, 1967

Definitions and Terms of Reference
The following terms will apply throughout the Policy:

Definition of Violence:
"Any incidents where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health"
(DOH, 2000)

Definition of Challenging Behaviour:
" Challenging behaviour refers to any behaviour of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy or behaviour that is likely to seriously limit or delay access to use of ordinary community facilities".
(Emerson et al, 1987)

Physical Intervention Techniques:
The term physical intervention technique can refer to any physical contact between a staff member and a service user. In order to clarify the types of physical intervention referred to within this Policy, two types of physical intervention will be mentioned. These are 'disengagement techniques', by which an individual is disconnecting him/herself from another, and 'restrictive physical intervention techniques'. Restrictive physical intervention techniques are used to describe techniques that involve the use of physical holds to restrict a persons' movement or mobility in order to avoid injury or public unrest , and differs from 'non-restrictive physical interventions':

	Bodily Contact	Mechanical	Environmental Change
Non-restrictive	Manual guidance to assist a person walking	Use of protective helmet to prevent self-injury	Removal of the cause of distress, e.g. adjusting temperature, light or background noise
Restrictive	Holding a person's hands to prevent them from hitting someone	Use of arm cuffs or splints to prevent self-injury	Forcible seclusion or the use of locked doors (DOH, 2002)

As indicated above, restrictive physical intervention should not generally be used by domiciliary care staff. One exception to this is where there is an immediate risk to life and limb, such as if a service user is about to run into a busy road or is about to assault another person. In such circumstances it is reasonable and appropriate to intervene physically in order to prevent serious injury. However, the Company does not expect staff to put themselves at risk in such circumstances. In the situation described above, for example, where a service user is about to run into a busy road, if the service user is much stronger than the staff member and begins to pull the staff member into the road, the service user should be released. In situations where a service user is attacking another person, a single staff member should not intervene if doing so would put him/her at serious risk. Where there is such a risk, consideration must be given to safety based action such as de-escalation or withdrawal until help can be summoned. A second type of exception might be appropriate in the communal area of a supported living scheme where several trained staff members might be available to safely restrain a service user who is presenting an immediate risk to themselves or others.

The amount of force used when using disengagement or physical intervention techniques should be appropriate to the situation presented.

The use of any physical intervention must always be reported and fully documented. The staff member should be able to justify that his/her actions were reasonable.

EXPECTATIONS OF STAFF

At all times, staff are expected to:

- Take all reasonable precautions to prevent incidents happening
- Attempt to use de-escalation skills and avoid incidents escalating
- Respect the service user regardless of behaviour
- Call for help, gain assistance if needed
- Assess the situation as carefully as possible
- Adhere to relevant policies
- Notify other members of the service
- Complete the appropriate documentation
- Recognise their own limitations
- Contact a senior member of staff should they have concerns.

PREVENTION OF INCIDENTS

Staff must take all reasonable precautions to prevent dangerous incidents happening. This must include undertaking risk assessments to identify high risk situations, warning signs and 'triggers' for challenging behavior for the individual service user. The risk assessments must be documented in the service user's case notes and used to inform care/management plans that detail preventative measures. Such preventative measures might include:

- Avoidance of over-stimulating environments
- Avoidance of dangerous environments/activities
- Working with the service user to reduce exposure to over stimulating substances (e.g. alcohol, illicit drugs, fizzy drinks)
- Provision of interesting/absorbing activities
- Debriefing after upsetting or traumatic events
- Therapeutic programmes that promote/encourage non-challenging behavior.

All staff have a responsibility to familiarize themselves with the service user's risk assessments and care/management plans and act in accordance with the guidance contained within them.

Staff interventions may need to be in response to 'warning signs' i.e. a verbal/non-verbal indication from the service user that all is not well. Knowledge of the service user will help staff to detect subtle warning signs, such as someone staring into space, pacing, withdrawing etc., and therefore intervene sooner.

The Domiciliary Care Manager must ensure that staff are equipped with a mobile phone when visiting service users. Screech alarms may also be issued if staff could be at risk through working in isolation or at night.

DE-ESCALATION AND DEFUSING SITUATIONS

Staff should make every effort to de-escalate/defuse a situation that is at risk of escalation. De-escalation is a calming technique to be used when a service user has become, or is thought to be becoming, upset or agitated.

De-escalation skills that could be used include:

- Re-directing the service user away from the trigger
- Active listening
- Distraction/diversion
- Problem-solving
- Making environmental changes
- Having a calm and interested manner
- Suggesting medication where appropriate.

Staff should avoid doing anything that may escalate the situation. In certain circumstances this may entail replacing a member of staff with one who has a more therapeutic relationship with the service user.

PHYSICAL INTERVENTION TECHNIQUES

Disengagement
"The law imposes a duty on a potential victim to retreat and escape and it is only when no opportunity to disengage is available that self-defense is likely to be considered legitimate"
(Martin, 1990)

A disengagement technique is designed to assist an individual to physically disengage them from an attacker. Disengagement techniques should use reasonable force within the context of the situation in which they are employed.

Disengagement can be used by individuals who are alone and in a threatening situation. Staff need to maintain awareness of their posture, balance and stance. They must assess the situation and ask themselves:

- Is disengagement necessary?
- Is it appropriate to disengage in order to re-engage with the service user?
- Is it necessary to disengage and move to a safe position?

Restrictive physical intervention

PLEASE NOTE THAT THERE IS NO SUCH THING AS A 'SAFE' RESTRICTIVE PHYSICAL INTERVENTION TECHNIQUE. There are risks with all positions simply due to the nature of restricting movement and the likelihood of a struggle. There is also no such thing as a safe time limit. There is a possibility that an individual could collapse at any time during the restraint. Therefore such techniques should only be considered when all other options have been tried and failed and for as little time as possible.

Within the Domiciliary Care Service, restrictive physical intervention could only be used in an emergency situation, where an unforeseen incident has occurred. This cannot be planned for, and

there is a higher risk of injury to those involved in this situation. The purpose of the intervention is to take immediate control of a dangerous situation, and to "contain or limit the service users' movement or mobility for no longer than necessary to end or significantly reduce the threat to him/herself or those around" (DOH, 1995)

Regardless of the techniques used (disengagement or restrictive) the Securicare approach upholds that the actions of the staff must be in response to the actions/needs/safety of the service user. Any force used should be REASONABLE within the context of the situation. At all times, the situation will be viewed in a person-centred way, whereby staff involved in the incident must decide which skills are reasonable to use. This decision is based upon the activity, actions and risk assessment of the service user.

The physical intervention skills taught are done so within a legal and ethical framework. Holding skills are not designed to inflict pain and therefore do not rely on the use of pain to work. However, in high risk situations, whilst carrying out physical intervention, the person whom physical intervention is being used upon may be struggling heavily and some degree of discomfort may be experienced by both the individual and/or staff involved. Should this occur staff must inform their Line Manager and seek medical attention if needed? The Training Specialists will also need to be informed, via supporting documents.

WEAPONS

Disarming people is not a topic included in the Securicare Courses as led by the Superior Healthcare Care Academy Training Specialists. Staff are advised not to physically intervene with a service user who has a weapon, or if faced with an attacker who has a weapon. A weapon can be any object with an implied threat to use offensively.

The situation should be viewed as an emergency, and until help arrives from the emergency services the following should be borne in mind:

- Evacuate the immediate area.
- If possible, remove yourself from the situation.
- If possible, contact a manager and seek advice.
- If you are leaving the individual on their own, attempt if possible to remain within earshot.
- If you cannot leave the situation and become involved in negotiating with the service user

1. Don't accept the weapon if offered – ask them to place it on the floor and gently kick it away from themselves
2. Avoid becoming blocked out from your escape route
3. Keep your distance from the individual
4. Be aware of the risks such as the potential of the individual and the limitations of your environment
5. Consider your verbal and non-verbal skills
6. Avoid being threatening, try to be calm
7. Avoid being controversial or argumentative
8. Speak clearly, using non-complicated language
9. Give the individual options
10. Read the individuals body language, know when to speak and when to be quiet

HOSTAGE SITUATIONS

If you find yourself in a hostage situation:

Remain calm - Easier said than done but important to settle the situation down
Do not give up hope - Others are hard for your safety
Use your mobile phone to summon assistance - You may be able to use this if the captor leaves the room or if you can use the toilet (perhaps by text message)
Do not show emotions - Over excitement and hysteria will raise tension and worsen the situation
Do not speak unless spoken to - Particularly in the initial phase as it may make the captor angry
Do as you are told - Be compliant to establish a degree of trust
Do not argue or make suggestions - This may make the captor angry and resentful
Relax - Although difficult, keep relaxed but also keep the captor facing you if possible
Keep alert As release may be imminent
Rescue In case of rescue attempt expect noise, lights, smoke etc. Lie flat on the floor. Guide rescuers to other hostages.

RECORD KEEPING

The use of physical intervention should ordinarily be recorded on the relevant Superior Healthcare Care Incident Report Form (this may be in paper or electronic form). The information must include:

- Date and time of incident
- Location of incident
- Preceding events or 'triggers'
- Service user involved
- Staff involved
- Technique(s) and duration of intervention used
- Reason for any use of physical intervention
- Outcome of intervention, including any injuries (these must be cross-referenced with relevant Health & Safety requirements, both Superior Healthcare Care's internal policies and 'Reporting of Injuries, Diseases and Dangerous Occurrences Regulations' (RIDDOR) where necessary)
- Impact on the service user and staff
- Names of people/agencies notified
- Actions that might help prevent further incidents.

POST INCIDENT PROCEDURES

Post Incident Support

Support for staff, service users and witnesses must be made available if required for those who want it following an actual or potential incident. However, it should not be forced on someone who refuses it. The Lead Training Specialists are available to support staff as required and/or requested by managers. However, it must be understood that it is a manager's primary responsibility to undertake a debrief with their staff.

Support may also be required by the service user's family/careers.

It can be helpful to discuss the incident prior to the staff member leaving work. Individuals may find it helpful to recount their own story of the event and discuss how the experience affected them.

An individual who has experienced an event such as an incident of aggression may find that they require further support, particularly if he/she is experiencing a psychological reaction to the stress experienced. Support can be offered informally or formally as required. The Psychology Department can offer assistance as required/requested.

Post Incident Review of Service User's Care/Management Plans

The service user (where possible) and all members of the service user's care team should be involved in a post-incident review. Care Plans and Management Plans should be updated accordingly. An incident of aggression may change aspects of the care plan, or indeed make its existence unnecessary. Therefore a post- incident review of all plans of care is imperative. The following variables may be reviewed:

- Triggers and warning signs
- Placement of service user
- Medication
- Attempts at de-escalation
- Care plans/management plans
- Risk assessment
- Post-incident support

Monitoring and Recording

Following an incident of actual or potential aggression a detailed entry should be made in the service user's notes. An incident form and physical intervention form (if required) should also be completed. If injuries have been sustained an Accident Report must also be completed. On completion, and as soon as possible after the event, the necessary forms must be forwarded to the Domiciliary Care Manager to be logged. Any incidents that have resulted in physical intervention must be referred to the Lead Training Specialists for analysis.

TRAINING

Commitment to Appropriate Training

The training provided by Superior Healthcare Care meets current national and service objectives.
The Superior Healthcare Care Academy Training Specialists are licensed and monitored by Securicare. The model used promotes the use of a graded response, with the first emphasis on the provision of a therapeutic environment and de-escalation skills.

Trainers training
All Training Specialists providing physical intervention training within Superior Healthcare Care are required to have completed a recognized level of training i.e. Securicare Physical Skills Tutor Award Course. This is a 5 day course which includes both practical skills and theoretical issues regarding the prevention and management of challenging behaviour. Specialist trainers are licensed for 1 year, at which time they will be required to attend a refresher course with Securicare.

Staff Training
All health and care staff working are required to attend a 1.5 day course provided by the Training Specialists involving theoretical, legal and ethical issues in the prevention and management of challenging behaviour. This includes the teaching of de-escalation skills, disengagement and restrictive physical intervention techniques. All new employees attend the 1.5 day course during their initial induction week.

The courses provided do not rely upon physical strength but manage movement safely by maximizing the use of body mechanics. Therefore the training is suitable for a wide range of staff in health and care settings. Staff attending courses should expect that the fitness level and range of movement required is no more than that required in a busy care environment. All staff will be expected to complete a health questionnaire to ensure they can complete the course.

Staff need to be aware that attendance on courses is compulsory. Delegates will be continuously assessed throughout individual courses regarding their ability, attitude and approach. Concerns on the part of the Specialist Trainers regarding competency may result in delegates being deferred. It should be noted that it is a requirement that all staff reach an acceptable level following assessment due to the increased risk to themselves, their colleagues, and service users through lack of competence. In the case of those delegates who are unable to reach that acceptable level of competence there may need to be a referral to Human Resources for further advice. However, the trainers will give input as necessary to assist delegates who may require more intensive support.

All staff will be required to attend a refresher course every 6 months. This is compulsory in order to maintain standards and reduce risk. In addition, the Training Specialists are readily available to staff who may require impromptu assistance with regard to the techniques used in order to ensure competence and personal confidence. If a specific situation regarding physical intervention arises, the Lead Training Specialists will designate time to the attached staff in order to ensure techniques used are appropriate and effective. Staff attending the Refresher Course will also be expected to attend a First Aid course in order to ensure those involved in restrictive physical interventions are able to perform Basic Life Support.

It is understood that staff may have been taught and used alternative techniques in the past. However, following attendance at the above courses all staff are expected to USE ONLY THOSE TECHNIQUES TAUGHT BY THE TRAINING SPECIALISTS.

LEGAL MATTERS

Any staff who have not been approved to use Securicare techniques are covered by the Criminal Law Act 1967 to protect themselves and others, providing that the force used falls within the guidelines of the Human Rights Act, 1998 (P.L.A.N.):

P Proportionate – am I using the right level of force?
L Legal – am I covered by law to do what I am doing?
A Accountable – I am accountable for my actions and so is the Company. I must rightly justify what I did, how I did it and why I did it.
N Necessary – was the action I took necessary, could it have been done a better way i.e. did I need to use force to get away or would he/she have let go if I had asked them?

Common law provides that everyone has the right to protect themselves or others by the use of reasonable force. This means that:

- the force used must be no more than is necessary to accomplish the object for which it is required;
- punishment or retaliation is not permitted in any way;
- the force must be in proportion to the harm or danger that is threatened;
- all circumstances must be taken into account, such as contrasts between the size, strength and skills of the people involved the type of harm or danger threatened and the possibility of retreating from a threatening situation.

Service users who behave in ways that put themselves or others in physical danger have the same rights and responsibilities under the law as any other member of the public.

The legal position on the use of physical restraint represents a mixture of statute and common law. The general position is that the law allows such force as is reasonable under the particular circumstances. This means that the force used must be necessary. In other words, if the situation can be dealt with by non-physical means, force must not be used. Any force used must be proportionate, in terms of degree and duration, to the harm that is to be avoided.

Statute law: Section 3(i) of the Criminal Law Act 1967 provides as follows: "A person may use force as is reasonable in the circumstances, in the prevention of crime or in effecting or assisting in the lawful arrest of offenders or suspected offenders or of persons unlawfully at large". This means it may be lawful to apply physical intervention to someone who you think is about to commit a crime or is actually in the process of committing a crime, provided such intervention is consistent with the legal rights of the service user and with the responsibilities of Superior Healthcare Care.

Appendix 1

The Assault Cycle

Trigger Phase:
Irrespective of the setting, all service users have a baseline set of behaviours. Almost everybody's normal behaviour is non-aggressive for most of the time. The triggering phase is the aggressor's first behaviour, which indicates movement away from how they usually behave.

Unless you have a detailed understanding of the person, these early warning signs can be missed.

If identified early, it is important to try out various interventions.

Escalation Phase:
This phase leads directly to violent behaviour. The service user deviates more and more from baseline. If there is no intervention the deviation becomes increasingly more obvious, and it becomes more difficult to divert them to other activities.

They become overly focused on the particular issue and are less likely to respond to any form of rational intervention. It is therefore important to intervene as early as possible in this phase by, for example, counseling, removal from the immediate environment, supplying an alternative task, physical activity, anger management techniques and so on.

Crisis Phase:
As they become increasingly physically, emotionally and psychologically aroused, control over aggressive impulses lessens and direct violent behaviour becomes likely. Simultaneously, your physical and psychological responses may also be hampering your control and effectiveness.

In this phase, the least effective strategy is to adopt an intervention that presumes they can respond rationally. It is important to focus on the safety of yourself, the aggressor and anyone else who may be threatened.

Options available to you may be limited.

Recovery Phase:
They (and you) gradually return to baseline behaviour.

BEWARE! It is at this point that most intervention errors occur.

After having experienced the crisis, you may well want to get the whole episode over and done with as soon as possible. Hopefully, this will relieve your own anxiety and allow you to carry out your professional duty and help them recover from the incident.

Do not forget that adrenaline, once produced, can remain effective for up to 90 minutes after the initial assault. Their high state of physical and psychological arousal can remain a threat for one and a half hours after the incident. If you fail to remember this and, for example, you insist on discussing with them why he/she had been feeling violent, you may run the risk of being assaulted again.

NB. Staff intervening in the recovery phase inappropriately have received some of the most serious injuries.

Post-crisis phase:
The service user's behaviour regresses below their normal baseline behaviour.

Mental and physical exhaustion is common and the service user is perhaps:

- Tearful
- Remorseful
- Guilty
- Ashamed
- Distraught
- Despairing

The crisis is over and they may be receptive to interventions designed to relieve guilt, understand the incident and prevent a reoccurrence.

END