Preventing and managing challenging behaviour

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Nursing Standard

CPD/violence and aggression

Patient safety

Preventing and managing challenging behaviour

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[Q in some instance the interventions used, such as de-escalation and physical intervention, appear to be relevant to the prevention and the management of challenging behaviour, rather than only the prevention. Would it be ok to change the wording used in these instances (highlighted)?]
The term prevention, as I've used it and as is commonly used in relation to violence, encompasses the term management. Using the public health model, management would probably equate to tertiary prevention because it is about harm prevention. I've added a sentence to the abstract to clarify that, but it would not make sense to talk about management.

Abstract

Patients exhibiting challenging behaviour, which includes any non-verbal, verbal or physical behaviour, is a significant issue in healthcare settings. Preventing such behaviour and the harm it can cause is important for healthcare organisations and individuals, and involves following a public health model comprised of three tiers: primary, secondary and tertiary prevention. Primary prevention aims to reduce the risk of challenging behaviour occurring in the first instance, secondary prevention involves reducing the risk associated with imminent challenging behaviour and its potential escalation, and tertiary prevention focuses on minimising the physical and emotional harm caused by challenging behaviours, during and after an event. De-escalation should be the first-line response to challenging behaviour, and healthcare staff should use a range of techniques comprising maintaining safety, self-regulation, effective communication, and assessment and actions, to minimise patients' challenging behaviours. In some situations, physical interventions may be required to protect the safety of the individual, healthcare staff and other individuals involved, and

healthcare staff should be aware of local policies and procedures for this. Following a serious incident [Q What defines a serious incident?], healthcare organisations should use post-incident reviews to learn from the situation, while healthcare staff should be offered the opportunity for debriefing. Positive responses to challenging behaviour at an organisational and individual level can lead to improved work environments for healthcare staff and optimal patient care and outcomes.

Keywords

aggression, assault, challenging behaviour, de-escalation, patient safety, safety, violence, violence prevention

Aims and intended learning outcomes

The aim of this article is to provide information on how to prevent and manage patients' challenging behaviour in healthcare settings. While the focus is on patients' behaviours, many of the techniques discussed in this article can be applied to other contexts, such as managing conflict between colleagues. After reading this article and completing the time out activities you should be able to:

- Describe the five main conflict response styles.
- Understand the three-tier public health model for preventing challenging behaviour.
- Explain the potential causes of challenging behaviour.
- Identify organisational, individual and patient measures to prevent and manage challenging behaviour.
- Outline the elements of de-escalation.

Relevance to The Code

Nurses are encouraged to apply the four themes of The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives to their professional practice (Nursing and Midwifery Council (NMC) 2015). The themes are: Prioritise people, Practise effectively, Preserve safety and Promote professionalism and trust. This article relates to The Code in the following ways:

- It outlines the techniques that can be used by nurses to prevent and reduce the risk associated with patients' challenging behaviour, enabling them to practise effectively in these situations.
- The Code states that nurses must act without delay if they believe that there is a risk to patient safety or public protection. This article emphasises the importance of ensuring the safety of the individual, oneself and others involved when challenging behaviour is occurring or imminent.
- It emphasises the importance of effective communication and provides strategies that nurses can use during de-escalation, such as active listening. The Code states that nurses must communicate clearly and use a range of verbal and non-verbal communication methods to respond to patients' needs, as part of the theme of practising effectively.

Introduction

Patients exhibiting challenging behaviour in healthcare settings is a significant issue (Iozzino et al 2015). Challenging behaviour is defined as 'any non-verbal, verbal or physical behaviour exhibited by a person which makes it difficult to deliver good care safely' (NHS Protect 2017a). Most of the behaviours exhibited could be described as violent, aggressive or assaultive. The definition of non-physical assault used in the NHS is 'the use of inappropriate words or behaviour causing distress and/or constituting harassment' (NHS Security Management Service 2004), and includes, but is not limited to: offensive language, racist comments, abusive remarks, invasion of personal space, brandishing objects or weapons, threats, intimidation and stalking. The definition of physical assault used in the NHS is 'the intentional application of force to the person of another without lawful justification resulting in physical injury or discomfort' (NHS Counter Fraud and Security Management Service 2003), and includes: spitting, pushing, scratching, throwing objects at a person, punching, kicking, sexual assault, reckless behaviour resulting in physical harm and failed attempts to cause physical harm. These behaviours can occur in any setting,

but are most frequently experienced by healthcare staff in mental health settings and emergency departments (Bowers et al 2011, Phillips 2016). For the purpose of this article 'challenging behaviour' will be used to describe any non-verbal, verbal or physical behaviour.

Challenging behaviour can arise from interpersonal conflict, when there is disagreement between individuals (Balzer Riley 2011). Interpersonal relationships have the potential for conflict, particularly when there is a level of interdependency. Conflict for nursing staff can occur with other nursing staff, other healthcare professionals, and patients and their families (Brinkert 2010). The focus of this article is on conflicts that may arise in relation to patients; however, many of the techniques, particularly in relation to de-escalation, can be applied to the management of conflict between colleagues.

People typically respond to conflict in one of five ways: avoidance, competition, accommodation, compromise or collaboration (McCabe and Timmins 2013). These five responses can be plotted along two dimensions: assertiveness and cooperation (Thomas and Kilmann 1978). People who avoid conflict tend to ignore the situation and will avoid addressing the issues; this is considered to be unassertive and uncooperative. Competition is about winning and losing, whereby one person attempts to dominate the other, this is considered to be assertive but uncooperative. Conversely, accommodation is considered to be unassertive but cooperative, because it involves neglecting one's needs to satisfy those of the other person. Compromise is intermediate in terms of assertiveness and cooperation, and involves identifying a mutually acceptable solution that partially satisfies both parties. Collaboration involves working with the other person to identify a solution that fully satisfies both parties, and is considered to be assertive and cooperative (Sportsman and Hamilton 2007).

Collaboration is usually the most time-consuming response to conflict, since it requires that both parties voice their issues and concerns as a starting point for exploration of possible solutions (McCabe and Timmins 2013). This approach is associated with the most meaningful outcomes when managing conflict; however, there may be situations where other styles are more useful. For example, in an emergency situation, where it is necessary to make decisions quickly and there is little, if any, time for discussion, a competition response may be most appropriate (Vivar 2006). Alternatively, it may be appropriate to diplomatically avoid an issue, or postpone dealing with it until a more appropriate time, which would be an avoidance response (Sportsman and Hamilton 2007).

TIME OUT 1

Consider how you respond to conflict. Is it by avoiding, competing, accommodating, compromising or collaborating? Does your response change depending on the situation? Think about the last time you responded to a conflict situation, which style did you use, and was it the most appropriate style? Would using a different style have enabled you to manage the situation more effectively?

The costs associated with managing challenging behaviour and conflict are significant, both in terms of financial costs to healthcare organisations (Flood et al 2008), and the physical and psychological costs in terms of harm to healthcare staff (Hahn et al 2008). Managing such behaviour can lead to reduced productivity (Gates et al 2003) and interrupted patient care (Roche et al 2010). Providing a safe work environment for healthcare staff and patients is essential, and there is increasing recognition that patients exhibiting challenging behaviour may be particularly vulnerable **[Q To what?]** (NHS Protect 2017a **[Q This document and related web address can't be accessed. Please advise]**). Therefore, healthcare staff have an important role in recognising patients' vulnerability, anticipating their needs and responding accordingly.

Prevention of challenging behaviour

A public health perspective is commonly used to describe the prevention of challenging behaviour in healthcare settings (Hallett et al 2014). The public health model of prevention has three tiers: primary, secondary and tertiary prevention (Figure 1). Primary prevention refers to actions that take place to prevent challenging behaviour from occurring in the first instance. Secondary prevention refers to the actions taken to reduce the risk associated with imminent challenging behaviour and its potential escalation, and tertiary prevention focuses on minimising the physical and emotional harm caused by challenging behaviours, during and after an event (**Paterson et al 2004)** **[Q please add to the reference list].**

Primary prevention

Primary prevention aims to prevent challenging behaviour from occurring in the first instance and begins with a focus on the physical environment. Ensuring that there is an appropriate acoustic environment and adequate lighting, ergonomic designs and suitable layouts can reduce staff and patient stress, enhance communication with patients, improve patients' sleep, reduce patient's pain and increase patient satisfaction (Ulrich et al 2008). Primary prevention requires action by healthcare organisations, staff and patients. At an organisational level there should be clear leadership, articulating a mission and philosophy regarding the prevention of challenging behaviour and outlining the roles and responsibilities of all staff (Huckshorn 2004). There should be a reporting system for violent incidents, and all such incidents should be appropriately monitored, and investigated where necessary. There should be local policies in place relating to violence, complaints, post-incident reviews and behaviour agreements, which comprehensively meet the needs of the healthcare organisation, its staff and patients.

In relation to staffing, there should be a balanced skills mix of newly qualified and experienced healthcare staff **[Q Please state how this contributes to prevention of challenging behaviour]**, and adequate staffing levels should be maintained through recruitment and retention **[Q Please state how this contributes to prevention of challenging behaviour]**. Healthcare staff should receive role-specific training that equips them to recognise, prevent and manage challenging behaviour (NHS Protect 2017a).

TIME OUT 2

Access your local trust policy on the prevention and management of challenging behaviour or violence and aggression. Download the sample policy template for the prevention and management of challenging behaviour from **NHS Protect: www.reducingdistress.co.uk/reducingdistress/resources/template-documents [Q this link appears to be broken – the problem here is that the reference is also used throughout the article to support statements, recommendations and findings sand the document can't be accessed so we can't direct our readers to this. please advise].** Compare the two documents. Does your local trust policy contain all of the elements suggested in the policy template?

All healthcare staff are expected to adhere to local policies, report incidents to their line manager using their local incident reporting system, and ensure that they are up to date with relevant training (NHS Protect 2017b). Clinical staff are also expected to have knowledge of the causes, prevention and management of challenging behaviour, in particular violence and aggression, as well as understanding and reducing risks. For example, in long-term care settings, a lack of structured activities has been found to increase the likelihood of acts of violence and aggression; therefore, providing a predictable yet stimulating environment reduces this risk (Antonysamy 2013). Although an understanding of potential risks is important, providing person-centred, **recovery-oriented care** **[Q What is this and how does it prevent challenging behaviour?]** forms a significant part of primary prevention of challenging behaviour (Barton et al 2009). A person-centred approach is developed through the establishment of therapeutic relationships with patients and those significant to them, and is underpinned by the values of respect, self-determination and understanding (McCormack et al 2011).

Primary prevention at the patient level is focused on individual care planning. All patients in the NHS must have a care plan. In instances where challenging behaviour, particularly acts of violence and aggression might be an issue, perhaps because of a historical risk, care planning should include assessment for this to identify any underlying concerns (NHS Counter Fraud and Security Management Division 2007). Patients should be involved in care planning where possible, and family members and carers may also provide information on potential triggers of patient's challenging behaviour as well as patterns of behaviour (NHS Protect 2017a).

Secondary prevention

When challenging behaviour, in particular acts of violence and aggression, is imminent, secondary prevention measures are necessary. However, it is important to consider the source of this behaviour. Often, acts of violence and aggression follow a similar pattern involving five phases known as the assault cycle, and including: trigger, escalation, crisis, recovery and post-crisis depression (Kaplan and Wheeler 1983) (Figure 1). **This [Q What is being referred to here? The assault cycle?]** is based on the idea that people have a baseline set of non-aggressive behaviours.

The assault cycle begins with a trigger, which is the event that initiates the person's anger reaction. The trigger could be something obvious, for instance having an argument with another person, or it could be something less obvious that perhaps occurred hours or even days ago that the person has been ruminating on. It could be something that may seem unimportant to an observer, but is nonetheless important and a trigger for the person. At the trigger phase, it is still possible for others to calm the person, or for the person to calm themselves (Kaplan and Wheeler 1983).

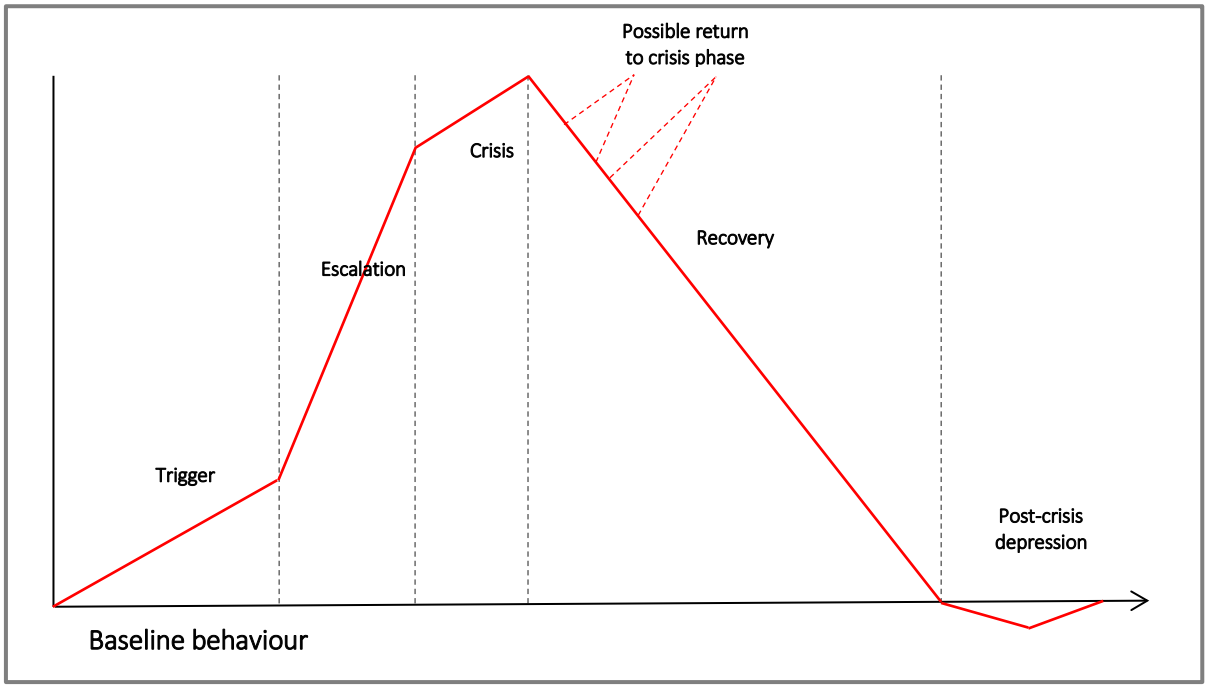
In the escalation phase, the person's anger increases and their body prepares for 'fight or flight', the physiological response to danger where the person can either defend themselves (fight) or flee (flight) (Snooks 2009). The individual's adrenaline (epinephrine) level increases and this can affect their ability to think and act rationally. While it is less likely that the person will be able to calm themselves during this phase, it is still possible for others to intervene and prevent the individual reaching the crisis phase (Kaplan and Wheeler 1983).

The crisis phase occurs when the person becomes increasingly physiologically, emotionally and psychologically aroused, using directly assaultive behaviour, which may include physical assault and threats of violence. During this phase, it will be challenging for the person to respond rationally; they are unlikely to respond to de-escalation techniques, **and others may have to adopt a physical response, for example escape, self-defence or restraint of the individual [Q Is this correct as re-written?]**. During this phase, the main aim of those attending to the situation is to ensure the safety of the individual, themselves and others involved (Kaplan and Wheeler 1983).

As the person's aggression subsides, they enter the recovery phase, and gradually return to their baseline mood **[Q Or is this their baseline set of non-aggressive behaviours as previously referred to?]**. However, it can take at least 90 minutes for adrenaline levels to return to normal, so although the immediate crisis may have passed, the person's anger can easily be reignited (Kaplan and Wheeler 1983).

In the final post-crisis depression phase, as the person's ability to think and act rationally begins to return, they may feel remorse for what has occurred and their mood dips below their baseline **[Q Is this their baseline set of non-aggressive behaviours as previously referred to?]** before returning to normal (Kaplan and Wheeler 1983).

Figure 1. Assault cycle



Apart from the length of time it takes for adrenaline levels to return to normal, no other timings are referred to in the assault cycle. This is because the progression between phases could take minutes or hours. When the progression from trigger to crisis is quick, it may be challenging for healthcare staff to identify the trigger, which might explain why in studies investigating the antecedents of violence and aggression, healthcare staff frequently report that there was no clear cause (Bowers et al 2011). In this instance, there may not be an opportunity for secondary prevention measures, and instead, tertiary prevention measures, which involves prevention and management and aims to preserve the safety of all involved in an incident by minimising the harm caused by violence during and after an event, will be necessary.

Preparatin

Preparation is essential to halt the assault cycle or prevent the person's progression through the phases; this involves healthcare staff being aware of potential triggers that may affect other people, but also being aware of their own triggers (Kaplan and Wheeler 1983). The causes of violence and aggression are multifaceted and depend on the individual and the setting; for example, common causes of violence in an emergency department setting may differ to those in a mental health setting or a care home for older adults. However, the causes can generally be divided into the following categories: environment, situation, staff and patient (Nijman et al 2002). Box 1 lists some of the potential causes of violence and aggression in the healthcare setting.

Box 1. Potential causes of violence and aggression in the healthcare setting

Environment	• Long waiting times • Overcrowding • Lack of privacy • Lack of information • Boredom

Situation	• Activities, for example dressing • Inadequate staffing levels • Time of day • Patient mix [Q Please provide an explanatory sentence here] • Restrictions or denial of requests
Staff	• Suboptimal staff-patient communication • Suboptimal staff-patient relationships • Suboptimal staff attitudes • Inaccessibility of staff • Inconsistent rules
Patient	• Drug and alcohol intoxication • Active symptoms of mental health conditions, for example command hallucinations • Physical health conditions, for example delirium caused by a urinary tract infection • Communication difficulties and other cognitive issues • Fear and anxiety and other emotional issues
(Nijman et al 2002, NHS Protect 2017a)	

TIME OUT 3

Collaborate with a colleague and write a list of the potential triggers for challenging behaviour and in particular, acts of violence and aggression, in your clinical area. Is there something that you could do to reduce these triggers, or are they unavoidable? If they are unavoidable, what can you do to mitigate them?

Many of the causes of aggression **[Q For consistency can challenging behaviour be used there or does it relate specifically to aggression, violence or aggression and violence?]** relate to unmet needs, so if strategies can be identified to meet those needs, the assault cycle can be halted (NHS Protect 2017a). Furthermore, healthcare staff have a duty of care towards their patients, and this includes assessing whether the person understands and can take responsibility for their actions (NHS Counter Fraud and Security Management Division 2007).

If healthcare staff are aware of potential triggers in their clinical area, it may be possible for them to use primary prevention measures to ensure these do not become an issue **[Q It would be helpful to provide an example here to enhance the article's practical application]**. However, there may be constraints that mean this is not possible, so being aware of triggers can enable staff to respond empathetically **[Q It would be helpful to provide an example here to enhance the article's practical application]**. It can also be useful for healthcare staff to be aware of the behaviours that may trigger their own anger to avoid conflict and behaviours that are likely to escalate rather than de-escalate a situation.

TIME OUT 4

List the behaviours that trigger your anger, and what your likely response is. Consider how the causes and your responses change depending on the situation.

De-escalation

Irrespective of how proactive the healthcare organisation is, the care plans in place, and healthcare staffs' awareness of potential triggers in their clinical area, there are times when escalation of aggression is unavoidable. In this instance, the National Institute for Health and Care Excellence (NICE) (2015) recommends de-escalation as the first-line response. A definition of de-escalation in the healthcare context is provided in Box 2. When managing a potentially violent situation, de-escalation is the least restrictive method. It has several benefits compared with more restrictive practices, such as pharmacological or physical restraint. **De-escalation can also assist in developing or maintaining a therapeutic relationship with the person, and can improve healthcare staff's self-esteem and job satisfaction [Q How? This requires further explanation]** (Hodge and Marshall 2007). There are a range of de-escalation techniques that can be used in response to challenging behaviour, including maintaining safety, self-regulation, effective communication, and assessment and actions.

Box 2. Defining de-escalation in the healthcare context

De-escalation describes a range of interwoven staff-delivered components comprising maintaining safety, effective communication, self-regulation, and assessment and actions, which aim to mitigate or reduce patient aggression and/or agitation irrespective of its cause, and improve staff-patient relationships while eliminating or minimising coercion or restriction.

(Hallett and Dickens 2017)

Maintaining safety

The primary and overarching aim of de-escalation is for healthcare staff to maintain their safety and the safety of others involved. Initially, this may involve activating panic alarms and calling for assistance from other healthcare staff, security or the police. However, it should be noted that 'a show of force' may escalate a situation (Duperouzel 2008). Therefore, careful assessment of the situation is required. Reducing the number of onlookers or moving the person to a quieter area can maintain safety and provide a relaxed environment to enable de-escalation (Bowers 2014). Maintaining a safe distance from the person exhibiting challenging behaviour and potential violence and aggression is particularly important; at least two arm's lengths of distance is recommended (Richmond et al 2012). This gives the person the personal space they need and gives healthcare staff the space necessary to avoid physical assault.

Self-regulation

Self-regulation is an important element of de-escalation, and there are techniques that can assist healthcare staff before engaging in any interactions with the person exhibiting challenging behaviour. It is useful for healthcare staff to remind themselves to respond to the situation rather than react to it (Didonna and Gonzalez 2009). Reactions are automatic and impulsive, and often occur without thinking, whereas responses are measured and thoughtful – it can be beneficial for healthcare staff to pause, take a breath and consider the situation before responding. Healthcare staff should demonstrate empathy and attempt to understand the patient's perspective, even if they do not agree with it, since this can assist in diffusing the situation.

Taking several deep breaths before engaging in an interaction can assist with remaining, and importantly, appearing calm, even when feeling anxious (Arnold and Underman Boggs 2011). Remaining calm can mitigate some of the effects of adrenaline, increasing the likelihood of a rational, beneficial response. There is also a psychological phenomenon known as 'mood contagion' or 'mood matching' whereby people replicate or 'catch' another person's inner state (Echterhoff et al 2009). This means that if someone appears angry, anger is a likely response, but conversely, if someone is calm this may encourage the other person to remain calm.

Effective communication

Communication is about much more than the actual spoken word (verbal communication). Paraverbal communication is the way in which the words are spoken, including tone, tempo and volume, and non-verbal communication comprises visual communication cues, such as facial expression and body language. It is important that all of the projected elements of communication are congruent (Richmond et al 2012); for example, if a person's tone of voice or body language does not match their words, the wrong message may be received.

Healthcare staff should adopt a calm, gentle tone of voice when attempting to de-escalate a situation (Drach-Zahavy et al 2012). This may be beneficial in terms of mood matching. For example, it is difficult to continue to shout at someone if they are responding in a calm and measured tone. Similarly, if healthcare staff adopt a relaxed and open posture, this projects the message that they are not a threat, and can assist de-escalation (Richmond et al 2012). It can useful for healthcare staff to actively check that their body is relaxed, particularly thinking about their shoulders and hands, where tension can be visible. Maintaining a neutral facial expression is also important (Hankin et al 2011), as is an appropriate level of eye contact. Too much eye contact can appear threatening, but too little eye contact may give the impression that the healthcare professional is bored or uninterested (Stringer 2016).

The main elements of verbal communication for de-escalation can be described using the author's SHARE acronym:

- Simplicity.
- Honesty.
- Authenticity.
- Rapport.
- Empathy.

It is important to use simple language and short sentences because someone who has raised adrenaline levels may find it challenging to process complex information (Paterson and Leadbetter 1999). Healthcare staff should be aware that it may be necessary to repeat what they said if it is not understood. They should also be honest, both in terms of how they present themselves and in what they say (Dubin and Ning 2008). Making promises might assist in calming a person in the short term, but if these promises cannot be kept, the person's anger might be reignited later. It can sometimes be useful for the healthcare professional to honestly tell a person how they are making them feel, particularly if they appear intimidating, because causing fear may not be the person's intention. Authentic engagement involves making a connection with the person, allowing oneself to be really seen and for them to see you **[Q It is not clear how authentic engagement functions or is achieved. Please explain]** (Finfgeld-Connett 2009). This can encourage the person to regain control and assists in establishing and sustaining rapport. Rapport is established through developing a shared understanding of the patient's perspective, and is largely dependent on the level of perceived empathy (Norfolk et al 2007). It is possible to empathise with the feelings the person is experiencing without condoning their behaviour (Morrissey and Callaghan 2011).

Using open-ended questions provides the person with the opportunity to voice their issues or concerns (Morrissey and Callaghan 2011). It should be noted that eliciting answers is only useful if healthcare staff take the time to listen to them. Active listening can show a person that 'I understand your problem and how you feel about it, I am interested in what you are saying and I am not judging you' (Salem 2011). Boyd and Dare (2014) listed ten elements of active listening, including:

- Facing the speaker.
- Maintaining eye contact.
- Showing understanding by responding appropriately.
- Minimising external distractions.
- Minimising internal distractions.
- Focusing on the person speaking and what they are saying.
- Avoiding telling the person how you managed a similar situation.
- Demonstrating good manners, for example not interrupting the person.
- Asking clarifying questions.
- Keeping an open mind.

It is also worth considering the therapeutic use of silence. Silence can be an effective technique because it can provide the person with time to clarify their thoughts, which may lead to valuable insights (DelBel 2003). Furthermore, silence can be a way of communicating respect by showing that healthcare staff have time for the person (Morrissey and Callaghan 2011).

TIME OUT 5

Develop a poster or a slide presentation for colleagues describing the elements of communication for de-escalation. Include paraverbal and non-verbal communication techniques, as well as the elements of verbal communication that can assist in de-escalation.

Assessment and actions

The actions taken during de-escalation depend on the setting as well as the situation. It may be possible to use activities, such as going for a walk or watching television as distraction or to redirect the individual's attention (Hallett et al 2016, Stringer 2016). One person should lead the de-escalation attempt (NICE 2015), but healthcare staff should recognise when someone else may be required to lead (Gillespie 2008).

It is important to consider how de-escalation techniques are used. A flexible approach to the situation, assessing the effect each technique has on the person is crucial (Turnbull et al 1990). If one de-escalation technique is not effective, even if it has previously been effective, healthcare staff should be prepared to use a different technique. This requires constant assessment of the person and the situation, rather than relying on one or two specific techniques or a predetermined sequence of a range of techniques.

Throughout the de-escalation process, healthcare staff should use dynamic risk assessment, which is a 'continuous process of identifying hazards and risks and taking steps to eliminate or reduce them in the rapidly changing circumstances of an incident' (NHS Counter Fraud and Security Management Division 2007). Dynamic risk assessment involves healthcare staff:

- Being alert to warning signs.
- Ensuring that they are in a position to physically remove themselves from the environment if necessary.
- Judging the best course of action, for example whether to continue the interaction or withdraw.
- Assessing the need for physical security measures, for example calling for assistance from other staff, security or the police, or activating panic alarms where available.

The dynamic risk assessment should begin with a 'ten-second risk assessment', whereby if healthcare staff feel there is a risk of harm to themselves, they should immediately withdraw to a place of safety (NHS Counter Fraud and Security Management Division 2007). Healthcare staff should also ensure that they are not placing colleagues or other people at risk; they should consider the risks associated with the options they have available (Richter 2006). It might be that the situation cannot be managed using non-physical options and they may have to prepare for physical intervention.

TIME OUT 6

Reflect on a time when you experienced aggressive behaviour from another person, either at work or home. Think about your actions and whether they escalated or de-escalated the situation. Consider the elements of de-escalation described in this article – were there any that you used well, or that you could have used to improve the situation? You may wish to use a reflective framework to guide you, such as that by Gibbs (1988) or Rolfe et al (2001).

Tertiary prevention

When there is an imminent risk of harm from violent behaviour, the purpose of intervention changes from de-escalating the situation to preserving the physical safety of those involved or present (Leadbetter and Paterson 1995). Tertiary prevention encompasses management and may require the involvement of security staff or other people trained in managing violent incidents. Security staff may be able to engage the individual, or it may be necessary for them to be escorted off the premises (NHS Counter Fraud and Security Management Division 2007). However, for this to happen, national

recommendations state that staff must ensure that: 'patients whom they consider to be aggressive or violent are assessed as to their fitness for discharge by a senior doctor before their leaving the department, particularly where there is a risk of a head injury. The assessment must be recorded in their notes' (Independent Police Complaints Commission 2006).

TIME OUT 7

Access and read your local healthcare organisation policy on the prevention and management of challenging behaviour, and identify if there is a clear procedure for situations where physical intervention is deemed necessary. Discuss this procedure with a colleague, and how you could ensure all members of your team are aware of how they should respond in an emergency **[Q I think you need to be more specific here, i.e. is it not responding to a situation where there is an imminent risk of harm from violent behaviour, since an emergency situation could cover many things?]**.

Physical intervention may be necessary, but should only be used as a last resort, where de-escalation and other interventions have failed (NICE 2015). Physical interventions include: manual restraint, which is a 'skilled, hands-on method of physical restraint used…to prevent service users from harming themselves, endangering others or compromising the therapeutic environment' (NICE 2015); and mechanical restraint, which is the use of any device that is attached to the patient to limit movement (Freeman et al 2016). Physical interventions should only be undertaken by people who have received appropriate training (NICE 2015). This is because of the risks involved with incorrect application of physical interventions, which include mental trauma, physical injury and possibly death (NHS Protect 2017a).

Reporting and recording incidents

Accurate reporting of all incidents, whether minor or major, can be used to identify risks and to develop prevention strategies (Stout 2008). However, underreporting of incidents, particularly those where there is no physical injury, has been recognised as an issue (Arnetz et al 2015). Staff should be encouraged to report all incidents of **challenging behaviour** **[Q Or specifically violence and aggression?]**, including **low-level behaviour** **[Q What is this? Please define]**, through local incident reporting systems (NHS Protect 2017a). Patient safety incidents, for example when physical interventions are used, are also reported to the National Reporting and Learning System, a national database where data are analysed (NHS Improvement 2018).

The incident should also be recorded in the patient notes, if appropriate, including the rationale and justification for any actions taken (NHS Protect 2017a). To understand and learn from such incidents, it may be useful to record the incident using an Antecedent-Behaviour-Consequences (ABC) model chart. This involves recording the events that occur immediately before, during and after an incident (NHS Protect 2017a), and is commonly used in learning disability settings (Matson et al 2012) and with people with dementia (Elliot and Adams 2011).

TIME OUT 8

Complete an ABC model chart for an incident of challenging behaviour that you have witnessed or experienced. Use the following headings to assist you:

- Date and time of the incident.
- Description of the incident.
- Antecedent.
- Behaviour.
- Consequence.

You may wish to use Appendix 1 from the Information Sheet: Challenging Behaviour – Supporting Change (The Challenging Behaviour Foundation 2008) as a guide, which is available at: www.challengingbehaviour.org.uk/learning-disability-files/10_Challenging_Behaviour_Supporting_Change_2008.pdf.

For a single incident, completion of one ABC model chart may suffice to provide an understanding of the person's triggers, and therefore develop an action plan to reduce the challenging behaviour (McGeorge 2007). ABC model charts can also be used with individuals over a prolonged period to identify factors that may perpetuate the behaviour, which may not be obvious from a single incident. Often, minor modifications to the person's care may be identified using the ABC model chart that can have a significant effect on a person's behaviour (NHS Protect 2017a).

Post-incident review

Following a serious or severe incident **[Q i.e. one Involving acts of violence and aggression or harm?]**, there should be a post-incident review. This should take place as soon after the incident as possible, while accounting for any trauma, both physical and mental, that those involved may have experienced (NHS Security Management Service 2004). The NHS Security Management Service (2004) identified several questions that should be asked during the review, including:

- What can be learned?
- What can be done to avoid repeating mistakes?
- How can what is and is not working be assessed?
- What are the implications of what happened?
- Are policy and system revisions required?

The lessons learned from a post-incident review should be communicated to the wider healthcare team (NHS Protect 2017a).

Debriefing

While a post-incident review enables lessons to be learned at an organisational level, the healthcare team, patients and witnesses may also require debriefing to support them to manage their emotional and psychological responses to an incident, and to learn from what happened. Debriefing and post-incident reviews, when combined with other violence prevention strategies, have been shown to be successful in reducing the use of seclusion and restraint (Riahi et al 2016). Debriefing commonly takes place after major incidents, such as traumatic assault or major trauma, but occurs less often in response to less serious incidents (Healy and Tyrrell 2013), and patient debriefing takes place less frequently than it does for staff **[Q What is the consequence of this or the direction of the argument/discussion here?]**(Ilkiw-Lavalle and Grenyer 2003).

Debriefing in nursing can be a formal process, but it also occurs informally, through support from peers following an incident (Bohan and Doyle 2008). Formal debriefing can last up to three hours (Healy and Tyrrell 2013), and should be facilitated by someone with the skills to guide the process (Hanna and Romana 2007). While debriefing can assist healthcare staff to make sense of, and validate their experiences, it should not take the place of individual counselling (Hanna and Romana 2007). In the event of major incidents, single-session debriefing may be harmful, causing 'secondary re-traumatisation', whereby examination of the incident causes further trauma, and exacerbating negative experiences without assisting in emotional processing (Rose et al 2002).

Conclusion

An understanding of the causes and prevention of challenging behaviour and conflict are important for all healthcare staff, because related incidents can occur in any setting. The prevention of challenging behaviour has three tiers: primary, secondary and tertiary prevention. Ideally, primary prevention measures will be in place that significantly reduce the risk of challenging behaviours occurring in the first instance, and these are the responsibility of healthcare organisations, staff and patients. Identifying possible triggers specific to each clinical area can mitigate issues and may enable healthcare staff to empathise with individuals when such triggers cannot be avoided and cause issues.

When incidents of challenging behaviour occur, they typically follow a similar five-phase pattern, known as the assault cycle. In some situations, healthcare staff may have the opportunity to intervene before a crisis occurs, but at other times there will not be an opportunity for any interventions other than a physical response. When staff have time to intervene, de-

escalation should be the first-line response. Healthcare staff should attempt to respond to the situation, rather than react to it. There may be times when de-escalation fails, and the purpose of intervention changes to preserving the physical safety of those present. This may require the involvement of staff trained in the use of physical interventions, and all staff should know the procedures to follow if this occurs.

Following an incident of challenging behaviour, a post-incident review can be useful at an organisational level, while debriefing can assist staff in managing their emotional and psychological responses. Positive responses to challenging behaviour at an organisational and individual level can lead to improved work environments for staff and optimal patient care and outcomes.

TIME OUT 9

Nurses are encouraged to apply the four themes of The Code (NMC 2015) to their professional practice. Consider how preventing and managing challenging behaviour relates to the themes of The Code.

TIME OUT 10

Now that you have completed the article you might like to write a reflective account as part of your revalidation.

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