

Our Ref: NG/RM/24126  
Date: 2<sup>nd</sup> May 2024

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Reception: 0300 123 1535

Dear

### Freedom of Information Act Request

I am writing in response to your e-mail of the 5<sup>th</sup> April 2024. Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

#### ***Requested information:***

I am writing to make a request under the Freedom of Information Act 2000. I seek to obtain information regarding the policies and procedures your Trust has in place concerning debriefing/post-incident review processes following restrictive interventions.

Restrictive interventions may include, but are not limited to, physical restraint, mechanical restraint, seclusion, and rapid tranquilisation, used in the management of violent or potentially violent incidents. I am particularly interested in how staff and patients are supported through a debriefing/review process post-intervention, to ensure the wellbeing of all parties involved and to facilitate learning and improvement in practice.

Specifically, I am requesting:

1. A copy of any current policies, guidelines or procedures that refer to debriefing/ review following restrictive interventions within your services. This may be contained within broader policies regarding the prevention and management of violent behaviour or other related documents.

**Please see Appendix 1 attached.**

2. Any training materials or guidance provided to staff on conducting debriefing/ post-incident review sessions aimed at either staff or patients.
  - **The Trust provide Crisis Prevention Institute (CPI) Safety Intervention training. Within this training there is a module on the use of debrief following restrictive practices.**
  - **4 CISM Practitioner Courses that run each year to ensure that we always have sufficient number of CISM Trained Practitioners to Support Staff at the time and following incidents. CISM Training is provided in line with Critical Incident Stress Management Policy. Please see Appendices 2 and 3 attached.**

- **CISM The Basics** for all staff so that they are aware of supportive commitment to this.
- **The Trust also hold a Critical Incident Stress Management Conference each year which highlights incidents and responses.**

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely



**Nicola Griffiths**  
**Deputy Director of Governance**



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Chair: Janet Dawson  
Chief Executive: Dr Buki Adeyemo  
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**Document level:** Trust  
**Code:** R01  
**Issue number:** 2

## Policy on the Use and Reduction of Restrictive Practice

Lead executive	Chief Nursing Officer
Authors details	Reducing Restrictive Practices Lead

Type of document	Policy
Target audience	Clinical Staff
Document purpose	Information and guidance

Approving meeting	Quality Committee Trust Board	Meeting date	6 <sup>th</sup> May 2021 13 <sup>th</sup> May 2021
Implementation date	18 <sup>th</sup> June 2021	Review date	31 <sup>st</sup> May 2024

Trust documents to be read in conjunction with	
	Rapid Tranquilisation policy
	Seclusion and Long-term segregation policy

Document change history		Version	Date
What is different?	Changes to team name. (e.g., Reducing Restrictive Practices Team) Changes to job titles (e.g., QILN and site manager) Change to time of review for restraint episodes	1	01/05/21
Appendices / electronic forms			
What is the impact of change?			

Training requirements	Inform clinical staff of change to timeframe for review by QILN/Site manager from 2 hours to 30 mins
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Document consultation	
Directorates	Adult and urgent care, specialist directorate
Corporate services	Reducing Restrictive practices Group
External agencies	

Financial resource implications	None
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External references
1. <b>Department of Health (2015)</b> Mental Health Act, 1983. Code of Practice.

**2. Department of Health (2007):** Mental Capacity Act 2005, Code of Practice, HMSO, LONDON

**3. DFES/DoH (2002):** The use of restrictive physical interventions for staff working with children and adults who display extreme behaviour in association with learning disability and/or autistic spectrum disorder, HMSO, LONDON.

**4. NICE Quality Standard (2017):** Violent and aggressive behaviours in people with mental health problems.

**5. NICE (2015).** Violence and aggression: short term management in mental health, health and community settings.

**6. Stirling and West (2006).** Restrictive Interventions: a professional, ethical and legal perspective for use of physical restraint in educational, social and health care settings. IN: **Paley and Brooke (Eds).** Good Practice in Physical Interventions: a guide for staff and Managers (British Institute of Learning Disabilities).

Monitoring compliance with the processes outlined within this document	Compliance will be monitored through review of incident reporting and staff competency
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Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favourable / More favourable / Mixed impact
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– <b>Age</b> (e.g. consider impact on younger people/ older people)	No	
– <b>Disability</b> (remember to consider physical, mental and sensory impairments)	No	
– <b>Sex/Gender</b> (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– <b>Gender identity and gender reassignment</b> (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– <b>Race / ethnicity / ethnic communities / cultural groups</b> (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– <b>Pregnancy and maternity, including adoption</b> (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– <b>Sexual Orientation</b> (impact on people who identify as lesbian, gay or bi – whether stated as ‘out’ or not)	No	

<ul style="list-style-type: none"> <li>– <b>Marriage and/or Civil Partnership</b> (including heterosexual and same sex marriage)</li> <li>– <b>Religion and/or Belief</b> (includes those with religion and /or belief and those with none)</li> <li>– <b>Other equality groups?</b> (May include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)</li> </ul>	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: <ul style="list-style-type: none"> <li>- Can this impact be avoided?</li> <li>- What alternatives are there to achieving the document without the impact?</li> </ul> Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	N/A	
Enter details here if applicable		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact.		
For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at <a href="mailto:Diversity@northstaffs.nhs.uk">Diversity@northstaffs.nhs.uk</a>		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

## Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There <b>is no</b> specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	
There <b>is</b> specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	✓

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Career Grade Doctor				

Training Grade Doctor				
Locum medical staff				
Inpatient Registered Nurse (including staff located at Crisis care centre)	✓	One off	change to timeframe for review by QILN/Site manager from 2 hours to 30 mins. <ul style="list-style-type: none"> <li>• Handout/Poster</li> <li>• Face to face during MAPA course.</li> </ul>	✓
Inpatient Non-registered Nurse				
Community Registered Nurse				
Community Non Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Completed by	Reducing Restrictive Practices Lead	Date	01/05/21
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## 1. Introduction

Therapeutic environments are most effective for promoting both physical and emotional wellness and restrictive interventions should only be used in a modern, compassionate health service where there is a real possibility of harm to the person or to staff, the public or others (DOH, 2014). The purpose of this policy is to provide a framework to provide the development of service cultures and ways of delivering services which better meet people's needs and reduce the need for restrictive physical interventions.

It is recognised that at times some individuals by their actions can endanger their own safety and/or the safety of others. In these situations staff may need to use restrictive physical interventions in order to safeguard the individuals for whom they care. At such times, it is expected that staff will act professionally in accordance with their level of experience and training, following local policies, professional guidance and legal doctrine. There are many types of restrictive intervention and this policy aims to provide general guidance to staff. It aligns to the following policies which give specific guidance to particular issues:

- Formal detention under the Mental Health Act (MHA)
- Seclusion
- Locked Door Policy
- Weapons Policy
- Guidelines for staff regarding the police use of CS Spray
- Personal searches
- Lone worker guidelines

## 2. Scope of the policy

The aim of this policy is to ensure that all staff:

- Understand their responsibilities in the use of restrictive physical interventions are trained in their use.
- Understand their responsibilities for their actions or omissions (duty of care).
- Understand the process to follow following incident of using restrictive intervention e.g. incident form, completion of debrief.

The intention of this policy is to prevent undue restriction of patient's liberties, to promote good practice and to enhance the knowledge and skills of staff working within the Trust. The emphasis of care is based on restraint reduction strategies.

### 2.1 Diversity and inclusion

Clinical practice must take account of diversity and inclusion. All clinicians should consider the manner in which patients are treated, to ensure that this does not inadvertently discriminate against any groups in society based on their race, disability, gender, age, sexual orientation, religion or belief. The Trust is committed to ensuring that people are treated as individuals with privacy, dignity, respect and modesty. Modesty comprises a set of culturally or religiously determined values that relate to the presentation of the self to others. Care must actively promote privacy and dignity and respect modesty at all times.



To monitor this any protected characteristics of people subject to restrictive interventions must be gathered through the trusts incident reporting systems.

### 3. Framework

#### 3.1 Restrictive interventions

The National Institute for Health and Care Excellence (NICE, 2015) define restrictive interventions as:

*“Interventions that may infringe a person’s human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation”.*

The Mental Health Act 1983 Code of Practice (DOH, 2015) stipulates that physical restraint should be used only where other strategies such as de-escalation have proved insufficient. Physical restraint should always be used in conjunction with further efforts to de-escalate the situation. It should never be used as a punishment or in a punitive manner. Action taken must be based upon a person centred risk assessment and behavioural support planning or in an emergency, the situation and level of risk.

#### 3.2 Definitions of specific restrictive intervention methods

##### 3.2.1 Physical intervention

Physical holding: The use of physical holds to manage, limit or restrict an individual’s ability to move during the provision of safe care or in the management of a violent episode.

Disengagement: The use of physical actions to limit, stop or disengage from harmful or injurious physical contact initiated by another during the provision of safe care or in the management of a violent episode.

##### 3.2.2 Chemical intervention

The use of chemicals or pharmaceutical agents to alleviate, treat or manage an individual’s underlying psychological or psychopathological condition or reduce the risks presented by certain behaviours.

##### 3.2.3 Mechanical intervention

The use of splints, straps, tethers, harnesses or furniture (e.g. reclining chairs, wheelchairs, bed rails) to limit or restrict an individual’s autonomy.

##### 3.2.4 Environmental intervention

The use of locked doors, baffle handles, time out rooms, low stimulus environments, fences or gates to contain or limit an individual to or from one particular room, building or location. This could be related to legal restrictions e.g. MHA 1983 (2007).

##### 3.2.5 Social/psychological intervention

The use of verbal instructions or commands, withdrawal procedures, social restriction (e.g. time out from positive reinforcement) to limit, interrupt or stop an individual's behaviour which is viewed as potentially harmful, undesirable or socially unacceptable

### 3.3 Guidelines for best practice

The following guidelines set out standards for staff to safely manage actual or potential aggression ensuring that the prevention of harm is of paramount importance. The guidance within this document is of a generic nature and promotes person centred care therefore staff must interpret accordingly and apply the principles within their various work areas.

#### 3.3.1 Management of actual or potential aggression (MAPA®)

NSCHT has an ongoing programme of training in the Management of Actual or Potential Aggression (MAPA®). This training incorporates theoretical components including legal, ethical and professional issues, proactive management strategies and physical skill components. Each of these aspects are of equal importance and are interdependent, offering a broad continuum of care options when managing actual or potential aggression.

Throughout MAPA training the emphasis is on avoidance and de-escalation, with physical interventions being taught as a “last resort” via a ‘least restrictive response model’.

MAPA® is a registered trademark of the Crisis Prevention Institute (CPI) and MAPA® Training is certified by BILD-ACT under the Restraint Reduction Network (RRN) Training Standards. (Ridley J & Leitch S 2019).

CPI, licenses the Trust on annual basis, to teach MAPA® physical interventions to internal staff and through an exception clause to legitimate others, such as informal carers. The Trust is a BILD Association of Certified Training Affiliate Organisation, this means that the MAPA® training delivered to trust staff, by our certified instructors is certified against the RRN Training Standards.

All staff who have undertaken an initial MAPA® training program, must attend an annual update, in order to maintain their live status on the MAPA® training register.

### 3.4 Recognition and Prevention of Disturbed or Violent Behaviour

The primary focus when managing patients who potentially present with disturbed or violent behaviour should be the establishment of a culture which focuses on early recognition, prevention and de-escalation of potential aggression thereby minimising the risk of its occurrence.

Staff should attempt to engage and gain the confidence of patients so that they can learn to recognise potential stressful events at an early point. Thereby enabling potential

risks to be managed in a pro-active and non-physical way by the use of diffusion, de-escalation and diversion techniques.

Continuity of staffing is an important factor in both the development of skills and consistency in managing behaviours that present risk.

Patients who are identified as being at risk of disturbed or violent behaviour should, where capacity allows, be made aware of and provided with the opportunity to discuss their views and wishes. Any such views or wishes should be recorded in the form of an Advance Statement (Chapter 9, MHA 1983 Code of Practice, (2015)). These wishes should also be recorded in the patient's individual intervention plans.

Staff should demonstrate and encourage respect for diversity and recognise the importance of privacy and dignity in relation to the safe and therapeutic management of patients.

Staff should always see the behaviour of patients in context and not categorise behaviour as disturbed without taking into account the circumstances in which it occurs. Whilst past behaviour is an important factor in assessing risk it should not be assumed that a previous history of violence means that the behaviour will be repeated.

Individual risk assessment or behavioural support plans should be proactive and include primary and secondary preventative strategies. Care should be taken to ensure that there are no negative or stigmatising judgements made about certain diagnosis, behaviours or personal circumstances.

Individual person centred intervention or behavioural support plans are fundamental to the appropriate management of aggressive behaviour. Challenges can be minimised by promoting the therapeutic culture of the environment and by identifying and managing potential areas of concern/risk. Positive measures may include:-

- Empowering patients by engaging, communicating and involving them in their own care and treatment.
- Developing a therapeutic relationship between each patient and named Nurse
- Developing a therapeutic relationship between patient and the wider Multidisciplinary team
- Seeking patient co-operation and encouraging influence in their own care and support.
- Consideration of an appropriate patient mix and good balance of skills within the staff team.
- Encouraging patients to identify their own triggers and early warning signs for aggressive behaviour and assisting to develop individual coping strategies and de-escalation plans that are personal to the patient.

- Positive environmental factors such as patients having access to their own “space”, recreation rooms, single sex areas, visitor’s rooms and outside areas.
- Providing appropriate activities for all patients, including exercise and encouraging participation in activities **meaningful** to each individual.
- Ensuring that the cultural, religious and spiritual needs of the patient have been discussed, identified and responded to.
- Ensuring that complaints or issues of concern are dealt with promptly, transparently and fairly.

### 3.5 Use of physical interventions

The most common reasons for the use of restrictive physical holding (MAPA®) are:

- Physical assault
- Dangerous, threatening or destructive behaviour
- Self-harm or risk of physical injury by accident
- Prolonged and serious verbal abuse, threats, disruption of the living environment
- Extreme and prolonged over activity that is likely to lead to physical exhaustion
- Attempts to abscond (where the patient is detained under the Act).  
(*Mental Health Act 1983 Code of Practice, DOH, 2015*)

The use of restrictive physical holding techniques / skills will always be used as a last resort. They should not be used until all other approaches have been tried and have failed or the risk is so imminent that there is no safer alternative. Staff should balance the risks when deciding whether or not to physically intervene. There may also be times where, following risk assessment and individual behaviour support planning, that the proactive application of restrictive physical interventions are indicated as part of a broader plan of care. All efforts should be made to include/reflect on advance statements.

Individual characteristics aid the decision making process relating to the use of restrictive physical interventions. The person’s intent and potential to cause harm to self or others must be considered. Factors to be considered may include the person’s physical ability / disability, age, gender, physical characteristics, psychological and sensory disorders. Additional factors are the circumstances (i.e. the environment) and the persons “willingness to disengage” following an incident.

Any restrictive physical holding must be both reasonable and proportional in the circumstances. The force used being the minimum required to effectively reduce the risks of the aggressive behaviour i.e. - the least restrictive option (minimum use of force for the minimum time). All actions taken by staff should facilitate the de-escalation of the aggressive behaviour.

The purpose of the restrictive physical holding is to firstly take control of a dangerous situation and secondly to limit a person's autonomy for no longer than is necessary to reduce the likely hood for harm to self or others.

It is unsafe practice for staff to attempt to physically manage aggression on their own. If staff are alone and faced with actual or potential aggression they should attempt to disengage from the situation and summons assistance by the most appropriate means available e.g. use of alarm systems.

Where there is only a small number of staff present, they may also consider activating appropriate alarms if they feel more staff are required to safely manage the aggressive situation. In any event staff should summon support via alarm systems if they believe that this will decrease or minimise the risks of harm.

### 3.6 Guidelines for physical means of managing actual or potential aggression

The physical management of aggression will always involve a degree of risk to all parties involved. It is therefore essential that all staff discharge their duty of care in that no reasonable act or omission on their part will knowingly or negligently cause harm to the person displaying aggression, and that any action taken will ensure so far as is reasonably, the safety and wellbeing of everyone involved.

It is neither possible nor desirable to outline specific methods of restrictive physical intervention in these guidelines. However, the training and application of physical intervention skills will NEVER involve weight being applied to a person's neck, chest, or abdomen. Furthermore the use of pain compliance should never be used.

Only staff that have completed the full MAPA© course, including restrictive physical holding skills, and whose names appear on the live MAPA© Register should engage in the application of restrictive physical intervention. However in an emergency individual's who have not been trained or who have allowed their registration to lapse, may do so. However they must act in a manner that is safe, professional, and reasonable in the circumstances to prevent harm to themselves or others. If it is identified post event that it is likely that the individual may find themselves in a similar situation again, then they should attend MAPA® training as soon as it is reasonably practicable.

It is the responsibility of the Line Manager to ensure the safety and wellbeing of patients, staff and visitors. This responsibility will be appropriately delegated when the manager is not available. It is important that managers are aware of the capabilities of their staff in relation to restrictive physical interventions and maintain appropriate levels of training to meet the needs of the service.

### 3.7 Restrictive holding of children

If it is deemed necessary to physically hold a child, those staff involved must discriminate their size and weight in relation to the child, this may affect type and position of physical hold used. Wherever possible staff should endeavour to avoid the prone position, if this is impossible then staff must adhere to the guidance given in 3.11.

### 3.8 Points of good proactive practice

Proactive practice is as much to do with attitude as it is about clinical practice. It is about a willingness to actively identify and then manage risks posed by an aggressive person should they display aggressive behaviour (verbal / physical). This will involve a willingness to engage with the individual pro-actively at different levels in order to develop a good rapport.

Activities: Programmes of occupation and / or diversion may be useful in reducing boredom and frustration, both of which are key factors in aggressive behaviour. Additional activities that focus on individual coping strategies are beneficial.

Assessment plans: To support completion of assessment plans, staff will complete clinical risk assessments linked to individual behaviour support plans which highlight the appropriate measures to be taken in the event of the use of the restrictive physical interventions in the management of aggression.

Appropriate communication: It is vital that appropriate information is shared with managers, nurses and other colleagues (multi-disciplinary) about potentially aggressive individuals (patients / relatives).

Dress: Can you move freely? Maintain dignity? Do you have anything on you that could cause injury to yourself or others e.g. scissors, pens, or a tie?

Environment: The environment should be as pleasant and comfortable as possible, offering therapeutic value. This may enhance the service users experience and consequently may minimise the likelihood of an aggressive or violent incident.

- The environment should be managed and designed with consideration as to whether it may under or over stimulate an individual potentially leading to aggressive behavior.
- Dependent on the service provision consideration should be given to the security of the environment (doors, windows), and the availability of weapons (e.g. pens, vases, sharps)
- Only those staff involved in the restrictive physical intervention and required to help minimise risk and facilitate communication should be present, and if possible remove on-lookers so as to facilitate both de-escalation and dignity.

Factors that may increase the likelihood of aggression: People who feel dis-empowered, under represented, frustrated, under or over stimulated and unable to effectively communicate may be more likely to exhibit aggressive behaviour.

Medication: May be used as a proactive measure as well as in a crisis intervention. As required medication, should be given as indicated by the

Responsible Medical Officer or nominated deputy, and its effects monitored closely both in regards to the ability of the medication to treat the patient / client's physical and/or mental condition and minimise their aggressive behaviour (see Policy on Rapid Tranquillisation). *The above statement only applies to those clinical areas where the use of as required medication is a viable option, this will primarily be within inpatient/residential settings.*

**Relationships:** The establishment and maintenance of a professional therapeutic relationship between staff and service users is a key factor in reducing aggressive behaviour or in facilitating the de-escalation of an aggressive person. Staff should treat service users at all times with dignity and respect.

**Training:** All clinical staff are required to complete clinical risk training. Through risk assessment managers should be able to identify the further training needs of their staff and arrange appropriate training ensuring that services are appropriately covered. All staff in high-risk areas identified by risk assessments will require appropriate MAPA© training.

### 3.9 Person centred care planning

All service users who present with a risk of violent/aggressive behaviour should have person centred intervention plans that identify the level of risk, and the primary, secondary and tertiary interventions necessary to reduce the risk to an acceptable level. The intervention plan must be written by a first level nurse and agreed with the multi-disciplinary team. Involvement of the service user in the identification of trigger factors, safety plans and advance statements should always be sought. The plans must be documented, agreed, reviewed and shared across all professions, (NICE Quality Standards, 2017).

Where there is a history of violence, consider the context of this including the stressors e.g. (person/ environment). Ensure appropriate levels of observation and engagement for service users and consider the completion of a functional analysis.

The intervention plan must include a rationale for using restrictive holding, the levels of holding to be used and the preferred position the service user should be held in, bearing in mind any physical/medical conditions which would make certain positions a higher risk.

Re-assessment and evaluation of the intervention plan should be on- going and the restrictive physical intervention removed from the plan as soon as it is practical and safe to do so.

Any plan concerning restrictive physical intervention must not be used in isolation. Plans promoting primary and secondary prevention strategies and engagement must be in operation to minimise the need for physical holding.

All incidents of the use of restrictive physical holding techniques should be

documented via the electronic incident reporting system. This includes those which are required for the administration of planned care and treatments. Any protected characteristics should also be captured.

### 3.10 Weapons

When dealing with a violent or potentially violent situation it is important to make visual check for weapons.

A weapon may be defined as *“any object that is made for the purpose, adapted for the purpose, or intended for the purpose of inflicting physical injury upon a person”*, (Crime & Disorder Act 1956).

If a weapon is identified then withdraw, negotiate, and if necessary call the police. REMEMBER: no staff within NSCHT will have received training in disarmament techniques and they should therefore NEVER attempt to disarm an aggressor.

Within MAPA training, advice is given about what to do if attacked with a weapon; this is distinctly different from disarming an aggressor. In such situations the initial staff response should be to “back off” and try to put some distance between you and the attacker. If this is not possible try to utilise large items of furniture as a barrier between yourself and the attacker e.g. bed, dining table, large sofa or arm chair. Consider if it possible to isolate the attacker in an area whilst the police are summoned via 999.

### 3.11 Safe Practice

It is recommended that a minimum of two staff are involved in any process of physical holding. This number may have to be increased depending on the level of risk and severity of the incident.

The safety of both staff and service user are paramount therefore a sufficient number of staff should be identified to manage the incident as safely as possible. Staff should be allocated a specific task, bearing in mind that these roles may need to change during the incident.

Clear on-going communication within the team and with the service user is important, aiding de-escalation and co-ordination of the team. Therefore it is best if only one person at a time talks to the service user and leads the team.

Fewer well-briefed staff are likely to be more effective than a large number of staff acting in an un-coordinated manner. If more staff are in attendance than are needed they should be asked to leave the immediate vicinity to facilitate both de-escalation and the maintenance of the person's dignity and privacy.

Staff should seek to reduce the risks of the situation as swiftly as possible and then manage the person's aggressive behaviour. Staff should then consider moving



the person or others to achieve a low stimulus environment, to better facilitate the process of de-escalation. REMEMBER you should only consider moving the person when it is safe to do so and you will need their co-operation. Thus, it may be necessary to ask other service users to leave the area in order to maintain dignity.

In extreme circumstances it may be necessary to manage the aggressive person on the floor, although a seated position is more preferable, as it promotes dignity and avoids some of the risks involved in conducting physical holding on the ground, (NICE, 2015).

Any descent to the ground should be controlled and initiated by the Service User; it should never be initiated by staff. During the descent and when on the ground the service user's head should be protected from harm.

Normal respiratory function should not be compromised, and weight should never be applied to a person's head, neck, chest, or abdomen. A "THIRD PERSON" should always be available for communication with and observation of the service user in order to monitor the service user's physical wellbeing, (NICE, 2015).

Staff must explain to the service user the reasons for the application of restrictive physical intervention, actively seek the co-operation of the person and restore autonomy to the person as soon as it is safe to do so.

During the course of the restrictive physical interventions staff should remain mindful of issues relating to: human rights, dignity, respect, gender, race and ethnicity.

Staff should act without malice at all times.

NB: During all restrictive physical interventions it is imperative that the person being physically held is constantly monitored for signs of physical distress, this is particularly important when the person is held in the prone position i.e. (face down) the restraining staff should monitor breathing, skin colour, pulse rate etc., if possible a pulse oximeter should be applied this will monitor pulse rate and blood oxygen levels, an explanation of what is being done and why should be given to the service user (nursing staff need to be aware that pulse oximetry is only used to assist in good nursing observations and care). If the individual becomes physically distressed i.e. difficulty in breathing, it is essential that staff respond promptly with appropriate first aid/CPR. Where there are concerns about the patient's physical wellbeing following a period of restrictive holding, staff, with the patient's consent should utilise a pulse oximeter to assess oxygen saturation levels.

The physical/physiological profile of the individual may offer risk indicators e.g.

- History of respiratory/cardiac problems
- Obesity
- Under the influence of alcohol/drugs
- Recently eaten a large meal
- Pregnancy

The use of physical MAPA® skills should only be seen as a small part of the management strategy. Staff will bring their clinical experience, professionalism, knowledge and confidence to each situation. A confident approach is likely to aid the de-escalation process.

If the restrictive physical holding continues for more than 10 minutes, staff should consider the use of rapid tranquilisation and/or seclusion (NICE, 2015). In rare situations where physical restraint lasts beyond **30 Minutes**, then the Quality Improvement Lead Nurse/ Site Manager must be informed and asked to review the situation. They can then make a decision as to the appropriateness of continuing the physical management of the aggression.

*In those services where there is an out of hours on call system, the on call manager must be informed who will then carry out the review*

The RMO/Doctor or nominated deputy (whichever is appropriate) following the commencement of restrictive physical holding, should see the service user as soon as is reasonably practicable and ensure the application of appropriate medical / psychological care.

The Organisation will always support staff whose practice is compatible with this policy. *“Any reasonable action taken by an employee in good faith during a violent incident, providing appropriate professional judgments and personal behaviour were in accordance with trust and directorate policies and the law will receive the understanding, sympathy and support of the trust”.* (Violence and Aggression Policy 5.19).

### 3.12 Action to be taken after physical intervention

Following an event of restrictive physical interventions procedural responsibilities continue at an individual, service and organisational level. This responsibility falls broadly under three areas; reporting, support and learning.

#### 3.12.1 Reporting:

- All incidents involving staff regardless of setting (centre, ward, community) should be reported.
- A full account of the incident must be recorded in the person's Electronic patient record and the relevant incident forms completed - Safeguard Incident Report Form and forwarded to the Patient & Organisational Safety Dept., Weekly Incident Monitoring Group, and notification should go to the appropriate Service Line Manager/Service Head/Line Manager/Senior Nurse/Quality Improvement Lead Nurse.

- Immediately following the incident, the appropriate manager or designated senior staff member will assess the situation to identify action(s) required to reduce or prevent a recurrence of the incident and to ensure the safety of all individuals. This may include increased observation and / or discussion of the incident with the patient / client.
- The Line/Appropriate Manager must be informed of any aggressive incident as soon as is reasonably practicable, who then in conjunction with the appropriate manager and a senior staff member will review the incident, and assess the need for any additional staffing immediately and in the future.
- In the event of a staff member getting injured during the physical management of aggression, appropriate medical treatment should be sought as soon as is reasonably practicable.
- In the event of an aggressive person being injured during the management of their aggression and / or from an accident a decision has to be made regarding informing the patient's family. With minor injuries (cuts, bruises) these will usually be reported to relatives as soon as practicable but may with agreement of the patient and family be reported at next visit or within agreed time frames. With more serious injuries (fractures, hospitalisation) a senior staff member must inform the relatives as soon as is reasonably practicable and to do so by the most appropriate means.
- Any individual who sustains an injury as a result of violence has Rights under the Criminal Injuries Act to seek compensation (all necessary reporting mechanisms should be utilised to lend support to any subsequent claims). Individuals do not need permission from anyone else to bring a claim against another person who has assaulted them. Advice and assistance is available from the Local Security Management Specialist, Patient and Organisational Safety Department.

### 3.12.2 **Post** Incident Support:

Following an incident the Trust recognises the need for support for the service user and for staff. Ideally support should be offered to everyone involved in or by default observed the incident. Debrief should take place as soon as is practically possible which may need to be followed by further support as required.

The patient should always be offered the opportunity to be involved in a post incident debrief. This should occur as soon as they have recovered their composure (NICE, 2017). Although the latest NICE Quality Standards (2017) state that a doctor should be involved in patient de-brief, the Trust position is that this will initially be facilitated by a nurse but may involve a doctor if deemed to be necessary or requested by the patient. Longer term, more intensive support may be required in some scenarios. Further advice on staff support can be obtained from the Staff Counselling Service or by consulting Trust Policy.

### 3.12.3 Post Incident Learning:

The Trust recognises the importance of incident analysis and its role in restraint reduction. This requires clinical teams and the wider organisation to look objectively at an incident with those involved and where appropriate the service user, to identify what worked well and what can be learned in order to influence and shape individual restraint reduction plans. Risk assessments should be reviewed and / or conducted, as well as Incident Investigation Forms. The multidisciplinary team should meet to discuss the incident and discuss the future management of the individual(s) involved in the aggressive incident, involving the service user where possible.

The staff team are responsible within their available resources to take all reasonable actions necessary to reduce the chance of a re-occurrence of the incident. They should consider consulting with appropriate others for assistance in this task.

Senior Manager's and Department Heads have a responsibility if the incident is seen as actually or potentially serious to forward copies of all reports / forms to the appropriate Associate Director / Professional Head/Clinical Lead, and the Patient & Organisational Safety Department. Further information can be accessed via Trust Policy

## 4 The use of restrictive holding for invasive/investigative treatment purposes

The use of restrictive physical interventions within services for people with learning disabilities and mental ill health is widely accepted as a possible appropriate response to incidents of severe challenging behaviour, aggression and/or violence.

However the current national guidance presents difficulties in interpretation for clinicians developing a professional framework which supports the use of physical interventions for the purpose of invasive, investigative treatment or the delivery of personal care.

Consequently, there is a danger that some service users may not receive appropriate, safe or effective medical treatment because their behaviour presents a risk to themselves, to the medical practitioner or accompanying staff.

This section of the policy has therefore been developed to help clinicians make appropriate decisions relating to the assessment and treatment outcomes for those service users who may require some level of physical support or intervention as part of their treatment plan.

#### 4.1 Definition

The DH and DFES Joint Guidance broadly defines physical intervention as the *“use of force to control a person’s behaviour”*, and the Mental Capacity Act, 2005, section 6(4) states that someone is using restraint if they *“use force - or threaten to use force - to make someone do something that they are resisting, or restrict another person’s freedom of movement, whether they are resisting or not”*.

#### 4.2 Framework

A medical doctor involved in the care of an individual may request for investigative/treatment purposes an invasive procedure to be performed. For example, the use of venepuncture for the purpose of obtaining a sample of blood. Provision of essential care such as personal hygiene might also be an issue.

#### 4.3 Where a service user explicitly consents

A service user with capacity may require physical assistance or support, or may behave in a manner that presents risk to self or others. In such circumstances, clinical holding may be appropriate to support the service user during the course of the treatment. The procedure must have been discussed with the service user prior to it taking place and the patient must have provided informed consent. In such scenarios the patient can withdraw consent at any time and any clinical holding should be immediately terminated.

#### 4.4 Where a service user lacks capacity to consent

Where a person does not have capacity to consent, and it is the view of the treating doctor that it is in the best interests of the individual to undergo the relevant procedure, it may become necessary for staff to consider the use of some form of physical holding in order that the procedure can be undertaken. The Mental Capacity Act, 2005 (Policy MHA16) authorises staff to provide care and treatment to service users who lack capacity as long as it is in their best interests. Where restraint is considered under the Mental Capacity Act it must also be a proportionate response to the likelihood of the service user suffering harm and the seriousness of that harm. The use of holding techniques can only take place once all other efforts at gaining cooperation have been explored and exhausted and should represent the least restrictive and detrimental course of action. In all instances the decision to use an invasive procedure should be based on a “best interests” decision involving the MDT and (where possible) family/carers.

The Mental Capacity Assessment, Best Interests Decision and risk assessment around the use of an invasive procedure must be documented in the individual's clinical notes.

Where there is no one to consult (other than paid staff) as part of the process of establishing Best Interests, an Independent Mental Capacity Advocate (IMCA) must be consulted where the intervention is considered to be serious medical treatment (Chapter 10 MCA Code of Practice provides a definition of serious medical treatment as it can include relatively minor treatment) Referrals should be made to the IMCA service at Assist.

#### 4.54.5

Where service users are detained under the Mental Health Act and who will not or are unable to consent to venepuncture as part of their treatment where such intervention falls within the definition of '*clinical treatment*' or treatment '*ancillary or concurrent with the core treatment that the patient is receiving*' as defined in Section 145 Mental Health Act 1983 guidance should be sought via the Mental Health Act 1983, Code of Practice, 2015.

Where service users are not subject to the Mental Health Act, but intervention falls within the Section 145 definition of Medical Treatment, the need for restraint may constitute that the patient is objecting to treatment and as such consideration should be given to whether formal detention under the Mental Health Act is required.

Where the intervention does not fall within the Section 145 definition of medical treatment, or the service user does not meet the criteria for detention under the Mental Health Act for other reasons, but the use of restraint is frequent, cumulative and ongoing, it may indicate that the service user is being deprived of their liberty and may need authorisation under the Deprivation of Liberty Safeguards (See Policy MHA 18 DOLS) An example of this may be where the intervention is for an physical disorder that is unrelated to the service users mental disorder.

## 4.6 Duty of Care

It is the responsibility of all clinicians to avoid acts or omissions that are likely to cause harm to another person. The use of clinical holding as part of a service user's treatment plan is subject to this responsibility, as it could be argued that a failure to provide individuals with the necessary support, care or treatment they require may constitute neglect or an omission of care.

It is the responsibility of all registered practitioners to safeguard the interests and wellbeing of all patients and clients in line with their individual professional codes of practice.

Consent must be obtained for any invasive procedure and an assessment of capacity to consent may be required and regularly reviewed with an individual

where the multidisciplinary team feel that the individual has intellectual impairment. (North Staffordshire Combined Healthcare Policy and Procedure for Advance Statements and Advance Decisions to Refuse Treatment - Policy 1.55)

Information will be shared with the individual at all times. There may be a requirement to utilise alternative methods of communication with individuals where there are communication difficulties and or limited intellectual ability.

The decision made by the multidisciplinary team, in conjunction with family members/carers and/or advocates must be written in the person's clinical and nursing notes. For each instance of clinical holding an Incident Notification Form must be completed under the incident type "Clinical Incident" and cause group "Treatment/Procedure" and cause "Use of MAPA® for Clinical Intervention" with a written description of the reasons for using clinical holding, listing the names of the staff involved

The decision to use clinical holding is considered to be a 'once only' decision. For any subsequent instance of clinical holding a further decision must be made by the multi-disciplinary team for its use unless deemed inappropriate by that team.

#### 4.7 Best Practice

The clinical holding intervention to support invasive or investigative procedures will be planned and based on risk assessment. There must be adequate numbers of staff available for the clinical holding intervention to be safely carried out. All staff involved in clinical holding must be MAPA® trained and be live on the current register. If there is uncertainty regarding either the use of clinical holding or the appropriate technique to be used, then advice should be sought from a MAPA® trainer. This will be via the MAPA® Training Department at Harplands Hospital, telephone no 01782 441600 ext. 1389 or 1354. Out of hours, the normal on call arrangements apply, although wherever possible proactive plans should be made within normal working hours if it is apparent that an issue may arise out of hours.

#### 5. Monitoring of Restrictive Practice within the Trust

The Weekly Incident Review group should review all reported incidents. This multidisciplinary group, which represents all service lines, meets on a weekly basis. The purpose of this group is to identify and evaluate incidents and if deemed necessary investigate them. Additionally they may offer support and assistance to individuals affected by the incident and identify priority-training needs.

A review of all incident reports involving the use of restraint is also undertaken on a weekly basis by the Reducing Restrictive Practices team. Particular attention is focussed on the length of time of physical restraint, restraint

position (particularly around the use of prone restraint), and ensuring that staff adhere to policy, training and national guidelines.

## 6. MAPA Live Register

In the interests of safety and good clinical practice staff who have undertaken MAPA® training will require updating, and that attending such dates is each individuals own responsibility. The recommendation is that staff should attend at least one update per year. If a member of staff goes beyond 18 months without attending an update the MAPA® training team will decide on an individual basis whether the staff member requires extra training. This may include having to re-attend a 5 day MAPA® Foundation Course. Those that do not attend within the specified time will not be live on the register.

It is also the responsibility of Ward/Service Managers and Associate directors of each directorate to ensure so far as is reasonably practicable that the staff they have responsibility for are trained appropriately for the area in which they work.

Staff who have attended MAPA® training and whose name appears on the live Register (Learning management system located via intranet) should be able to offer advice and guidance to those staff who have not been trained or to those whose names are no longer on the register during an incident where restrictive physical interventions are required (but only qualified / currently registered trainers will teach MAPA® skills).

## 7. Duties and responsibilities

- 7.1 The Trust Chief Executive through the Chief Operating Officer, Medical Director and Director of Nursing has overall responsibility to ensure that processes are in place to:
  - Ensure that staff are aware of this policy and adhere to its requirements.
  - Ensure that appropriate resources exist to meet the requirements of this policy.
- 7.2 The Associate director of each Directorate are responsible for ensuring that relevant Directorate policies and procedures are in place and their effectiveness is monitored as part of the Directorate Governance Plan. They are also responsible for ensuring that all operational managers in their areas are aware of this policy, understand its requirements and support its implementation with relevant staff.
- 7.3 Clinical Team Managers (Ward Managers, Community Team Managers) are responsible for implementing the policy with their immediate staff and



ensuring that they adhere to the requirements of the relevant policies and procedures.

- 7.4 North Staffordshire Combined Healthcare NHS Trust (NSCHT) adopts the policy that all staff regardless of grade or discipline have a responsibility for the safety and well-being of service users, visitors and each other. With this in mind it is the duty of each and every member of staff to offer all reasonable assistance where and when necessary in line with their experience and training. This does not mean that all staff must become directly involved in restrictive physical interventions, but that they may be able to offer all other reasonable assistance in meeting other needs of the situation.

## 8 References

Department of Health (2015) Mental Health Act, 1983. Code of Practice.

Department of Health (2007): Mental Capacity Act 2005, Code of Practice, HMSO, LONDON

DFES/DoH (2002): The use of restrictive physical interventions for staff working with children and adults who display extreme behaviour in association with learning disability and/or autistic spectrum disorder, HMSO, LONDON.

NICE Quality Standard (2017): Violent and aggressive behaviours in people with mental health problems.

NICE (2015). Violence and aggression: short term management in mental health, health and community settings.

Ridley J & Leitch S (2019). Restraint Reduction Network ( RRN ) Training Standards First edition Ethical training standards to protect human rights and minimise restrictive practices.



**Document level:** Trust

**Code:** 5.13

**Issue number:** 2

# Critical Incident Stress Management (CISM) Policy

Lead executive	Chief Nursing Officer
Authors details	Head of Patient and Organisational Safety

Type of document	Trust Policy
Target audience	All Trust Staff
Document purpose	To advise and inform all staff of the support available to all staff affected by critical incidents at work. To give information on training and to provide appropriate support signposting mechanisms

Approving meeting	Quality Committee Trust Board	Meeting date	15th January 2020 16th January 2020
Implementation date	16 <sup>th</sup> January 2020	Review date	31 <sup>st</sup> May 2024

Trust documents to be read in conjunction with	
<a href="#">5.30</a>	Stress at Work Policy
<a href="#">5.19</a>	Violence & Aggression Policy
<a href="#">5.32</a>	Serious Incident Policy
<a href="#">5.01</a>	Incident Reporting Policy
<a href="#">4.18b</a>	Risk Management Policy
<a href="#">3.11</a>	Supporting Staff at Work Policy
<a href="#">3.29</a>	Induction Policy

Document change history		Version	Date
What is different?	Only minor changes to wording. Equality and Diversity Section Updated		
Appendices / electronic forms			
What is the impact of change?	None		

Training requirements	Training is available at two levels. 3 Day Critical Incident Stress Management for high level staff in areas where support is likely to be more likely Half Day CISM The Basics Training Training needs for staff are identified by appropriate manager
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Document consultation	
Directorates	
Corporate services	
External agencies	

Financial resource implications	None
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External references
1. Health and Safety at Work Act 1974 2. The management of Health and Safety at Work Regulations 1999 3. NICE guidelines supporting staff

Monitoring compliance with the processes outlined within this document	Compliance to this policy will be monitored through production of reports of activity, training records, activity to be provided to relevant groups and committees.
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Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favourable / More favourable / Mixed impact
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– <b>Age</b> (e.g. consider impact on younger people/ older people)	No	
– <b>Disability</b> (remember to consider physical, mental and sensory impairments)	No	
– <b>Sex/Gender</b> (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– <b>Gender identity and gender reassignment</b> (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– <b>Race / ethnicity / ethnic communities / cultural groups</b> (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– <b>Pregnancy and maternity, including adoption</b> (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– <b>Sexual Orientation</b> (impact on people who identify as lesbian, gay or bi – whether stated as ‘out’ or not)	No	
– <b>Marriage and/or Civil Partnership</b> (including heterosexual and same sex marriage)	No	
– <b>Religion and/or Belief</b> (includes those with religion and /or belief and those with none)	No	

<p>– <b>Other equality groups?</b> (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)</p>		
<p>If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.</p>		
<p>Enter details here if applicable</p>		
<p>If you have identified potential negative impact:</p> <ul style="list-style-type: none"> <li>- Can this impact be avoided?</li> <li>- What alternatives are there to achieving the document without the impact?</li> </ul> <p>Can the impact be reduced by taking different action?</p>		
<p>Enter details here if applicable</p>		
<p>Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?</p>	<p>No</p>	
<p>If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason</p>	<p>Yes / No</p>	
<p>Enter details here if applicable</p>		
<p>Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact.</p> <p>For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at <a href="mailto:Diversity@northstaffs.nhs.uk">Diversity@northstaffs.nhs.uk</a></p>		
<p>Was a full impact assessment required?</p>	<p>No</p>	
<p>What is the level of impact?</p>	<p>Low</p>	

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## 1 INTRODUCTION

**1.1** North Staffordshire Combined Healthcare Trust (the Trust) is committed to protecting the health, safety and well-being of its employees. The Trust recognises and supports staff who, in the course of their work may be subjected to actual or threatened violence and aggression or any other untoward incident that may cause trauma, distress or raise the normal stress response in individuals.

**1.2** The aim of the policy is:

- To give clear definition of a critical incident and how the Trust supports staff following such incidents
- Provide a framework to enable managers and staff to support themselves and their colleagues
- Enable the Trust to identify, control, manage and monitor critical incidents in the workplace
- Ensure legal compliance

## 2 PURPOSE

**2.1** The aim of the guidance in this policy is to lessen the impact of critical incidents on staff, and reduce the likelihood of long-term detriment by means of a consistent and effective support mechanism.

**2.2** Any situation or event at work that may be distressing for the staff members involved.

**2.3** The Trust recognises that it has a duty under the Health and Safety at Work Act 1974 to take all reasonably practicable measures to protect the health, safety and welfare of employees at work. This includes taking steps to ensure that staff do not suffer, where ever possible, a critical incident in the workplace, (see The Management of Violence & Aggression Policy, Incident Reporting Policy and Risk Management Policy).

The Management of Health and Safety at Work Regulations (1999) require employers to assess health and safety risks, and to introduce prevention and control measures based on those risk assessments. Critical Incidents are seen as being a health and safety risk, and in accordance with the Regulations, the Trust will give priority to reducing incidences in the work place and providing staff with the appropriate support who have been involved in a critical incident.

**2.4** The main objectives of the Critical Incident Stress Management Policy (CISM) are to:

- define a critical incident
- define support available for staff who have been involved in incidents and how to access support available
- define roles and responsibilities for all employees in relation to CISM
- ensure staff receive appropriate awareness and/or training on CISM
- work in partnership with the Trust Patient and Organisational Safety Team to ensure that incidents are reported and responded to in a timely manner.

## 3 SCOPE

- This Policy applies to all areas and staff employed by the Trust equally and includes (but not an exhaustive list):
- Volunteers;

- Agency staff;
- External secondees working temporarily with the Trust;
- Locum staff;
- Executive and Non-Executive Directors;
- Those employed in a temporary capacity.

## **4 COMPLIANCE STATEMENTS**

### **4.1 Equality and Inclusion**

We are a diverse and inclusive Trust and there is no place in our organisation for discrimination, harassment or personal abuse.

The procedure applies to all employees of the Trust. The procedure should be applied equally to all employees ensuring that there is no discrimination, including (but not limited to) discrimination on the grounds of age, disability, race, ethnicity, gender or gender identity, sexual orientation, religion, belief, offending background, trade union activities, family circumstances or domestic/care arrangements.

## **5 DEFINITIONS**

### **5.1 Definition of a Critical Incident**

A critical incident is a serious violent, aggressive or traumatic incident in which both of the following were present:

- (i) the person(s) experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others.
- (ii) The person(s) response involved intense fear, helplessness or horror

Events that can trigger the need for support include, but are not limited to:

- Being involved in a critical clinical or non-clinical incident, near miss, complaint or claim, especially one involving serious harm to a patient, or patient suicide on a Trust site
- Being involved with a major incident involving a large number of casualties and/or deaths, especially incidents involving children
- An attack upon a member of staff by a patient
- Being witness to an act of serious self-harm or suicide
- Being witness to an act of violence at work
- Being threatened and made to feel vulnerable by a patient, a patient's relative(s) or other persons within the workplace.
- The sudden death or serious injury of a work colleague.
- The sudden unexpected death of a patient or work colleague.
- The sudden death of a patient who has received long-term care within the Trust
- Providing witness statements and/or information for Trust investigations into an incident, near miss, complaint or claim
- Appearing as a witness at internal Trust investigations
- Appearing as a witness at professional/registering bodies' investigations and/or hearings, e.g. The General Medical Council, the Nursing and Midwifery Council and the Health Professions Council
- Appearing as a witness or attending the Coroner's Court, High Court, County Court or Employment Tribunal
- Being interviewed by the Counter Fraud Service and/or policy for a work-related matter



- Being interviewed by the police for a work-related matter
- Face-to-face meeting with a complainant or claimant

## **5.2 Definition of Critical Incident Stress Management (CISM)**

Critical incident stress management (CISM) is an adaptive, short-term psychological helping-process that focuses solely on an immediate and identifiable problem. It can include pre-incident preparedness to acute crisis management to post-crisis follow-up. The framework of support available include:

## **5.3 Critical Incident Stress Debriefing (CISD)**

Critical Incident Stress Debriefing is a specific, 7 phase, group supportive crisis intervention process. It is one option of support under the umbrella of Critical Incident Stress Management. The CISD process does not constitute any form of psychotherapy or counselling, it is simply a supportive, crisis-focused discussion of events (frequently called critical incident or serious incidents) to those involved. It aims to reduce the distress and reactions that staff are having or have experienced and offers “normalisation” processes, information and signposting support.

CISD support is usually only conducted after serious events, that is, it involves death, serious injury or the perceived potential for them. CISD support is conducted by a professional specifically trained in this area. Attendance and participation in such a session is voluntary and should never be imposed upon staff.

The ideal time to conduct a CISD support is between 72 hours and 14 days following an incident, although the timing is less important than the CISD support actually taking place. CISD support should only involve those team members who were involved in the actual incident and are willing to attend. CISD support can take between one and three hours dependent upon the incident and number of staff requiring support.

CISD purpose is NOT to critique the incident and is outside of any other or subsequent organisation processes ie investigation. The contents of a CISD support are confidential; notes or records are made for purely statistical purposes.

CISD support has three benefits:

1. To mitigate the impact of a critical incident on the staff involved and to educate staff on the impact of trauma and the psychological and physiological effects
2. To accelerate NORMAL recovery in normal people who are experiencing the NORMAL signs, symptoms and reactions to an ABNORMAL event
3. The process can be adapted to different situations (for example, to provide group support to witnesses following a serious disciplinary hearing, work based change etc) and can help to restore group cohesion, performance and working relationships

## **5.4 Defusing**

Defusing is a short intervention which can be undertaken by the manager of the team or other staff member not directly involved in the incident and who has attended the relevant training. It is a form of immediate support and can be used to establish whether there is a need for a full CISD support to be arranged or whether the support can be contained within the team.

# **6 ROLES AND RESPONSIBILITIES**

## **6.1 Chief Executive and Trust Board**

The Chief Executive has overall accountability for Health, Safety and Welfare for all persons, as identified in section 3.1 of this policy.

The Trust Board acknowledges its responsibility in terms of providing and maintaining a healthy and safe working environment for all its employees. It is responsible for monitoring the policy and procedure and any concerns raised as a result The Trust Board will promote a positive culture across the Trust through policy, training, information, consultation and provision of appropriate support services for staff and managers. The Trust Board will provide and maintain appropriate resources to implement the policy.

## **6.2 Executive Lead**

The Executive Lead for this policy is the Director of Leadership and Workforce. They are responsible for ensuring that there is an appropriate policy lead, the policy is reviewed and updated appropriately and that compliance with this policy is monitored.

## **6.3 Policy Lead**

- Ensure review of the policy on an annual basis and meets the requirements of the policy on policies (4.30).
- Full review of the policy every three years or sooner if changes are required
- To ensure that the policy is produced in the agreed trust format using the trust template
- All contributors are contacted at times of review
- Ensure that compliance is being met against this policy

## **6.4 Managers**

Line Managers have a responsibility to:

- Consider the impact of critical incidents seriously and provide and provide immediate and ongoing support to staff in line with the CISM Policy.
- To understand the importance of confidentiality if they were involved in the incident and were attending the Critical Incident Stress Management session themselves. The role of a Critical Incident Stress Management session is to support staff and help them to understand the impact an incident may have upon them and to educate and normalise any symptoms they may be experiencing. It is not used to assess possible errors or lessons to be learned as this would be the role of an operational debrief and inappropriate in this forum. The only exceptions to a break of confidentiality should be in extreme circumstances such as serious professional misconduct or where other staff, patients, clients, relatives etc could have been put at risk of harm resulting in failure in duty of care.
- Understand the various levels of CISM support available to all staff and to ensure that support is provided.
- To ensure that appropriate consideration has been given to the training needs of the department regarding CISM training and wherever possible ensure that staff attend either 3 Day CISM training or half day CISM Essentials training ( see section 8.1 for training selection criteria) Be vigilant for prolonged distress or uncharacteristic behaviour in staff following a Critical Incident, and ensure that remedial action is taken (See Appendix 2)
- Ensure a supply of “Coping With a Personal Crisis” leaflets as well as the general “Staff Support and Counselling Services” leaflets are available. (These can be obtained from the Staff Support and Counselling Services Department and also available on the Trusts Intranet Site).
- To raise awareness of this policy and the CISM Team

Senior Managers i.e. Directorate heads, General Service Managers are responsible for:

- Taking a lead in ensuring that staff support a priority in the aftermath of a serious critical incident

- Ensuring sufficient staffing/resources to make CISM support operationally possible
- Ensuring appropriately identified staff receive training in Critical Incident Stress Management Awareness enabling the appropriate support to be available either directly from team members, via the Critical Incident Stress Management Team or the Staff Support and Counselling Service.

## **6.5 Staff Support and Counselling Service**

- To provide awareness and support to managers and staff in developing a greater awareness of the impact a critical incident may have including trauma and potential Post Traumatic Stress Disorder (PTSD) and support available.
- To provide supportive sessions to staff to help staff process the accumulation effects of working in areas of high stress as a normal aspect of their role – these sessions will be provided as and when required and on request from staff but do not have to be in response to any one specific incident
- To provide training to staff as identified by Heads of Department, Team Leaders and Critical Incident Stress Management Team as follows:
  - 3 Day Critical Incident Stress Management Training
  - Half Day CISM Essentials
- To offer support to individuals who have been off sick following an incident(s) designed to enable them to return to work
- Refer to specialist agencies as required
- To provide confidential counselling/support for individuals who self-refer to the Staff Support and Counselling Service
- Inform the Trust of any changes and developments in the field of CISM
- To support the Critical Incident Stress Management Team members via regular update training workshops, information and resources, support post incident, development of updated toolkit and in house promotion
- Staff Support and Counselling Service will produce Annual Usage Reports clearly identifying the number of debrief and/or support sessions provided including numbers of staff, locations and hours.

## **6.6 Critical Incident Stress Management Team**

Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful. Therefore members of the CISM Team are staff working in areas with other staff where incidents may take place and therefore offering support, empathy and understanding and providing a framework in which to operate can have great impact.

CISM Team Members:

- Are identified and nominated for the 3 Day Training Programme via their manager, heads of department or service
- Will attend 3 Day Critical Incident Stress Management Training
- Will attend annual update workshops
- Appear on the CISM Team Register (managed and maintained by the Staff

#### Support and Counselling Service

- Promote and support the CISM Policy
- Provide appropriate support in the form of defusing and/or CISD
- Will ensure that activity is recorded on the CISM Register of Activity Database maintained and managed by the Staff Support and Counselling Service

### **6.7 Staff**

- As individuals we are all responsible for our own welfare and need to be aware when our ability to perform our role effectively may be impaired. In some circumstances, following a critical incident, some staff may be affected and therefore should seek appropriate support
- Raise issues of concern with your Safety Representative, Line Manager, Human Resources, Occupational Health or Staff Support and Counselling Services
- Consider opportunities for counselling and other forms of support when recommended.
- Attend appropriate training as identified by the line manager.
- Accept responsibility to willingly work with managers/other departments.
- Attend organised CISM support sessions ie defusing sessions or Critical Incident Stress Debrief sessions when offered

### **6.8 Health, Safety and Well-Being Group**

- The Health, Safety and Well-Being Group (HSW-B) will perform a pivotal role in ensuring that this policy is implemented.
- The HSW-B Group will oversee monitoring of the efficacy of the policy and other measures to reduce stress and promote workplace health and safety.
- The HSW-B Group will notify the Staff Support & Counselling Service whenever possible of any incidents that are reported that they recognise would benefit from the support of the Service.

## **7 FRAMEWORK**

### **7.1 Providing Support**

The manager/person in charge of the area at the time is responsible for ensuring that the environment returns to normal functioning, with minimum disruption to staff and patient care as soon as possible and to report the incident in line with Trust procedures and policies.

Directorate Heads and Managers, however, also have a responsibility for the welfare of staff involved in critical incidents, and should not underestimate the value of making personal contact at this time to express their concern for staff. This can prevent the later onset of morale problems.

Managers should reinforce the use of Defusing and CISM support and assist in enabling this process by making it operationally possible, that is, through the provision of additional short term cover for the period of the Defusing or CISM support. Managers/team leaders/persons in charge should also be mindful in offering support to individuals

(Appendix Guidance for Managers Attached).

## 7.2 Critical Incident Stress Management - Support Options

Type of Support	Description	Who can offer this support
<b>Defusing Process</b>  This can be provided to individuals and groups/teams	<p>The purpose of the defusing process is to offer reassurance and support and to check out staff are safe and unhurt. The emphasis is to normalise, educate and inform on the possible Effects that the incident could have upon them in order to reduce the potential for the development of prolonged or extreme reactions to the incident. It can also be used to establish if a CISM support should be arranged.</p> <p>Defusing should take place immediately after the area has been made safe, or at the latest at the end of the shift, preferably before any staff members involved go home. Depending upon the size of the team and the seriousness of the incident, the time taken for the Defusing is approximately a half an hour.</p>	<p>Staff who have attended</p> <p>Critical Incident Stress Management Half Day Essentials Workshop</p> <p>Critical Incident Stress Management Team Member</p> <p>Staff Support &amp; Counselling Service telephone</p> <p>0300 124 0104</p>
<b>Critical Incident Stress Debrief</b>  <i>Only to be provided for groups in line with NICE Guidelines in relation to post traumatic Stress (March 2005), and only for those who were present or witnessed events.</i>  CISD sessions should <u>always</u> be considered for serious incidents, involving death, injury or high levels of emotion or anxiety.	<p>Critical Incident Stress Debriefing (CISD) is a specific, 7-phase, group, supportive intervention process. The CISD process does not constitute any form of psychotherapy or counselling. It aims at reduction of distress and restoration of group cohesion and relationships. In general all those present during the critical incident should be offered to be included in the CISD however it is <u>not obligatory</u> to attend if a member of staff feels unable to for whatever reason.</p> <p>Team members who were away or not on duty during the incident also need to be considered for a <u>separate</u> support meeting as they too can be affected by the news of such events.</p> <p>Absent members of staff often feel guilty or responsible in some way, particularly if for example, someone who was hurt had exchanged a shift with a colleague.</p>	<p>Critical Incident Stress Management Team Member</p> <p>Staff Support &amp; Counselling Service telephone</p> <p>0300 124 0104</p>

## 8 IMPLEMENTATION

### 8.1 Training

Appropriate awareness and training will be available to staff, records of which will be recorded and monitored via the LMS system within the Trust as well as reported via the Staff Support & Counselling Service Annual Report. This training aims to raise awareness of critical or serious incidents in the workplace and how to respond effectively to such events and the implications on the

Trust and awareness on how to support staff in the workplace. It aims to provide information and understanding on the psychological and physical effects of trauma and to provide the skills to assess when it is appropriate to request formal critical incident stress management support for staff affected by serious or untoward incidents in the workplace.

Training also gives staff effective skills required to support other staff following serious or untoward incidents in the workplace where staff may be left feeling shocked or distressed by such events. Managers and supervisory staff having completed the training will then be equipped with the skills required to support staff but will also be able to identify additional training staff needs in their own areas and nominate appropriate staff to attend this course.

## 8.2 Critical Incident Stress Management - Training Options

The following courses will be made available to staff via an annual programme of training:

Training Available	Course Contents	Target Group
<p>Critical Incident Stress Management – The Basics Half Day Workshop</p> <p>Available regularly across the year in addition teams can request Staff Counselling Service to deliver short sessions to raise awareness within their own areas of work</p>	<p>The aim of this day workshop is to raise awareness of critical or serious incidents in the workplace and how to respond effectively in supporting staff in such events. It will equip delegates with the knowledge to:</p> <ul style="list-style-type: none"> <li>• Recognise what constitutes a critical incident</li> <li>• To identify the need for a full CISD and referral process to gain support</li> <li>• To understand the need to support staff following such incidents</li> <li>• An introduction to a Defusing Skills</li> <li>• An introduction into Psychological First Aid</li> <li>• The importance of peer support</li> </ul>	<p><b>Recommended for any staff working in areas where incidents are likely to be experienced.</b></p>
<p>Critical Incident Stress Management 3 Day Training</p>	<p>This is an intense programme designed to equip staff with the skills to deliver defusing skills and to conduct or participate in CISD events.</p>	<p><b>Heads of Department are responsible for ensuring that teams in key areas nominate appropriate staff to attend.</b></p>

## 9 MONITORING

This policy will be reviewed every 3 years or earlier in light of new national guidance/other significant changes.

Compliance with this policy will be monitored through the mechanisms detailed in the following table.

Where compliance is deemed to be insufficient and the assurance provided is limited an action plan will be developed to address the gaps; progress against the action plan will be monitored at the specified group/committee.



Minimum requirement to be monitored	Process / Method	Responsible individual/ group / committee	Frequency of monitoring	Responsible individual / group / committee for review of results	Responsible group / committee for monitoring action plan
Process for identifying the number of incidents within the Trust	Review of incident reporting numbers , category, location and severity summarised in minuted form and held on a database	Patient and Organisational Safety Team	Weekly Incident Review meeting	Membership of the Weekly Incident Review Group in line with Terms of Reference	Health, Safety and Well-Being Group
Process for identifying and escalating trends from weekly review of incident reports	Minutes of Weekly Incident Review Group held on database and summarised in quarterly Integrated Quality Report	Patient and Organisational Safety Team	Weekly Meeting	Health, Safety and Well-Being Group	Quality and Governance Committee
Process for identifying the number of support (CISMs) provided	Staff Support & Counselling Service Annual Usage Report  Bi monthly statistical report	Staff Support and Counselling Service  Staff Support and Counselling Service/Organisational Safety Group	Annually  Bi-monthly	Patient and Organisational Safety Team	Directorate Boards
How will staff know about the support available	At Induction  MAPA Training  Health & Safety Training  Trust's intranet website including access to the CISM Policy and information on the Staff Support & Counselling Service  Post incident information to be provided by Line Manager	Training Department  Patient and Organisational Safety Department  Staff Support and Counselling Service  Line Managers	Annually  Annually  Annually	Directorate Boards	Directorate Boards



## 10 REFERENCES

Health & Safety Executive (HSE) (1974) Health & Safety at Work Act. *HSE website*.  
HSE. Available at: [www.hse.gov.uk](http://www.hse.gov.uk)

Health and Safety Executive (HSE). 'Workplace Trauma & its Management' *HSE website*. HSE. Available at: [www.hse.gov.uk](http://www.hse.gov.uk)

NICE Guidelines. 'Early Intervention for PTSD in Adults' 2005 NICE website. Available at: [www.nice.org.uk](http://www.nice.org.uk)

## 11 ASSOCIATED DOCUMENTS

Stress at Work Policy 5.30

Violence & Aggression Policy 5.19

Serious Incident Policy 5.32

Incident Reporting Policy 5.01

Risk Management 4.18b

Supporting Staff at Work Policy 3.11

Induction Policy 3.29

## Appendix 1

### REACTIONS IN THE EARLY WEEKS AND MONTHS

**Shock.** Initially, you may feel very little or nothing at you. You may have difficulty understanding what has happened. Everything may seem unreal and you may have a sense of disbelief. Some people describe this as “in a dream”, or feel as if things were happening to someone else.

**Thoughts about what happened.** Painful pictures of what happened may push their way into your mind. You may find yourself going over things again and again, or even reliving the feelings you had at the time of the event.

**Anger.** Feelings of anger are common. This event may seem so senseless and you may feel picked on “why me?” You may feel badly treated by ‘the management’. You may look to blame someone. Your anger may be expressed at everyone and anyone.

**Helplessness.** You may feel totally out of control of your feelings and of what happens to you. This may make you feel anxious about the state of your mind. In fact any changes you have are the normal reaction to shock and trauma.

**Fear.** When things go badly wrong we become aware of how easily such things can happen and how unsafe we really are. The world around us can now seem much more dangerous. You may feel frightened that the same thing could happen again, and fear for the safety of those you love. You may become over-protective towards your children or scared to leave your home.

**Shame and Guilt.** No matter what actually happened or what we did, it is often the case the people feel guilty. You may wonder if you should have done more for others or why you should be alive when others are not. You may find yourself saying things like “if only”, “why not me”.

**Loss.** For any reason the sense of loss may feel overwhelming. Some describe waves of physical sensations which can come and go at any time. Deep feelings of sadness, anguish, grief and hopelessness may follow.

**How your body can be affected.** Some feelings are experienced in your body. This may cause you to worry that you are physically ill when in fact your body is showing signs of emotional distress which is normal.

#### The following are common:

- Tiredness
- Racing heart, palpitations and even shakes
- Feeling sick and diarrhoea
- Difficulty in breathing
- Tightness in the throat and/or chest
- Headaches, neck and backache
- Forgetful or lack of concentration

#### Sleep problems are common too:

- You may find it hard to get to sleep
- You may wake in the middle of the night
- You may find yourself waking very early

### IN THE LONGER TERM

**Loss of Interest.** You may discover that you are not as involved as you were in your usual everyday activities.

**Loss of Confidence.** You may not even notice this until someone tells you. You may feel numb, and you may be unable to experience the feelings that you used to have.

**Feeling cut off.** You may feel cut off or distant from people you love and are normally close to. This, with the irritability and anger you may have can make relationships very difficult.

It is very important to know that these feelings are understandable reactions to abnormal events. Although they are very intense and difficult to put up with, these are the ways that people can feel.

## Appendix 2

### GUIDANCE FOR MANAGERS - SUPPORTING STAFF

1. Be aware of what are natural responses to trauma/highly stressful situations and reassure staff that what they are experiencing is natural and normal and that the incident/situation itself is the abnormal event.
2. Be alert to staff who might be especially vulnerable, perhaps because of past experience or particularly close involvement with the incident or those involved in it. Talk to employees individually, and check if extra support is needed.
3. Be present and around if possible. People need to spend time talking to each other as they work, and it helps for the manager to join in casually and encourage this by example. This applies not only to those directly involved in the incident, but also those who witnessed it, had friends or colleagues involved, etc. Sharing experiences in this everyday way is helpful. Utilise the skills of any CISM Team members from the team in offering immediate support. Consider and explore with the team the need to arrange formal Critical Incident Stress Management Sessions. If individuals are affected encourage them to attend the Staff Counselling Service to gain understanding and coping methods.
4. Communicate about what is happening. Informing staff of what has happened, and of unfolding events, needs to be done sensitively and quickly. Managers may wish to convene a 'first thing every morning' meeting for staff in the aftermath of a big disaster. It is best to keep such meetings brief, factual and information sharing, practical rather than emotion focused
5. Do not necessarily send people involved in an incident home. As far as possible, immediate psychological first aid is best provided by being with and sharing experiences with work colleagues and friends, rather than removed to talk to a stranger. Wherever possible, re-establish normal working routines as soon as possible, albeit gently and flexibly, and enable people to talk about what has happened as they work, thereby avoiding any onset of denial.
6. Do not normally encourage staff to "go home for a few days to get over it". It is far better (i.e. less likely PTSD symptoms will follow) if they get on with routine and are with 'the team'. Evidence and research suggests that suggesting staff remain within their work role. All the evidence is that keeping people at work to encourage and reinforce a normal identity is far better than encouraging "victim" or "ill" identities by putting someone on sick leave. This will often require tolerance and support for a period when staff are not as productive as normal.
7. Keep in touch. In the weeks that follow an incident, GPs may sign people off work on sick leave "to get over it"; occasionally it may be important to do so. However, line managers should keep in touch by telephone, visiting and/or getting colleagues to visit. Encourage a rapid return to work, even part-time, etc. as being back at work among colleagues is normally the best possible therapy for preventing long-term complications.
8. There are special situations which tend to bring to the surface fundamental cultural issues. Different cultural and religious attitudes to death, disaster and trauma are one of the areas where this is to be expected.
9. Give Time. Many people take up to three weeks to settle down after major trauma/incidents. Counselling in the form of reassurance, explanation, and general normalisation of the response may be appropriate during this period but most people need nothing more.
10. Accept that for a period normal working may be disrupted. For some staff, workloads may need to be temporarily re-assessed, or less complex tasks assigned. However, after a period of time, it is appropriate to gently re-instate the boundaries of normal working.

## WHAT ARE THE MOST USEFUL THINGS TO DO?

- Don't expect the memories and feelings to go away quickly – they will come and go for a while.
- Trying to forget or avoiding things to do with the events may seem like a good idea at the time and can be helpful for a short while. However it may be impossible to forget – the thoughts may return however hard you try.

You need to reach a point where remembering is not so painful.

- Allow feelings to come out. Showing anger and sadness can be helpful. Keeping feelings in will be a drain on your energy.
- Try to share what has happened to you with people who are prepared to listen.

It is a mistake to think that “no-one understands”. This may be embarrassing at first, but talking does help.

However, don't get involved with too many people – find one person to talk to over time.

- If you feel able, it is better to share your experiences with someone also involved in the incident. Take the opportunity to meet with them. However, respect their wishes if they say they do not wish to talk about it.
- Take care not to drink or smoke too much. It may help for a short time and then become a problem itself later. The same may be true of sleeping tablets and tranquillisers.
- Do drive more carefully and take care at home – accidents are more common after stress.
- Attend a Critical Incident Stress Debrief if this is offered to you – seek support from the Staff Support and Counselling Service.

There is no shame in asking for help. It does not mean you are weak or useless or going mad. The help of an outsider is not an easy answer, but it may help you get things in order in your mind and enable you to use your strengths better.

If contacting the Staff Support and Counselling Service for help feels too uncomfortable for you remember friends, colleagues and your GP can provide support.

## Appendix 3

# Staff Support &



## Counselling Service

# Coping with a Personal Crisis

**INFORMATION FOR THOSE INVOLVED, WITNESSING,  
HEARING OR SUPPORTING SOMEONE FOLLOWING A  
TRAUMATIC EVENT**

**For help, information and support contact:**

**Longton  
Stoke-on-Trent  
ST3 4QX**

**Telephone: 0300-123-0995 Extension 4428**

At some time or another, everyone goes through a crisis or tragedy. You may believe you should be coping better or that you are not dealing with things as well as others. This may mean that you do not tell those around you how bad things really are because you feel ashamed of asking for help.

**This leaflet will help you to understand your reactions, what to expect and what to do.**

It is also useful to share this leaflet with family and friends who may be confused about your behaviour in the coming weeks. This will help them to understand what you are experiencing.

People have accidents at home or work. You may have been involved in a violent or threatening situation. An incident may have occurred at work that you were not prepared for and although you responded professionally at the time you are now left feeling the effects of this.

Young and old can die unexpectedly. A tragedy is nearly always something we feel could have been avoided. It is something we are unprepared to meet, something that leaves us with all sorts of confusing and unpleasant feelings.

The worst time can be when “all the fuss” has died down but the strong feelings remain. Everyone expects us to be alright – and we are not. The world goes on much the same as before while inside we may feel alone and that no-one understands.

## REACTIONS IN THE EARLY WEEKS AND MONTHS

**Shock** Initially, you may feel very little or nothing at all. You may have difficulty understanding what has happened. Everything may seem unreal and you may have a sense of disbelief. Some people describe this as “in a dream”, or feel as if things were happening to someone else.

**Thoughts about what happened** Painful pictures of what happened may push their way into your mind. You may find yourself going over things again and again, or even reliving the feelings you had at the time of the event.

**Anger** Feelings of anger are common. This event may seem so senseless and you may feel ‘why me?’ You may feel badly treated by ‘the management’. You may look to blame someone. Your anger may be expressed at everyone and anyone.

**Fear** When things go badly wrong we become aware of how easily such things can happen and how unsafe we really are. The world around us can now seem much more dangerous. You may feel frightened that the same thing could happen again, and fear for the safety of those you love. You may become over-protective towards your children or scared to leave your home.

**Shame and Guilt** No matter what actually happened or what we did, it is often the case the people feel guilty. You may wonder if you should have done more or

why you should be alive when others are not. You may find yourself saying things like “if only”, “why not me”.

**Helplessness** You may feel totally out of control of your feelings and of what happens to you. This may make you feel anxious about the state of your mind.

**Loss** For any reason the sense of loss may feel overwhelming. Some describe waves of physical sensations which can come and go at any time. Deep feelings of sadness, anguish, grief and hopelessness may follow.

**How your body can be affected** You may worry that you are physically ill when in fact your body is showing signs of emotional distress, which is normal.

### The following are common:

- ☐ Tiredness
- ☐ Racing heart, palpitations and even shakes
- ☐ Feeling sick and diarrhoea
- ☐ Difficulty in breathing
- ☐ Tightness in the throat and/or chest
- ☐ Headaches, neck and backache
- ☐ Forgetfulness or lack of concentration

### Sleep problems are common too:

- ☐ You may find it hard to get to sleep
- ☐ You may wake in the middle of the night
- ☐ You may find yourself waking very early

### IN THE LONGER TERM

**Loss of Interest:** You are not as involved as you were in your usual everyday activities.

**Loss of Confidence:** You may not even notice this until someone tells you. You may feel numb, and you may be unable to experience the feelings that you used to have.

**Feeling cut off** Feeling cut off or distant from people you love and are normally close to. This, with the irritability and anger you may have can make relationships very difficult.

It is very important to know that all of these feelings are understandable reactions to abnormal events. Although they are very intense and difficult to put up with, these are some of the ways people can feel.

### WHEN SHOULD YOU ASK FOR HELP?

You can ask for help at anytime, but especially:

- ☐ If your feelings have not begun to fall into place after a couple of months and you are still feeling tense, confused, exhausted, uncontrollably angry, anxious, or very low.
- ☐ If you continue to feel numb, or are keeping active so as to shut out your feelings.
- ☐ If you continue to have poor sleep or nightmares.
- ☐ If you have no-one to talk to and you feel the need to do so.
- ☐ If your relationships at home or work are suffering.
- ☐ If you think you are smoking or drinking too much or taking too many tablets.

## Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There <b>is no</b> specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	✓
There <b>is</b> specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Career Grade Doctor				
Training Grade Doctor				
Locum medical staff				
Inpatient Registered Nurse				
Inpatient Non-registered Nurse				
Community Registered Nurse				
Community Non Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Although there are no specifics it is highly recommended that staff in areas where support will be required to support staff following incidents is highly recommended.

Completed by

Date



**Staff Support & Counselling Service**

# **CRITICAL INCIDENT STRESS MANAGEMENT**

## **3 DAY PROGRAMME 2024**

**12/13/14TH MARCH 2024**

**14/15/16TH MAY 2024**

**17/18/19TH SEPTEMBER 2024**

**15/16/17TH OCTOBER 2024**

**Critical Incident Stress Management (or CISM). Upon completion of this 3 day Programme delegates will be equipped in how to respond effectively to incidents in the workplace and be able to offer appropriate interventions and support including Psychological First Aid, Normalisation, Defusing and Psychological Debriefing.**

**To book your place email:  
Staffsupportandcounsellingse  
vice@combined.nhs.uk**

